Welcome to our Practice

EBRIGHT & SMART FAMILY DENTISTRY

Please take a few minutes to answer the following questions so we can help you with your dental needs.

PATIENT INFORMATION

DATE___________________

NAME____DATE OF BIRTH____________________

SOC. SEC. #_________________________ DRIVER'S LIC#_________________________________

HOME PHONE______________________________CELL PHONE___________________________

HOME ADDRESS____

EMAIL ADDRESS____

EMPLOYER__________________________________ WORK PHONE________________________

BUSINESS ADDRESS______________________________________OCCUPATION____________

Spouse______________________________________ Number of children in family_______________

Names of children____

Who should we thank for referring you?____

Who should we contact in case of an emergency?____________________________________

DENTAL INSURANCE INFORMATION

SUBSCRIBER'S NAME_____________________________________ S.S.#/ID#_______________

INSURANCE NAME & ADDRESS____

EMPLOYER____GROUP #______________________

DOES THIS PLAN COVER ALL FAMILY MEMBERS?__________YES____________NO

ADDITIONAL INSURANCE INFORMATION

SUBSCRIBERS NAME____

DOB:_____________________________________S.S.#/ID#____________________________________

INSURANCE NAME & ADDRESS____

EMPLOYER____GROUP #_________________________

DOES THIS PLAN COVER ALL FAMILY MEMBERS?__________YES ______________NO

ASSIGNMENT OF BENEFITS

I AUTHORIZE PAYMENT OF DENTAL BENEFITS TO MYSELF OR THE NAMED PROVIDER FOR PROFESSIONAL SERVICES RENDERED.

Signed____ Date____________________

RELEASE OF INFORMATION

I AUTHORIZE THE RELEASE OF ANY DENTAL INFORMATION NECESSARY TO PROCESS THIS CLAIM.

Signed____Date____________________

About financial arrangements and dental insurance

We are committed to providing you with the best possible care. If you have dental insurance, we will help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our payment policy.

Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance by our staff. We accept cash, checks, MasterCard, Visa, Discover and Care Credit. **As a courtesy to our patients we will be happy to process your insurance information or help you process the information for your reimbursement, however, ALL insurance information must be provided.**

Returned checks will be subject to an additional collection fee of $20. Charges may also be made for "NO SHOW" appointments.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that:

- Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
- Our fees are generally considered to fall within the acceptable range by most companies and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50 % or 80%) of "U.C.R" which is defined as usual, customary and reasonable fees for this region. Thus, our fees are considered usual, customary and reasonable by most companies.

- Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

We must emphasize that as dental providers, our relationship is with you, not your insurance company. **While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered.** We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE don't hesitate to ask. We are here to help you.

Who is financially responsible for this bill?____

Payment for today's visit will be by CASH__________ CHECK__________

CREDIT CARD__________________________________ Exp.______________

<u>I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered.</u> I have read all the information on these forms and have completed the answers. I certify this information to be true and correct to the best of my knowledge.

NAME____**(print)** DATE____________________

SIGNATURE____

MEDICAL HISTORY

NAME____ DATE____________________

WHO IS YOUR PHYSICIAN?____

PHYSICIAN'S
ADDRESS____

WHEN WAS YOUR LAST PHYSICAL EXAM?____

ARE YOU BEING TREATED FOR ANYTHING NOW?_____________________________________

HAVE YOU HAD ANY RECENT SURGERY ?____

DO YOU HAVE ANY ARTIFICIAL HIPS, KNEES, SHOULDERS, HEART VALVES OR OTHER? IF YES, WHAT?____

HAVE YOU BEEN TOLD YOU NEED TO PREMEDICATE BEFORE DENTAL TREATMENT BY YOUR PHYSICIAN? ____

DO YOU OR DID YOU EVER HAVE:

___kidney disease
___high cholesterol
___heart trouble
___liver disease
___thyroid problems
___high blood pressure
___tuberculosis
___asthma
___anemia
___rheumatic fever
___AIDS or HIV
___diabetes
___seizure disorders
___hepatitis
___venereal disease
_______________________________________other

Blood pressure reading_______________

Have you ever been treated with radiation?____

Are you allergic to any medications? If so what:____
___Latex
___other allergies?

Are you pregnant?_______ If so, due date?______________

Are you taking any medications? If so,
what?____

Are you subject to prolonged bleeding?____

MEDICAL HISTORY CONTINUED

Are you high strung?______________________________

Has your diet ever been evaluated?______________________________

Do you have trouble sleeping?______________________________

Do you have problems with your digestion?______________________________

Do you smoke or chew tobacco? If so, what and how much per day?____________________

DENTAL HEALTH HISTORY

When was your last dental exam?______________________________

What concerns you most about your dental history?______________________________

Do you have pain in any part of your mouth or in any tooth :
- While biting or chewing?______________________________
- With hot food or drinks?______________________________
- With cold foods or drinks?______________________________
- With sweets?______________________________

Does food catch between your teeth? Where?______________________________

Do your gums bleed or feel irritated or sore?______________________________

Do you clench or grind your teeth?______________________________

How often do you brush your teeth?______________________________

How often do you floss your teeth?______________________________

Are you happy with your teeth?______________________________

Do you have all of your teeth other than wisdom teeth?______________________________

Do you want to keep your teeth for as long as possible?______________________________

How often do you have your teeth cleaned?______________________________

Have you ever had gum surgery?______________________________

Signature____Date________________