ALL BRITE DENTAL

www.allbritesmiles.com

Date:

PATIENT INFORMATION

Patient's last name: First: Middle:			❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Widow
(Former name):	Social Security no:	Driver's License no:	Birth date: / /	Age:	Sex: ❑ M ❑ F
Street address:	City:	State & ZIP Code			
Home Phone no:	Cell Phone no:	Email Address:			
Occupation:	Employer:	Employer phone no.: ( )			
How did you select our office? (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital		
❑ Family	❑ Friend	❑ WebSite	❑ Close to home/work	❑ Yellow Pages	❑ Other	❑ Advertising
Name of Family or Friend					

INSURANCE INFORMATION

(*Please give your insurance card to the receptionist*)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )
Is this person a patient here? ❑ Yes ❑ No			
Occupation:	Employer:	Employer address:	Employer phone no.: ( )
Is this patient covered by insurance? ❑ Yes ❑ No			

Name of primary insurance:	Subscriber's name:	Group no.:	Policy no.:	
Subscriber's S.S. no.:	Birth date: / /			
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other
Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:	
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the dentist. I understand that I am financially responsible for any balance. I also authorize All Brite Dental or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

ALL BRITE DENTAL
Woodhaven (734)675-8844 • West Dearborn (313)562-3388
www.allbritesmiles.com

Name (Last, First, Middle):	☐ M ☐ F	DOB:	DATE:

DENTAL HEALTH HISTORY

PREVIOUS OR REFERRING DENTIST:		DATE OF LAST COMPLETE SET OF X-RAYS:	
ADDRESS OF DENTIST:		DATE OF LAST DENTAL VISIT:	
HOW OFTEN DO YOU BRUSH?		HOW OFTEN DO YOU FLOSS?	
PLEASE CHECK ALL THAT APPLY:	☐ BAD BREATH	☐ LOOSE TEETH OR BROKEN FILINGS	☐ SENSITIVITY TO SWEETS
	☐ BLEEDING GUMS	☐ ORTHODONTIC TREATMENT	☐ SENSITIVITY WHEN BITING
	☐ BLISTERS ON LIPS OR MOUTH	☐ PAIN AROUND EAR	☐ FREQUENT HEADACHES
	☐ FINGER NAIL BITING	☐ PERIODONTAL TREATMENT	☐ JAW, HEAD OR NECK INJURIES
	☐ GRINDING/CLENCHING	☐ SENSITIVITY TO COLD	☐ JAW DIFFICULTY: CLICK AND/OR PAIN
	☐ LIP OR CHEEK BITING	☐ SENSITIVITY TO HEAT	☐ TOOTH PAIN

MEDICAL HEALTH HISTORY

PHYSICIANS NAME: PHONE NUMBER:		DATE OF LAST VISIT:	
ARE YOU CURRENTLY UNDER MEDICAL TREATMENT? HAVE YOU EVER HAD A SERIOUS ILLNESSES OR OPERATIONS? ARE YOU CURRENTLY TAKING ANY MEDICATIONS? PLEASE DESCRIBE:		DO YOU HAVE ANY ALLERGIES? Please Describe if Any:	
DO YOU SMOKE? DO YOU USE ALCOHOL, COCAINE OR OTHER DRUGS? DO YOU WEAR CONTACT LENSES?		(WOMEN ONLY) ARE YOU: PREGNANT? NURSING? TAKING BIRTH CONTROL PILL?	
PLEASE CHECK ALL THAT APPLY:	☐ AIDS	☐EMPHYSEMA	☐ PACEMAKER
	☐ ANEMIA	☐EPILEPSY	☐ PSYCHIATRIC CARE
	☐ ARTHRITIS, RHEUMATISM	☐FAINTING OR DIZZINESS	☐ RADIATION TREATMENT
	☐ ARTIFICIAL HEART VALVES	☐GLAUCOMA	☐ RESPIRATORY DISEASE
	☐ ARTIFICIAL JOINTS	☐ HEADACHES	☐ RHEUMATIC FEVER
	☐ ASTHMA	☐ HEART MURMUR	☐ SCARLET FEVER
	☐BACK PROBLEMS	☐HEPATITIS-TYPE _____	☐SHORTNESS OF BREATH
	☐BLEEDING ABNORMALLY, WITH EXTRACTIONS OR SURGERY	☐HERPES	☐SINUS TROUBLE
	☐BLOOD DISEASE	☐HIGH BLOOD PRESSURE	☐SKIN RASH
	☐CANCER	☐HIV POSITIVE	☐STROKE
	☐CHEMICAL DEPENDENCY	☐JAUNDICE	☐SWELLING OF FEET/ANKLES
	☐CHEMOTHERAPY	☐JAW PAIN	☐SWOLLEN NECK GLANDS
	☐CHRONIC FATIGUE SYNDROME	☐KIDNEY DISEASE	☐THYROID PROBLEMS
	☐CIRCULATORY PROBLEMS	☐LATEX SENSITIVITY	☐TONSILLITIS
	☐CONGENITAL HEAT LESIONS	☐LIVER DISEASE	☐TUBERCULOSIS
	☐CORTISONE TREATMENTS	☐LOW BLOOD PRESSURE	☐TUMOR OR GROWTH ON HEAD/NECK
	☐COUGH - PERSISTENT OR BLOODY	☐MITRAL VALVE PROLAPSE	☐ULCER
	☐DIABETES	☐NERVOUS PROBLEMS	☐VENEREAL DISEASE

How would you rate the appearance of your smile on a scale of 1 – 10, 10 being perfect ? _____

The above information is true to the best of my knowledge

(SIGNATURE OF PATIENT / GUARDIAN) _____Date_____

FINANCIAL POLICY

Thank you for choosing our office for your dental needs. We realize that every person's financial situation is different. For this reason, we have worked hard to provide a variety of payment options to help you receive the dental care you need and deserve. Dental treatment is an excellent investment in an individual's medical and psychological care. We will always be available to answer your questions or assist you in any way.

We will bill your insurance company, if the services provided to you are covered by your insurance. Please understand that we will provide an insurance estimate to you, however it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid. All charges you incur are your responsibility regardless of your insurance coverage. **You are required to pay the deductible and co-payment at the time of treatment. However, you remain responsible for the balance of the charges if your insurance company does not pay.** Financial arrangements are available if the estimated portion of your charges is $200 or more, and you cannot pay it in full at the time of service. We offer various payment and financing options, please ask front desk for details.

To maintain the practice operations and to prevent potential misunderstandings, we ask patients to accept and adhere to financial arrangements regarding their dental treatment. Payments are expected at the time services are rendered. **We accept cash, checks, debit cards and all major credit cards.**

Broken appointments: Your appointment time that **has been reserved especially for you and no one else,** we strongly encourage all patients to keep their appointments. If you must change your appointment, we require **at least two business days notice.** Time is valuable and failure to give proper notice, may result in a broken appointment charge of $75 per hour. We understand that emergencies do arise and will take them into consideration.

Finance Charges: If patient portion of bill is not paid within 90 days of date of service, a 1% per month finance charge will apply.

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our financial policy.

PATIENT Signature (Parent/Guardian of Child)_____Date_____

Representative of the Dentist_____Date

Patient Consent to Receive Mail and/or Telephone Messages

Please Print (Last Name) (First Name) (M.I.)

Do we have your permission to:

Send a recall appointment reminder to your home? Y_____ N_____

Leave appointment, billing or dental information on your answering machine/voice mail/e-mail: Y_____ N_____

I give permission to share appointment, billing or dental information with the person named below:

Name: _____

_____ _____
Signature of Patient / Parent or Legal Guardian Date

Acknowledgment of Receipt of Notice of Privacy Practices

I have received a copy of the Notice of Privacy Practices with an effective date of April 14, 2003.

_____ _____
Signature of Patient / Parent or Legal Guardian Date