



Date:

PATIENT INFORMATION									
Patient's last name:		First:		Middle:		<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Widow	
(Former name):		Social Security no:		Driver's License no:			Birth date: / /		Age: Sex: <input type="checkbox"/> M <input type="checkbox"/> 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):					<input type="checkbox"/> Dr.		<input type="checkbox"/> Insurance Plan		<input type="checkbox"/> Hospital
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> WebSite	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other		<input type="checkbox"/> Advertising		
Name of Family or Friend									
INSURANCE INFORMATION									
<i>(Please give your insurance card to the receptionist)</i>									
Person responsible for bill:		Birth date: / /		Address (if different):			Home phone no.: ()		
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No									
Occupation:		Employer:		Employer address:			Employer phone no.: ()		
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No									
Name of primary insurance:			Subscriber's name:		Group no.:		Policy no.:		
Subscriber's S.S. no.:			Birth date: / /						
Patient's relationship to subscriber:			<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other			
Name of secondary insurance (if applicable):			Subscriber's name:			Group no.:		Policy no.:	
Patient's relationship to subscriber:			<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> 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.									
_____ <i>Patient/Guardian signature</i>					_____ <i>Date</i>				



Name (Last, First, Middle):		<input type="checkbox"/> M <input type="checkbox"/> 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:	<input type="checkbox"/> BAD BREATH	<input type="checkbox"/> LOOSE TEETH OR BROKEN FILINGS	<input type="checkbox"/> SENSITIVITY TO SWEETS	
	<input type="checkbox"/> BLEEDING GUMS	<input type="checkbox"/> ORTHODONTIC TREATMENT	<input type="checkbox"/> SENSITIVITY WHEN BITING	
	<input type="checkbox"/> BLISTERS ON LIPS OR MOUTH	<input type="checkbox"/> PAIN AROUND EAR	<input type="checkbox"/> FREQUENT HEADACHES	
	<input type="checkbox"/> FINGER NAIL BITING	<input type="checkbox"/> PERIODONTAL TREATMENT	<input type="checkbox"/> JAW, HEAD OR NECK INJURIES	
	<input type="checkbox"/> GRINDING/CLENCHING	<input type="checkbox"/> SENSITIVITY TO COLD	<input type="checkbox"/> JAW DIFFICULTY: CLICK AND/OR PAIN	
	<input type="checkbox"/> LIP OR CHEEK BITING	<input type="checkbox"/> SENSITIVITY TO HEAT	<input type="checkbox"/> TOOTH PAIN	
	MEDICAL HEALTH HISTORY			
PHYSICIANS NAME: PHONE NUMBER:		DATE OF LAST VISIT:		
ARE YOU CURRENTLY UNDER MEDICAL TREATMENT?		DO YOU HAVE ANY ALLERGIES? Please Describe if Any:		
HAVE YOU EVER HAD A SERIOUS ILLNESSES OR OPERATIONS?				
ARE YOU CURRENTLY TAKING ANY MEDICATIONS? PLEASE DESCRIBE:				
DO YOU SMOKE?		(WOMEN ONLY) ARE YOU: PREGNANT? NURSING? TAKING BIRTH CONTROL PILL?		
DO YOU USE ALCOHOL, COCAINE OR OTHER DRUGS?				
DO YOU WEAR CONTACT LENSES?				
PLEASE CHECK ALL THAT APPLY:	<input type="checkbox"/> AIDS	<input type="checkbox"/> EMPHYSEMA	<input type="checkbox"/> PACEMAKER	
	<input type="checkbox"/> ANEMIA	<input type="checkbox"/> EPILEPSY	<input type="checkbox"/> PSYCHIATRIC CARE	
	<input type="checkbox"/> ARTHRITIS, RHEUMATISM	<input type="checkbox"/> FAINTING OR DIZZINESS	<input type="checkbox"/> RADIATION TREATMENT	
	<input type="checkbox"/> ARTIFICIAL HEART VALVES	<input type="checkbox"/> GLAUCOMA	<input type="checkbox"/> RESPIRATORY DISEASE	
	<input type="checkbox"/> ARTIFICIAL JOINTS	<input type="checkbox"/> HEADACHES	<input type="checkbox"/> RHEUMATIC FEVER	
	<input type="checkbox"/> ASTHMA	<input type="checkbox"/> HEART MURMUR	<input type="checkbox"/> SCARLET FEVER	
	<input type="checkbox"/> BACK PROBLEMS	<input type="checkbox"/> HEPATITIS-TYPE _____	<input type="checkbox"/> SHORTNESS OF BREATH	
	<input type="checkbox"/> BLEEDING ABNORMALLY, WITH EXTRACTATIONS OR SURGERY	<input type="checkbox"/> HERPES	<input type="checkbox"/> SINUS TROUBLE	
	<input type="checkbox"/> BLOOD DISEASE	<input type="checkbox"/> HIGH BLOOD PRESSURE	<input type="checkbox"/> SKIN RASH	
	<input type="checkbox"/> CANCER	<input type="checkbox"/> HIV POSITIVE	<input type="checkbox"/> STROKE	
	<input type="checkbox"/> CHEMICAL DEPENDENCY	<input type="checkbox"/> JAUNDICE	<input type="checkbox"/> SWELLING OF FEET/ANKLES	
	<input type="checkbox"/> CHEMOTHERAPY	<input type="checkbox"/> JAW PAIN	<input type="checkbox"/> SWOLLEN NECK GLANDS	
	<input type="checkbox"/> CHRONIC FATIGUE SYNDROME	<input type="checkbox"/> KIDNEY DISEASE	<input type="checkbox"/> THYROID PROBLEMS	
	<input type="checkbox"/> CIRCULATORY PROBLEMS	<input type="checkbox"/> LATEX SENSITIVITY	<input type="checkbox"/> TONSILLITIS	
	<input type="checkbox"/> CONGENITAL HEAT LESIONS	<input type="checkbox"/> LIVER DISEASE	<input type="checkbox"/> TUBERCULOSIS	
	<input type="checkbox"/> CORTISONE TREATMENTS	<input type="checkbox"/> LOW BLOOD PRESSURE	<input type="checkbox"/> TUMOR OR GROWTH ON HEAD/NECK	
	<input type="checkbox"/> COUGH - PERSISTENT OR BLOODY	<input type="checkbox"/> MITRAL VALVE PROLAPSE	<input type="checkbox"/> ULCER	
	<input type="checkbox"/> DIABETES	<input type="checkbox"/> NERVOUS PROBLEMS	<input type="checkbox"/> VENEREAL DISEASE	

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