A+ TENDER DENTAL CARE

PATIENT INFORMATION

PATIENT

Name _____
Address _____ (Last) _____ (First) Apt. # _____
City _____ Zip _____
How long at this address? _____
Phone ( ) _____ Cell Phone Pager ( ) _____
E-mail _____
Social Security # _____ DL# _____
Age _____ Birthdate _____

RESPONSIBLE PARTY (If same as above, please skip)

Name _____
Address _____ (Last) _____ (First) Apt. # _____
City _____ Zip _____
How long at this address? _____
Phone ( ) _____
Social Security # _____
Relationship to Patient _____
Age _____ Birthdate _____

EMPLOYMENT

Occupation _____
Employer _____
How long? _____
Business Address _____
City _____ Zip _____
Business Phone ( ) _____ Ext. # _____
Verified By _____ Date _____
(Office use only)

REFERENCES

Name _____
Address _____ (Last) _____ (First)
City _____ Zip _____
Phone ( ) _____
Name _____
Address _____ (Last) _____ (First)
City _____ Zip _____
Phone ( ) _____
Spouses Name _____
Spouses Work # ( ) _____ (Last) _____ (First)

PERSON TO CONTACT FOR EMERGENCY:

_____ (Last) _____ (First)
_____ (Address)
City _____ Zip _____ Tel # ( ) _____
Physician Name _____ Tel # ( ) _____

GETTING TO KNOW YOU

Are there other members of your household who are not patients at our office
YES ___ NO ___ Please list names & relationship (son, daughter, husband) below:
1: _____ 2: _____
3: _____ 4: _____
How did you hear of us? _____
_____
Are you or anyone in your family a Union member? ___ YES ___ NO
If yes, specify Union/Local: _____
I want information in Spanish: ___ YES ___ NO

REFERENCES

Primary Insurance Company
Name _____
Address _____
City, Zip _____
Insurance Co. Phone # _____
Employer _____
Union/Local _____ Group # _____
Insured's Name _____
Insured's Soc. Sec. # _____ Birthdate _____

INSURANCE

Secondary Insurance Company
Name _____
Address _____
City, Zip _____
Insurance Co. Phone # _____
Employer _____
Union/Local _____ Group # _____
Insured's Name _____
Insured's Soc. Sec. # _____ Birthdate _____

MANAGED CARE PLAN (HMO)

Plan Name _____ Group # _____ Plan # _____
Employer _____
Insured's Name _____
Soc. Sec. # _____

1. **I hereby certify that the above information is accurate and will be relied upon for granting credit and providing dental services. I understand that I am financially responsible for the charges not covered by or paid for by my insurance for whatever reason.**
2. **By signing below, I understand that you may verify and exchange information on me and any additional applicants, including requiring reports from credit reporting agencies.**
3. **I hereby authorize payment directly to the dentist of the group insurance benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by the authorization. I authorize release of any information relating to any dental claim or claims.**
4. **I understand that Bright Now! Dental provides business support services to independent dentists and recognize that this dental practice is owned and operated by an independent dentist. I acknowledge that each dentist is individually responsible for the dental care provided to me and no other dentist nor Bright Now! Dental is responsible for my dental treatment.**

Signature of responsible party or patient (Parent if patient is a minor) Date

GENERAL HEALTH INFORMATION

DATE: _____

PATIENT NAME: _____ BIRTH DATE: _____ AGE: _____
LAST FIRST

DENTAL HISTORY

1. Are there other conditions of which we should be aware? YES ____ NO ____ If yes, please specify: _____
2. Why are you here today? Check-Up _____ Cleaning _____ Other _____
   Toothache _____ Chief Complaint _____
3. When did you last visit a dentist? _____ 4. What treatment was performed? _____
5. Was the treatment completed? _____ 6. Did you have a cleaning? _____
7. When were dental x-rays taken? _____
8. Have you ever had prolonged bleeding after an extraction? YES ___ NO ___ If yes, please specify: _____
9. Have you had any problems with past dental treatment? YES ____ NO ____ If yes, please specify: _____
10. Do you have symptoms near your ears associated with movement of your lower jaw such as clicking, popping, pain or locking open?
    YES ____ NO ____ If yes, please specify: _____
11. Have you ever been diagnosed or treated for TMD (Temporomandibular Joint Dysfunction sometimes called TMJ)?
    YES ____ NO ____ If yes, please specify: _____
12. Do your gums bleed easily? YES _____ NO _____ 13. Do you feel you have had breath? YES _____ NO _____
14. Are your teeth sensitive to hot or cold? YES _____ NO _____ 15. Would you like your teeth whiter? YES _____ NO _____
16. Are there any cosmetic changes you would like to have done on your teeth? YES _____ If yes, please specify: _____

MEDCIAL HISTORY

1. Are you under a Doctor's care at this time? YES ____ NO ____ If yes, please specify: Dr. Name: _____
   Dr. Ph. #: ( ) _____
2. Are you allergic to penicillin, codeine, local anesthetics, tranquilizers or any other drugs or medicine? _____
3. Are you taking any medications at this time, including birth control? YES ___ NO ___ If yes, please specifiy: _____
4. (Woman) Are you pregnant at this time? YES ____ NO ____ If yes, please specify how many moths: _____
5. Are there any other health problems of which we should advised? Please specify: _____
6. Do you have, or have you had, any of the following?

Please check "YES" or "NO"			Doctor Comments	Please check "YES" or "NO"			Doctor Comments
ARTIFICIAL Heart Valve	YES ❑	NO ❑	_____	HEPATITIS	YES ❑	NO ❑	_____
AIDS/HIV+	YES ❑	NO ❑	_____	HIGH BL. PRESSURE	YES ❑	NO ❑	_____
ANEMIA	YES ❑	NO ❑	_____	JAUNDICE	YES ❑	NO ❑	_____
ANGINA	YES ❑	NO ❑	_____	JOINT PROSTHESIS	YES ❑	NO ❑	_____
ARTHRITIS	YES ❑	NO ❑	_____	KIDNEY DISEASE	YES ❑	NO ❑	_____
ASTHMA	YES ❑	NO ❑	_____	LATEX ALLERGY	YES ❑	NO ❑	_____
BLEEDING PROBLEMS	YES ❑	NO ❑	_____	LIVER PROBLEMS	YES ❑	NO ❑	_____
CANCER	YES ❑	NO ❑	_____	LOW BL. PRESSURE	YES ❑	NO ❑	_____
CHEMO/RAD THERAPY	YES ❑	NO ❑	_____	LUNG DISEASE	YES ❑	NO ❑	_____
COSMETIC SURGERY	YES ❑	NO ❑	_____	PACEMAKER	YES ❑	NO ❑	_____
DIABETES	YES ❑	NO ❑	_____	PHEN-FEN	YES ❑	NO ❑	_____
DIZZY SPELLS	YES ❑	NO ❑	_____	PSYCHIATRIC CARE	YES ❑	NO ❑	_____
DRUG ADDICTION	YES ❑	NO ❑	_____	RHEUMATIC FEVER	YES ❑	NO ❑	_____
EMPHYSEMA	YES ❑	NO ❑	_____	SINUS TROUBLE	YES ❑	NO ❑	_____
EPILEPSY	YES ❑	NO ❑	_____	SMOKING TOBACCO	YES ❑	NO ❑	_____
FAINTING	YES ❑	NO ❑	_____	STROKE	YES ❑	NO ❑	_____
GLAUCOMA	YES ❑	NO ❑	_____	THYROID PROBLEMS	YES ❑	NO ❑	_____
HEART ATTACK	YES ❑	NO ❑	_____	TMD OR TMJ	YES ❑	NO ❑	_____
HEART SURGERY	YES ❑	NO ❑	_____	TUBERCULOSIS	YES ❑	NO ❑	_____
HEART MURMUR	YES ❑	NO ❑	_____	VENEREAL DISEASE	YES ❑	NO ❑	_____
HEART PROBLEMS	YES ❑	NO ❑	_____				

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. I further certify that I consent to the performing of x-rays and oral examination.

Patient's signature _____ Date _____
For Parent if patient is a minor

Doctor Signature _____

RECALL REVIEW:

1. Patient's signature _____ Doctor's Signature _____ Date _____
2. Patient's signature _____ Doctor's Signature _____ Date _____
3. Patient's signature _____ Doctor's Signature _____ Date _____

HOW DID YOU HEAR ABOUT US?

□ Walk-in / Drive by □ Sign/Banner □ Others _____
□ Insurance Company □ Yellow Pages □ Doctor's Referral Who? _____
□ Newspaper Ads □ Flyer □ Friend/Family Referral, Who? _____*
□ Magazine Ads □ Website * *your family or friend will receive free gifts from us!*

"What was it about the advertisement that caught your attention?" _____

Are you a student? □ Full Time* □ Part Time* □ No *Please provide a copy of your student ID

Would you like to receive a postcard reminding you of the 6-month exam and cleaning? □ YES □ NO

Please provide your email address so we can send you reminder of your appointment _____

NOTICE OF PRIVACY PRACTICES

We recognize that patients have the Right of Privacy concerning their personal health information. We make every effort to protect and preserve patient records in a manner that secures this information. By signing the acknowledgement below, you are confirming that you have received and read our Privacy Practices. If, for any reason, you would like to have your record transferred, there will be duplication fees of $25 dollars. I also give doctor the permission to take X-rays and perform an examination for me. I will inform the doctor, if for any reason, I can not take X-rays (e.g. Pregnancy)

X _____ X _____
Signature of Patient / Responsible Party Date

PERMISSION FOR X-RAYS

I am not pregnant or possibly be pregnant. I gave A Tender Dental Care permission to take all the necessary x-Rays.

X _____ X _____
Signature of Patient / Responsible Party Date

OUR POLICY OF CARE AND PAYMENT

Our practice is committed to provide highest quality dental care. Payment is due at the time of treatment.

As courtesy to our patients, we submit dental claims to your insurance company for payment. Patient's insurance coverage is a contract between patient's employer and the insurance company. Not all services are a covered benefit. Some insurance companies arbitrarily select certain procedures they will not cover. We must emphasize that as dental care providers, our relationship is with you, and not your insurance company. We ask that each patient pay their deductible and their estimated portion of the charges at the time of services. If, for any reason, your insurance company does not pay the estimated amount within 60 days, it becomes your financial responsibility.

Our practice is committed in providing the best treatment possible for our patients and we charge what is Usual and Customary Rates for our area. You are responsible for paying the bill in full regardless of the insurance company's determination of usual and customary rates. In effort to maintain our excellent service, a $55.00 charge will be made for missed appointments that are not cancelled or rescheduled 24 hours prior to the scheduled appointment time. Please indicate below the form of payment you choose to settle your account:

- ❑ Cash
- ❑ Visa or Master Card
- ❑ CareCredit Payment Plan (Subject to credit approval, available to uninsured patient only)

I have read, understand, and agree to the above Financial Policy regarding my payment and insurance obligations. I will notify A+ Tender Dental Care if any changes in insurance, address, or phone number occur.

X _____ X _____
Signature of Patient/Responsible Party Date