TIME 03:27 PM

DATE 9/5/2023

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

Preferred Pharmacy

Employer

Drivers License #

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Bright Smiles Family Dental

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	
Do you use controlled substances?	◯ Yes ◯ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Other? ☐ If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Easily Winded	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Angina	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Excessive Thirst	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No
Blood Transfusion	◯ Yes ◯ No	Frequent Diarrhea	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No
Breathing Problems	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Genital Herpes	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No
Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Convulsions	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No
						Yellow Jaundice	◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____

BRIGHT SMILES
FAMILY DENTISTRY

Privacy Policy

USES AND DISCLOSURES -Our office must provide you, the patient, a description and at least one example of the types of use and disclosures that our office is permitted to make for the purpose of treatment, payment, and health-care operations (all uses and disclosures by the way that is permitted by the law without authorization by the patient.

TREATMENT- Our office will use and disclose your protected health information for purposes of treatment, meaning the provision, coordination and management of your healthcare and related services. For instance, we will use and disclose your health information to coordinate benefits with a third-party payer, or for consultation between our office and specialist if required for your care.

PAYMENT- Our office will use and disclose the minimum necessary amount of your PHI to obtain payment for services rendered. For example, our office may share your treatment plan with your insurer to determine the coverage allowed for your benefit plan.

HEALTH-CARE OPERATIONS- Our office will use and disclose, as needed, your PHI in order to support the business activities of the practice. These activities include, but are not limited to, quality assessment and employee review activities, shadowing of dental students, and conducting or arranging for other business activities.

REQUIRED BY LAW: REPORTING ABUSE, NEGLECT OR DOMESTIC VIOLENCE- Our office may use and disclose the minimum necessary amount of your personal health information to the extent necessary to inform the appropriate government authority if we reasonably believe you to be a victim of abuse, neglect or domestic violence.

YOUR RIGHTS:

The Patient- You have the right to inspect or obtain a copy of your PHI from our office. Our office requires you to submit such requests in writing. Our office must act on your request within 14 days after the receipt of your request. Under federal law, however, you may not inspect or copy records in use of a civil, criminal or administrative proceeding, and protected health information that is subject to law prohibits access to protected health information.

Restrictions- You have the right to request restrictions on certain uses and disclosures of your PHI, though our office is not required to grant such requests.

Confidential communications- You have the right to request, and our office must accommodate, reasonable requests to receive confidential communications of PHI from our office by alternative means or at alternative locations.

Electronic notice- You have the right to receive a paper form of this notice of privacy policies upon request.

Accounting of disclosures- You have the right to receive and account for certain disclosures we have made, if any, of your PHI.

Right to Amend- You have the right to have the doctor amend your PHI. If we deny your request for the amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal

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I, _____ acknowledge that I have reviewed the office Privacy Policy of Bright Smiles Family Dental.

_____

Patient or Responsible Party Signature Date

BRIGHT SMILES
FAMILY DENTISTRY

Financial Policy

Thank you for choosing our office as your dental health care provider. We are committed to providing you with the highest quality lifetime dental care, so that you may fully attain optimum oral health. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy, which we ask that you read, agree to, and sign prior to any treatment.

Payment is due at the time service is provided, unless prior arrangements have been made. Our office accepts cash, personal checks, Visa, MasterCard, Discover, and American Express. Any balance carried by this office is subject to finance charges. Outside financing is available through Care Credit or Lending Club upon request and approval, but must be set up prior to services being completed. Short term payment plans through our office are available, but must be set up prior to dental work being performed. (Please let us know if you would like more information on our payment plan options).

Please note: Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance, you will be responsible for any collection and/or legal charges incurred.

Do you have insurance?

- As a courtesy to you, we will help you process your insurance claims. 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. Your insurance policy is a contract between you, your employer, and your insurance company. Our office is not a party to the contract.
- Our practice is committed to providing the best treatment for our patients and we charge a fair fee for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.
- We ask that you pay the deductible and co-payment, which is the estimated amount not covered by your insurance company, by cash, check, Visa, MasterCard, Discover, or American Express at the time we provide the service to you.
- Insurance payments are ordinarily received within 30-45 days from the time of filing. If your insurance company has not made payment within 45 days, we will ask that you contact your insurance company to verify payment amount and date.
- If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
- We will cooperate with the regulations and reasonable requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

Thank you for the opportunity to serve you. We welcome any questions you may have concerning your care or our financial policy.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO BRIGHT SMILES FAMILY DENTAL OR DR. THOMAS SNARR.

_____ _____

Patient Name Date

_____ _____

Print Name of Patient or Guarantor, if minor Date