MEDIA
brite smile
Family, Cosmetic, and Implant Dentistry

1025 N. Providence Road
Media, PA 19063
610-566-2711
info@mediabritesmile.com

PATIENT INFORMATION

Patient's Name: (Last) _____ (First) _____ (MI) _____ Sex: _____

Date of Birth: _____/_____/_____ SSN: _____ Marital Status: Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐

If patient is student, name of school/college: _____ Full Time ☐ Part Time ☐

Address: (Street/Apt) _____ (City) _____ (State) _____ (Zip) _____

Primary (Cell) Phone #: _____ Secondary (Home/Work) Phone #: _____

Email: _____ Preferred Form of Contact: Call ☐ Text ☐ Email ☐

Emergency Contact: _____ Phone: _____

How did you hear about us? Facebook ☐ Google ☐ Insurance ☐ Family or Friend ☐ If so, who? _____

Previous Dentist's Name and Contact Info: _____

PRIMARY DENTAL INSURANCE

Name of Insurance Co: _____ Phone #: _____

Subscriber's Name: _____ Date of Birth: _____/_____/_____ Relationship: _____

Employer's Name: _____ SSN/ID#: _____ Group ID: _____

SECONDARY DENTAL INSURANCE

Name of Insurance Co: _____ Phone #: _____

Subscriber's Name: _____ Date of Birth: _____/_____/_____ Relationship: _____

Employer's Name: _____ SSN/ID#: _____ Group ID: _____

DENTAL HEALTH HISTORY

YES	NO	
____	____	Is there a specific reason for your visit today? If so, why? _____
____	____	Are you having any pain or discomfort at this time? If so, where? _____
____	____	When was your last exam/cleaning? _____ Where? _____
____	____	Have you ever had full mouth x-rays taken of your teeth? If so, when? _____
____	____	Have you ever had treatment for your gums?
____	____	Do your gums hurt or bleed when you brush?
____	____	Do your teeth hurt when you chew?
____	____	Have you ever been aware of a bad odor or taste in your mouth?
____	____	Are your teeth sensitive to hot, cold or sweet?
____	____	Do you clench or grind your teeth during the day or at night?
____	____	Do you ever wake up from sleep due to shortness of breath?
____	____	Have you ever had orthodontic treatment or worn braces?
____	____	Are you interested in in-office whitening?
____	____	Are you interested in Invisalign?
____	____	Do you use any tobacco products? What/how much/how often? _____
____	____	Do you use any controlled substances? What/how much/how often? _____

Is there anything that bothers you about the appearance of your teeth or smile? _____
Please rate how anxious you are about dental treatment (1-totally relaxed, 10-highly anxious): _____
Why did you leave your previous dentist? _____

HEALTH HISTORY

Physician's Name: _____ City: _____ Phone #: _____

YES	NO	
____	____	Have you had a serious illness, operation or been hospitalized in the past 5 years? Reason: _____
____	____	Have you been under the care of a medical doctor the past year? Reason: _____
____	____	Has a physician ever recommended that you take an antibiotic pre-medication prior to a dental visit? Prescription: _____ Reason: _____
____	____	Are you taking or scheduled to begin taking oral or IV bisphosphonates such as, alendronate (Fosamax®), risedronate (Actonel®), Aredia® or Zometa®, for osteoporosis or Paget's disease?
____	____	Are you currently undergoing or have you undergone any radiation therapy to the head or neck region? Reason: _____

Check any of the following you have had or have at present:

____Anemia
____Angina
____Arthritis
____Artificial/Prosthetic Heart Valve*
____Artificial Joint (Type: _____)
____Asthma
____Bleeding Problems
____Blood Thinners (e.g. Coumadin)
____Cancer (Type:_____)
____Chemotherapy
____Cold Sores
____Congenital Heart Disease*
____ Unrepaired, cyanotic CHD
____ Repaired in the last 6 months
____ Repaired CHD w/ residual defects
____Drug Addiction
____Diabetes
____Emphysema
____Epilepsy/Seizures
____Glaucoma
____Heart Disease/Heart Attack
____Hemophilia
____Hepatitis A or B
____Hepatitis C
____Herpes
____High Blood Pressure
____History of Infective Endocarditis*
____Kidney Problems
____Liver Problems
____Low Blood Pressure
____Lung Disease
____Mitral Valve Prolapse
____Multiple Sclerosis
____Osteoporosis
____Pacemaker
____Radiation Treatment
____Rheumatic Fever/Rheumatism
____Sinus Trouble
____Sickle Cell Disease
____Stroke
____Thyroid Disease
____Tuberculosis
____Venereal Disease/STD's

*Except for the conditions asterisked above, antibiotic prophylaxis is no longer recommended for any other form of CHD or joint replacement unless specified by a physician

List any other condition(s) not listed above: _____

Are you taking any medications? If yes, please list:

Medication Name	Dosage/Frequency	Condition
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you allergic or have reacted adversely to any of the following medications?

____Aspirin
____Acetaminophen/Ibuprofen
____Barbiturates/Sedatives
____Codeine
____Demerol/Other Narcotics
____Latex
____Local Anesthetics ("Novocaine")
____Nitrous Oxide
____Penicillin
____Sulfa
____Tetracycline

Any others please list: _____

FOR WOMEN ONLY

YES	NO	
____	____	Are you now or do you think you may be pregnant? If yes, which trimester? _____
____	____	Are you nursing?
____	____	Are you presently taking birth control pills?

AUTHORIZATION AND RELEASE

I certify that the above information is complete and accurate to the best of my knowledge. I will inform this office of any chance in my health status. I understand that dental treatment and local anesthesia entail risks such as bleeding, infection, nerve damage, jaw necrosis, or fracture of teeth or bone. I authorize the dentist to release any information, including the diagnosis, and the records of any treatment or examinations rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize my insurance company to make payments directly to the dental office for benefits otherwise payable to me. I authorize release of my records to third party payers, other healthcare professionals or operations, or other entities as deemed necessary by this office. I authorize use of this signature for all insurance submissions. I understand that I am responsible for all changes whether or not they are covered by insurance, as well as any additional collection costs if this office determines they are necessary.

X_____ **Date:** _____

Signature of Patient, Parent or Responsible Party

DENTAL OFFICE INFORMED CONSENT

It is important to us that you, our patient, understand the treatment we are recommending and any invasive procedures we may, with your agreement, perform. We want to involve you in all decisions concerning invasive procedures you may need. We take informed consent very seriously in our office. Therefore, we only want you to sign this form when you understand that there is a risk associated with dental procedures, and all your questions have been answered.

Dental treatment and procedures are not to be taken for granted as being routine or without risk for complications. As with all medical treatment to one's body, including dental treatment, there are no guarantees that the results will be as planned and to each individual's satisfaction. When dealing with the human body there are potentially many variables, some predictable and others are not. Complication rates in dentistry are low but do exist. Even a minor procedure like a "filling" can lead to major complications that cannot be foreseen. For example, "Novacaine" injection could lead to allergic reaction, anaphylaxis, facial hemorrhage, swelling, bruising, and even hospitalization or death. Granted these are fairly uncommon occurrences but individuals who are contemplating this should be aware of this prior to consenting. Whenever drilling is involved, even a simple cavity can lead to pulpal (nerve) problems, abscess, fractured tooth, and/or post treatment pain to biting and to temperature extremes (hot and cold). These complaints can be transient or may persist requiring further treatments. The above examples are some samples of possible complications with dental treatment and are not limited to these. In general, complications include but are not limited to pain, swelling, bleeding, infection, and other nerve problems.

I **have read, understand and consent to dental treatments.** Initials: _____ Date: _____

OFFICE POLICY

When we make your appointment, we are reserving a room for your particular needs. We understand that extreme or unavoidable emergencies or special circumstances do arise which may require you to cancel your appointment. We ask that if you must change an appointment, please give us at least 48 hours notice. This courtesy makes it possible to give your reserved room to another patient who would like it. We reserve the right to charge for any appointment(s) broken without a 48 hour notice. **The charge will be $50.00 for every thirty minutes of appointment time.** ***Repeated cancellations or missed appointments will result in loss of future appointment privileges.*** We feel that our patient's time is valuable. When your appointment is made, a room is reserved, your records are prepared, and special instruments are readied for your visit. Except for emergency treatment for another patient, you can expect us to be prompt. We, of course, would appreciate the same courtesy from you.

Checks returned from the bank are subject to $35.00 service fee. Accounts delinquent more than 60 days from the date of billing are subject to a 1.0% per month (18% annually) finance charge. If your account is sent to our collection agency you will be responsible for collection and court costs along with attorney fees.

We welcome you to our office and want to provide you with the best dental care possible. If you have any questions regarding our policies and your treatment, please do not hesitate to ask.

NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practices legal duties with respect to my information. I understand that this practice reserves the right to change the term of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain this practice's current Notice of Privacy Practices on request.

Signature: _____ **Date:**_____

Relationship to patient (if signed by a personal representative of patient): _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledge of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

____ Individual refused to sign

____ Communication barriers prohibited obtaining the acknowledgement

____ An emergency situation prevented us from obtaining acknowledgement

____ Other (Please specify:_____)

OUR FINANCIAL POLICY

Thank you for choosing us as your dental care provider. We are committed to your dental treatment being successful. We agree in writing with every patient to sign our financial policy, as we have found with our past experience that this policy makes our mutual experience easier and without confusion. This policy is to ensure that all of our patients receive the highest level of quality dental care in a friendly and healthy environment while understanding their financial responsibilities. This policy as well as other health and insurance forms provided must be read, agreed to and signed prior to any dental treatment.

Cash Patients

Patients with no insurance are expected to pay in cash, check or credit card the day the service is rendered, unless specific arrangements are made in advance or getting our ***CUSTOMIZED MEMBERSHIP PLAN***.

Insurance Patients

For those patients covered by insurance, we may accept assignment of benefits. This means you must sign the portion of your insurance form that assigns payments to our office. Very few insurance policies cover 100% of the cost of your treatment. In this day and age many cover 50% or less on many services and actually cover nothing on others. Due to this, and the frequent delays in receiving payment from the insurance company, you will be asked to pay your deductible and your portion of your charges the day the service is rendered. We will estimate as closely as possible, your coverage, but until we actually receive the payment from the insurance company, it is just an estimate. Some patients request that we send in a pre-determination to their insurance carriers. We state what treatment you need, and they tell us what they will cover on that treatment plan. Many patients prefer to get service started immediately, and some treatments should be start immediately. In these cases we will ask you to pay for your services in full as they are done (for example: RCT, Implant Placement), and when the insurance company pays their portion we will reimburse you for what they pay. ***We will help you in dealing with the insurance company, but ultimately the responsibility of payment and insurance problems lies with you.*** If we do accept assignment of benefits from the insurance company, if the insurance company hasn't paid after 30 days, the full balance is expected from you personally.

The above policies apply equally to parents and guardians of minors being treated, and minors cannot be treated without a parent or guardian authorizing treatment and agreeing to financial responsibility. Thank you for reading and understanding our financial policy. If you have any questions or concerns; please feel free to ask them at any time. We wish to be of assistance in any way we can.

I HAVE READ AND UNDERSTAND THE ABOVE DENTAL OFFICE INFORMED FINANCIAL POLICIES.

_____

Print Name

_____ _____

Signature of Responsible Party **Date**