NEW PATIENT REGISTRATION FORM

Welcome to Bright Smiles, Kids & Family Dentistry
4115 Wilkens Avenue, Suite#101, Baltimore, MD 21229
410-737-9666

Patient Information

Patient Name: _____ Date: _____
Last First MI (Preferred Name)

Birth Date: _____Age: ____ Gender: _____ Marital Status: _____

Social Security #: _____ Email Address: _____

Phone (Home): _____ (Cell): _____ (Work): _____

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Please review this section closely. It is essential for us to have accurate health history, allergy, and medication information in order for us to give you the highest quality of care.

Date of Last Dental Visit: _____ Reason for today's visit: _____

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS/HIV Positive
- ☐ Alzheimer's Disease
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Breathing Problems
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Cold Sores
- ☐ Congenital Heart Disorder
- ☐ Convulsions
- ☐ Cortisone Medicine
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Easily Winded
- ☐ Emphysema
- ☐ Epilepsy/Seizures
- ☐ Excessive Bleeding
- ☐ Excessive Thirst
- ☐ Fainting Spells/ Dizziness
- ☐ Frequent Cough
- ☐ Frequent Diarrhea
- ☐ Frequent Headache
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Attach/ Failure
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hives or Rash
- ☐ Hypoglycemia
- ☐ Irregular Heartbeat
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Mental/Nervous Disorders
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Pain in Jaw
- ☐ Parathyroid Disease
- ☐ Psychiatric Care
- ☐ Radiation Treatments
- ☐ Recent Weight Loss
- ☐ Renal Dialysis
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Spina Bifida
- ☐ Stomach/Intestinal Disease
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors/Growths
- ☐ Ulcers
- ☐ Venereal Disease

• Do you have any allergies? ☐ Yes ☐No , If yes, Please explain: _____

• Are you taking any medications? ☐ Yes ☐No , If yes, Please explain: _____

• Are you Pregnant? _____

• Have you ever had any complications following dental treatment? ☐ Yes ☐ No
If yes, please explain: _____

• Are you now under the care of a physician? ☐ Yes ☐ No
Name of Physician: _____ Phone: _____

• Do you have any health problems that need further clarification? ☐ Yes ☐ No
If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice?

☐ Another patient ☐ Google ☐ Website/Online ☐ Postcard/Mail ☐ 1-800-Dentist ☐ Other _____

Name of person or office referring you to our practice: _____

Emergency Contact

Name: _____ Relationship to Patient: _____ ☐ Male ☐ Female

Phone (Home): _____ (Cell): _____ (Work): _____

Patient Employment Information

Employer Name: _____ Occupation: _____

Address: _____ Phone Number: _____

Dental Insurance Information

Primary Dental Insurance

Insurance Company: _____

Group #: _____ ID #: _____

If you are NOT the subscriber of this insurance plan, please fill in the following information about the subscriber:

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child/Dependent ☐ Other _____

Subscriber Name: _____
Last First MI

Birth Date: _____ Social Security #: _____ ☐ Male ☐ Female

Address: _____
Street City State Zip Code

Employer Name: _____

Secondary Dental Insurance (if applicable)

Insurance Company: _____

Group #: _____ ID #: _____

If you are NOT the subscriber of this insurance plan, please fill in the following information about the subscriber:

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Subscriber Name: _____
Last First MI

Birth Date: _____ Social Security #: _____ ☐ Male ☐ Female

Address: _____
Street City State Zip Code

Employer Name: _____

Consent for Services

I hereby authorize Bright Smiles, Kids & Family Dentistry to administer and perform the necessary procedures, such as x-rays, anesthetics and dental treatment deemed necessary or advisable with the diagnosis of my dental condition. I authorize the release of any information concerning my (or my child's) health care, advice, and treatment to another dentist.

I authorize the release of any information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits, and I authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

I understand that I am financially responsible for payments in full of all accounts, and I agree to be responsible for payments of services not paid, in whole or in part, by my dental insurance payer. If enforcement of payment is used through the services of a collection agency, I agree to be responsible for any incidental expenses, including collection costs, court costs, and attorney fees.

I understand that Bright Smiles, Kids & Family Dentistry reserves the right to charge for appointments canceled or broken without 24 hours advance notice.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of Patient (Or parent/guardian)

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

Bright Smiles, Kids & Family Dentistry

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Financial Policy

We appreciate the opportunity to serve you and being a patient of Bright Smiles, Kids & Family Dentistry. We've found that a clear understanding of our financial policy in advance of dental care helps to relieve some of the anxiety associated with dental visits. Please read the following carefully and ask us any questions you might have. We will do our best to answer them for you.

Payment for Services

Before treatment is performed, we will discuss treatment options and associated costs. You will always be informed of costs and financial options before beginning treatment. For large procedures and all treatment plans, we require payment in full prior to scheduling. If you are working with dental insurance, we will discuss estimated insurance benefit coverage, and we will take that into account prior to payment.

We know from experience that it is best to take care of financial arrangements prior to starting treatment, so that all subsequent visits are focused 100% on your treatment and taking care of your dental needs. For your convenience we accept cash, checks , Debit cards ands all major credit cards. In addition, we make available patient financing for qualified lenders through Care Credit. For more information about financing options, feel free to ask.

If payment arrangements or obligations are not met, your account balance may be sent to collections. You will be responsible for any collection charges, court costs, and attorney fees for collection actions on your account. Any balance more than 90 days past due may be subject to a finance charge of 1.5% per month past 90 days overdue.

Initials: _____

Dental Insurance

If you have dental insurance, we will do our best to ensure that you receive the maximum benefits of your coverage. We will handle the filing and processing of all claims, even though we are not in-network with any insurance provider. We will accept assignment of benefits for plans that will make claim payments directly to our office.

Insurance coverage is a contract between the patient and the insurance company, not between our office and the insurance company. Insurance companies change their rules, procedures, and payment basis often and arbitrarily, without notice to our office. We do our best to estimate what each plan will pay for different procedures, but the patient (or guardian or responsible party) is ultimately responsible for any balance that insurance does not cover.

If an insurance claim has not been paid out on by your insurance carrier after 60 days from submission, we may ask that you pay for any outstanding balance from the procedure. We will continue to pursue payment from your insurance company, and if the claim is later on paid, we will direct payments to you, the patient.

Initials: _____

Missed Appointments/Cancellation Policy

Our policy is to charge for missed appointments as the rate of no less than $25 per visit and no more than the cost of the appointment. Please help us serve you and our other patients by keeping scheduled appointments. Appointments that are canceled or changed less than 24 hours from the time of the appointment become time lost for the office and for our other patients. We require you to inform our office of a cancellation or need to reschedule of any appointment at least one business day, 24 hours before the appointment (ex. A Monday 9am appointment needs to be canceled by 9am the Friday before). Cancellations made with less than 24 hours notice may result in a charge out of no less than $50 and no more than the cost of the appointment. Due to the nature of the practice of dentistry, and the advanced planning of all major treatment, such notice is mandatory.

Initials: _____

Thank you for taking the time to read and understand our financial policy. Our practice is committed to providing the very finest in dental treatment for you. Please let us know if you have any questions at any time.

I understand the financial policy and agree to adhere to my obligations according to it.

_____ _____

Signature of Responsible Party Date