

NEW PATIENT REGISTRATION FORM

Welcome to Clarksburg Bright Smiles 23200 Brewers Tavern Way, Clarksburg, MD 20871

	Patie	nt Information	
Patient Name:	MI Las	(D) (IAI	Date:
	MI Las Age: Gender:		
Email Address:		Phone (Cell):	
(Work):	(Home):	_ Communication Preference:	_ Phone
Address:			
	Street	Apartm	ent#
	City	State Zip C	Code
	Healt	h Information	
	tion closely. It is essential for to give you the highest quality of		h history, allergy, and medication
	of the following? Please check		
☐ AIDS/HIV Positive	☐ Cortisone Medicine	☐ High Blood Pressure	☐ Renal Dialysis
☐ Alzheimer's Disease	□ Diabetes	High Cholesterol	☐ Respiratory Problems
☐ Anaphylaxis	☐ Drug Addiction	☐ Hives or Rash	☐ Rheumatic Fever
☐ Anemia	☐ Easily Winded	☐ Hypoglycemia	☐ Rheumatism
☐ Angina	☐ Emphysema	☐ Irregular Heartbeat	☐ Scarlet Fever
☐ Arthritis/Gout	☐ Epilepsy/Seizures☐ Excessive Bleeding	☐ Kidney Problems☐ Leukemia	☐ Shingles ☐ Sickle Cell Disease
☐ Artificial Heart Valve	☐ Excessive Bleeding ☐ Excessive Thirst	☐ Liver Disease	☐ Sickle Cell Disease ☐ Sinus Trouble
☐ Artificial Joint☐ Asthma	☐ Excessive Thirst☐ Fainting Spells/	☐ Liver Disease☐ Low Blood Pressure	☐ Sinus Trouble ☐ Spina Bifida
☐ Blood Disease	Dizziness	☐ Lung Disease	☐ Stomach/Intestinal
☐ Blood Disease ☐ Blood Transfusion	☐ Frequent Cough	☐ Mental/Nervous	Disease
☐ Breathing Problems	☐ Frequent Cough	Disorders	☐ Stroke
☐ Bruise Easily	☐ Frequent Headache	☐ Mitral Valve Prolapse	☐ Thyroid Disease
☐ Cancer	☐ Glaucoma	☐ Osteoporosis	☐ Tonsillitis
☐ Chemotherapy	☐ Hay Fever	☐ Pacemaker	☐ Tuberculosis
☐ Chest Pains	☐ Head Injuries	☐ Pain in Jaw	☐ Tuberculosis☐ Tumors/Growths
☐ Cold Sores	☐ Head Injuries ☐ Heart Attach/ Failure	☐ Parrathyroid Disease	☐ Ulcers
		☐ Psychiatric Care	☐ Venereal Disease
☐ Congenital Heart Disorder	☐ Hepatitis A☐ Hepatitis B or C	☐ Radiation Treatments	■ Venereal Disease
☐ Convulsions	☐ Herpes	☐ Radiation Treatments ☐ Recent Weight Loss	
Do you have any allergie	es? □ Yes □No , If yes, Pleas	se explain:	
	ications? □ Yes □No , If yes,		
Are you Pregnant?	If Yes, Due Date		
	complications following dental t	reatment? □ Yes □ No	
	care of a physician? ☐ Yes ☐		
Do you have any health	problems that need further clari	fication? ☐ Yes ☐ No	
			correct. If I ever have any change i

my health, I will inform the doctors at the next appointment without fail.

Referral Information						
Whom may we thank for referri	ng you to our practice?					
☐ Another patient ☐ Google	e □ Website/Online □	Postcard/Mail 🏻 🗖	1-800-Dentist	□ Other		
Name of person or office referri	ng you to our practice:					
Emergency Contact						
Name:	Relationsh	nip to Patient:		□ Male □ Female		
Phone (Home):						
Patient Employment Information						
Employer Name:	Occupation:					
Address:		_ Phone Number:				
Dental Insurance Information						
Primary Dental Insurance Insurance Company:						
Group #:	ID #:					
If you are <u>NOT</u> the subscriber of this						
Relationship to Patient: ☐ Self ☐ Spouse ☐ Child/Dependent ☐ Other						
Subscriber Name:						
Birth Date:	Social <mark>Security</mark> #:	st	^{MI} □ Male	☐ Female		
Address:						
Employer Name:		City	State	Zip Code		
Secondary Dental Insurance						
Group #:						
If you are <u>NOT</u> the subscriber of this						
Relationship to Patient: Self	☐ Spouse ☐ Child ☐ €	Other				
Subscriber Name:						
Birth Date:	ast Fi Social <mark>Security</mark> #:		^{MI} □ Male	☐ Female		
Address:						
Employer Name:		City	State	Zip Code		
	0 1					
		for Services				
I hereby authorize Clarksburg Bright Smiles 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 informat administering claims for insurance benefits,						
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 Clarksburg Bright Smiles 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.						
, ,						
Signature of Patient (Or parent/guardia		Relati	onship to Patient: _			
	n)					
	,	Relatio	onabin to Dations			



Clarksburg Bright Smiles

23200 Brewers Tavern Way, Clarksburg, MD 20871

Financial Policy

We appreciate the opportunity to serve you and being a patient of Clarksburg Bright Smiles. 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 lable ll be more

For your convenience we accept cash, checks, Debit cards and all major credit patient financing for qualified lenders through Care Credit. For more information about If payment arrangements or obligations are not met, your account balance may responsible for any collection charges, court costs, and attorney fees for collection actithan 90 days past due may be subject to a finance charge of 1.5% per month past 90 day	cards. In addition, we make available t financing options, feel free to ask. be sent to collections. You will be ions on your account. Any balance more
	Initials:
<u>Dental Insurance</u>	
If you have dental insurance, we will do our best to ensure that you receive the m will handle the filing and processing of all claims, even though we are not in-net will accept assignment of benefits for plans that will make claim payments directly contract between the patient and the insurance company, not between our office companies change their rules, procedures, and payment basis often and arbitrarily, best to estimate what each plan will pay for different procedures, but the patient (or gu responsible for any balance that insurance does not cover. If an insurance claim has carrier after 60 days from submission, we may ask that you pay for any outstanding continue to pursue payment from your insurance company, and if the claim is later on patient.	twork with any insurance provider. We to our office. Insurance coverage is a and the insurance company. Insurance without notice to our office. We do our ardian or responsible party) is ultimately not been paid out on by your insurance g balance from the procedure. We will
	Initials:
Missed Appointments/Cancellation Police	c <u>y</u>
Our policy is to charge for missed appointments as the rate of no less than \$55 per appointment. Please help us serve you and our other patients by keeping schedule canceled or changed less than 24 hours from the time of the appointment become tip patients. We require you to inform our office of a cancellation or need to resch business day, 24 hours before the appointment (ex. A Monday 9 am appointment Friday before). Cancellations made with less than 24 hours notice may result in a more than the cost of the appointment. Due to the nature of the practice of dentimajor treatment, such notice is mandatory. I understand when failed, missed or total number of three times without a proper advance notice, future appoint Clarksburg Bright Smiles has right to ask to seek services at another dental practice.	ed appointments. Appointments that are time lost for the office and for our other ledule of any appointment at least one ent needs to be canceled by 9 am the charge out of no less than \$55 and no listry, and the advanced planning of all canceled appointments accumulate a numents may not be scheduled and
	Initials:
Thank you for taking the time to read and understand our financial policy. Our p the very finest in dental treatment for you. Please let us know if you have I understand the financial policy and agree to adhere to my obligation. Signature of Responsible Party	any questions at any time.
Signature of Responsione Larry	Date