## Patient Information

Patient Name: _____ Date: _____
Social Security #: _____ Birth Date: _____ Male/Female

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

Address: _____
Street Apartment #

_____
City State Zip Code

## Emergency Contact information

The Following is for: _____ Relationship to patient: _____
Name: _____ Phone (Home): _____ (Cell): _____
Address: _____ City: _____ State: _____ Zip: _____

## Employment Information for the person responsible for payment

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

## Insurance Information

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ SS/ID #: _____ Group #: _____

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

## Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

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

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

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

# Patient's Medical History

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)
Date of Last Dental Visit: _____ Reason for today's visit: _____
Are you happy with your Smile? YES/NO Are you interested in whitening your teeth? _____

Do you have any allergies?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Food Seasonal
Other? If yes, please explain: _____

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

- ☐ AIDS
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Pace Maker
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Mental Disorders
- ☐ Mitral Valve Prolapse
- ☐ Nervous Disorders
- ☐ Psychiatric care
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sickle Cell Disease
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Substance Abuse
- ☐ Thyroid Disease
- ☐ Tobacco/Alcohol Abuse
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Other _____

List All Medications currently taking:

Blood Pressure: _____
Pulse _____

Women, are you:
Pregnant Trying to get pregnant Nursing Taking Oral Contraceptives

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- 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, friend ☐ Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

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

# BriteSmiles Dentistry

## Dr. Salguti's Office Policy

There will be a $ 25.00 charge for appointments that have been confirmed and a 24 hour notice has not been given to either reappoint or cancel the appointment. Thank you for your understanding in this matter, so we may be able to assist all of our patients and give them excellent care that we strive for at all times.

---------- Patients Signature

Thank You

Management

# Brite Smiles Dentistry

## Oral Cancer Exam

I _____ give Brite Smiles Dentistry permission to complete an oral cancer exam in office. I understand there is a fee of $ 65.00 that will be due at time of service, In the event that my insurance does not pay for this procedure, I understand I will be responsible for the fee.

**Print name:** _____

Signature _____ Date: _____

**No.** I would prefer not to have the oral cancer exam at this time.

**Print name:** _____

Signature: _____ Date: _____

Thank You

Brite Smiles Dentistry

Dr. Deepika Saiguti D.M.D.

# Brite Smiles Dentistry

Excellence in Cosmetic and Restorative Dentistry

Acknowledgement of Receipt of Privacy Notice,

And **HIPAA** Consent to Disclose Information

**Patient's Name:** _____

**Date of Birth:** _____

I hereby allow **Brite Smiles Dentistry**, to disclose the following protected health information:

_____ Appointment times and dates _____ Test results

_____ Tests that have been received _____ Other health information

To the following people because they are involved with my health care or payment (please provide name, preferred contact method, and contact information):

Spouse: _____

Child: _____

Friend: _____

Other: _____

I acknowledge that I have received a copy of Provider's Notice of Privacy Practices (HIPAA Information and Consent Form). I hereby consent and acknowledge my agreement to the terms set forth in the HIPAA Information Form and any subsequent changes in office policy. I understand that this consent shall remain in effect from this time forward. I understand that I may revoke this consent in writing at any time.

I also acknowledge that I have received a copy of the Office Policies for Dr. Deepika Salguti. I have reviewed and fully understand the office regarding office visits, cancellations, and not calling or showing for a scheduled appointment.

_____ **Date** _____

**Signature of Patient/Patient Representative**

_____

**Representative's Relationship to Patient**