BRITO FAMILY DENTAL

PATIENT REGISTRATION

PATIENT LAST NAME: _____ **FIRST:** _____ **INITIAL:** _____

How do you wish to be addressed? _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Telephone (Mobile) _____ (Work) _____ (Home) _____

Email _____

How did you hear about our practice? _____

INSURANCE INFORMATION

Primary Insurance	Secondary Insurance
Subscriber Name _____	Subscriber Name _____
Subscriber ID _____	Subscriber ID _____
Date of Birth _____	Date of Birth _____
Relationship to Subscriber ☐Self ☐Spouse ☐Child ☐Other	Relationship to Subscriber ☐Self ☐Spouse ☐Child ☐Other
Employer Name _____	Employer Name _____
Employer Phone _____	Employer Phone _____
Insurance Company _____	Insurance Company _____
Insurance Group _____	Insurance Group _____
Insurance Phone _____	Insurance Phone _____

Please present your insurance card to be photocopied for our records.

RESPONSIBLE PARTY *(If minor)*

Last Name: _____ First: _____ Initial: _____

Address *(If different)* _____ Date of Birth _____

City _____ State _____ Zip _____

Telephone (Home) _____ (Work) _____ (Mobile) _____

Email _____

EMERGENCY CONTACT

Last Name: _____ First: _____ Initial: _____

Telephone (☐Mobile ☐Work ☐Home) _____

AUTHORIZATION

I consent to the diagnostic procedures and dental treatment performed by my dentist, and to the release of information concerning my (or my child's) health care, advice, and treatment to another dentist, or for evaluating and administering any claims for insurance benefits. I consent to the direct payment of my insurance benefits to dentist or dental group and understand that my insurance benefits may pay less than the actual bill for services and that I am responsible for any services not paid or covered by my insurance benefits and any account balance.

ELECTRONIC COMMUNICATIONS. I consent to receiving HIPAA-compliant electronic communications, such as email and text messages regarding treatment, payment and health care operations. I understand that there is no obligation to receive these electronic communications.

I attest to the accuracy of the information on this page.

Signature _____ Date _____

(Responsible Party, if under 18)

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MEDICAL HISTORY

Last Name: _____ First Name: _____ Birthdate: _____

Name of Medical Doctor: _____ City/State: _____

List all medications

☐ None

List all medications or drugs you are allergic to:

☐ None

List any medical conditions you may have including: asthma, bleeding problems, cancer, diabetes, heart murmur, heart trouble, high blood pressure, joint replacement, kidney disease, liver disease, pregnancy, psychiatric treatment, sinus trouble, stroke, ulcers, or history of rheumatic fever or of taking fen-phen:

☐ None

Tobacco use? _____

Unusual reaction to dental injections? _____

Reason for today's visit _____ Are you in pain? _____

_____

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FINANCIAL AGREEMENT

Please read entire form carefully, then sign and date the bottom
The following defines the financial policies of this practice.

Payment is due at the time services are rendered

The front desk staff will estimate the amount you owe for procedures the doctor or hygienist has completed or those procedures which are in progress. Remember, this is only an estimate. The actual out -of pocket expense may be less than or greater than the amount estimated and collected. You may be reimbursed or apply the excess to another date of service if we have collected too much.

Some insurance plans require the patient to pay only a percentage or co-payment directly to our office. Some plans require the patient to pay the entire amount due for that visit. Some plans will reimburse the covered amount only to the patient. We will work with your plan, and submit the form necessary to receive the reimbursement as a service to our patients.

Insurance coverage

We accept many different insurance plans. All plans have a unique schedule of covered services depending on what plan you or your employer has purchased. There is no guarantee that services will be covered. You, or the person responsible for this account, will be responsible for payment of non-covered procedures. There may be additional charges to cover the cost of parts or labs fees, depending on the treatments provided and type of insurance coverage. If you wish, we can send a pre-determination to your insurance carries. The advantage of this is knowing approximately what your out-of-pocket expenses will be for labor charges, but a disadvantage is that treatment is delayed. This in itself could complicate matters as problems may worsen.

Major Work

Patients receiving major work (crowns, bridged, dentures) or bleaching kits must have their portions, including lab fees and parts fees, completely paid off before the work can be delivered or cemented.

Cancellation Policy

Our time is as important as yours. We attempt to schedule as efficiently as possible to reduce waiting time. We require patients to cancel appointments 48 prior to their appointment. A broken appointment fee of $50.00 is charged when the patient does not show up for an appointment or cancels without 48 hours notice prior to the appointment.

Patients with greater than three no show appointments/ less than 48 hour notice cancellations may receive a letter dismissing them from the practice based on their accumulated multiple no-shows/late cancellations.

For my convenience, this office may release my information to my insurance company, and receive payment directly from them.

I understand of the financial policies of Brito Family Dental and agree to them

Signature of Responsible Party _____ Date _____