☐ Specialty Dental Group
☐ Periodontal and Implant Dental Group

PATIENT INFORMATION

THIS INFORMATION IS NECESSARY FOR OUR FILES AND WILL BE CONSIDERED CONFIDENTIAL

DATE ________________

PATIENT'S NAME ____ AGE_______BIRTHDATE___________
LAST FIRST

IF PATIENT IS A MINOR, GUARDIAN'S NAME____RELATIONSHIP_________

RESIDENCE ADDRESS ____
STREET CITY STATE ZIP

PATIENT IS: [ ] SINGLE [ ] MARRIED [ ] DIVORCED [ ] SEPARATED [ ] WIDOWED [ ] MINOR [ ] MALE [ ] FEMALE

DRIVER'S LIC. NO. ____________________ SOCIAL SECURITY NO. ______________HOME PHONE ( ) ____________

EMPLOYED BY ____ OCCUPATION _______________

BUSINESS ADDRESS____ BUS PHONE ( ) ____________

E-MAIL ADDRESS ____ CELL PHONE ( ) ___________

SPOUSE'S NAME ___________________________DRIVER'S LIC. NO. _________________SOC. SEC. NO. ______________

BUSINESS ADDRESS____ BUS PHONE ( ) ____________

EMERGENCY CONTACT ____ PHONE NO ( ) __________

NAME OF PHYSICIAN ____ PHONE NO ( ) __________

NAME OF DENTIST ____ PHONE NO ( ) __________

WHOM MAY WE THANK FOR REFERRING YOU? ____

I PREFER TO BE CONTACTED BY:

☐ HOME PHONE ☐ BUSINESS PHONE ☐ CELLULAR PHONE ☐ E-MAIL ☐ OTHER: __________________

BEST TIME TO BE REACHED: ____

INSURANCE INFORMATION

DO YOU HAVE DENTAL INSURANCE? [ ] YES [ ] NO	DO YOU HAVE SECONDARY DENTAL INSURANCE? [ ] YES [ ] NO	DO YOU HAVE MEDICAL INSURANCE? [ ] YES [ ] NO
NAME OF INSURANCE COMPANY	NAME OF INSURANCE COMPANY	NAME OF INSURANCE COMPANY
NAME OF INSURED	NAME OF INSURED	NAME OF INSURED
SOCIAL SECURITY NO. BIRTHDATE	SOCIAL SECURITY NO. BIRTHDATE	SOCIAL SECURITY NO. BIRTHDATE
EMPLOYER GROUP NO.	EMPLOYER GROUP NO.	EMPLOYER GROUP NO

CONSENT FOR TREATMENT AND PAYMENT
The above information is complete and correct to the best of my knowledge. I authorize and give consent to perform dental services agreed between doctor and patient and/or guardian to be necessary or advisable. Including the use of local anesthesia and other medication as indicated. I agree that, regardless of insurance coverage, I am responsible for payment of services rendered.

____ _______________________
SIGNATURE OF PATIENT/PARENT/GUARDIAN DATE

OFFICE PROCEDURES OF
BRIGHTON SPECIALTY DENTAL GROUP AND
BRIGHTON PERIODONTAL & IMPLANT DENTAL GROUP

1. It is our office procedure that we will address you by your first or last name.
2. Phone Confirmations and Cancellation/Missed Appointment Policy: It is our office procedure that we call to confirm your appointment. It is also our procedure that you call **at least 72 hours in advance** to cancel your appointment or there will be a charge – New Patients: $150; Missed Hygiene Appointments: $75; Surgical Appointments or appointments that are scheduled for over 2 hours: $200/hour.
We may also call you regarding medical issues. If we cannot reach you, we may leave a message on your answering machine.
3. Verbal Authorization: It is our office procedure to get verbal authorization from all new patients to confirm appointments and leave messages if patient is not available. Also, patients must call 24 hours in advanced to cancel appointments.
4. Photo and Video Examinations: It is our office procedure that we may take photos/videos of your face, mouth, and teeth, which are stored in your chart.
5. It is our office procedure to share Protected Health Information with labs, consulting dentists, physicians, and hospitals. We will also call the pharmacy of your choice if you are prescribed a medication. We will only exchange minimum necessary Protected Health Information for each transaction.
6. Our office is HIPAA-compliant and the staff has been trained in the HIPAA Privacy Act. We will do everything we can to protect your Patient Health information. However, our office was designed before the HIPAA Law so please be respectful of other patients' privacy.

I, ____, agree to all of the above procedures of **Brighton Specialty Dental Group and Brighton Periodontal & Implant Dental Group,** and give my authorization to all of the above procedures.

Patient's Signature: ____

Date: ______________________________

List names of minor family members and their ages:

___________________________ __________ ___________________________ __________

___________________________ __________ ___________________________ __________

___________________________ __________ ___________________________ __________

I, ____, authorize **Brighton Specialty Dental Group and Brighton Periodontal & Implant Dental Group** to examine and provide medical/dental treatment. I assume full responsibility for any balance due. I authorize my insurance company to pay by check made out directly to **Brighton Specialty Dental Group** or **Brighton Periodontal & Implant Dental Group.** I authorize **Brighton Specialty Dental Group and Brighton Periodontal & Implant Dental Group** to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit. I understand that it is my responsibility to know all rules and restrictions of my insurance policy, to know which hospital, emergency rooms, laboratories, X-Ray departments, and specialists and specialist providers which are assigned to me according to my insurance policy rule. It is **Brighton Specialty Dental Group and Brighton Periodontal & Implant Dental Group's procedure** to share Protected Health Information with labs, X-Rays, consulting physicians, and hospitals. We will call the pharmacy of your choice regarding your prescriptions. We will only exchange minimum necessary Protected Health Information for each transaction.

____ _________________________
Patient or Responsible Party Signature Date