BRIGHTON DENTAL GROUP, P.C.

ACCOUNT # ☐☐☐☐☐☐ - ☐ DATE: _____

NAME _____
LAST FIRST MIDDLE

BIRTH DATE _____ SEX: M F MARITAL STATUS _____ SS# _____

ADDRESS _____
AND STREET CITY STATE ZIP

HOME PHONE _____ BUSINESS PHONE _____ OTHER/CONTACT _____
(CIRCLE THE NUMBER WHERE YOU CAN BE REACHED DURING THE DAY)

EMPLOYER _____ OCCUPATION _____

PERSON RESPONSIBLE FOR PAYMENT _____
IF DIFFERENT THAN LISTED ABOVE. LAST FIRST MIDDLE

RELATIONSHIP OF PATIENT TO PERSON RESPONSIBLE FOR PAYMENT: SELF / SPOUSE / CHILD / OTHER _____

DO YOU HAVE DENTAL INSURANCE? ☐ **YES** ☐ **NO**

DENTAL INSURANCE INFORMATION FOR SELF:

INSURED NAME _____
INSURED DATE OF BIRTH: _____
SS# _____
EMPLOYER _____
OCCUPATION _____
INSURANCE CO. _____
INSURANCE CO. ADDRESS _____
POLICY# _____
GROUP# _____ LOCAL# _____

DENTAL INSURANCE INFORMATION FOR SPOUSE:

INSURED NAME _____
INSURED DATE OF BIRTH _____
SS# _____
EMPLOYER _____
OCCUPATION _____
INSURANCE CO. _____
INSURANCE CO. ADDRESS _____
POLICY# _____
GROUP# _____ LOCAL# _____

NEAREST RELATIVE IN AREA: _____ PHONE _____
(IN CASE OF EMERGENCY)

ADDRESS: _____

WHOM MAY WE THANK FOR REFERRING YOU TO THIS OFFICE? _____

ADDRESS _____

* *

The undersigned hereby authorizes the staff of the Brighton Dental Group, P.C. to take x-rays, studymodels, photographs or any other diagnostic aids deemed appropriate by the doctor to make a diagnosis of the patient's dental needs. I also authorize the doctor to perform any and all forms of treatment, medication and therapy, that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that the responsibility for payment for dental services provided by this office for myself or my dependants is mine, and due and payable on the day of service unless financial arrangements are made in advance. I agree to pay the cost of collection if past due balance is referred for collection. I assign all insurance benefits to the Brighton Dental Group, P.C. and authorize the release of information to my insurance carrier or other health personnel..

SIGNED _____ DATE _____
PATIENT/PARENT OR AGENT (MUST BE 18 YEARS OR OLDER)

PATIENT REGISTRATION AND CONSENT FORM

BRIGHTON DENTAL GROUP, P.C.

Answers to these questions will help us decide how to best treat you.

PATIENT NAME: _____ **DATE OF BIRTH** _____

PHYSICIAN: _____ **PHYSICIAN'S PHONE** _____

DATE OF LAST PHYSICAL _____

MEDICAL HISTORY

CHECK YES OR NO

☐ YES ☐ NO Are you currently under a physician's care?

☐ YES ☐ NO Have you had any major operations? If so, what?

_____

☐ YES ☐ NO Have you ever had a serious accident involving head, neck or jaw injuries?

☐ YES ☐ NO Have you had any adverse response to any drugs including penicillin and aspirin?

☐ YES ☐ NO Have you ever had any of the following? If yes, check boxes below:

☐ Heart Ailment	☐ Liver Disease
☐ High Blood Pressure	☐ Kidney Disease
☐ Low Blood Pressure	☐ Stomach or Intestinal Disease
☐ Respiratory Disease	☐ Sexually Transmitted Disease
☐ Diabetes	☐ Yellow Jaundice or Hepatitis
☐ Rheumatism or Arthritis	☐ Epilepsy
☐ Tumors or Growths	☐ Hepatitis A (Infectious)
☐ HTLV/HIV Virus	☐ Hepatitis B (Serum)
☐ Organ Transplant	☐ Pace Maker
☐ Artificial Heart Valve	☐ Artificial Joints (Hip/Knee/other)
☐ Blood Disease	Pins/Screws in Bone_____ Date

☐ YES ☐ NO Are you in general good health at this time?

☐ YES ☐ NO Have you been informed that you need pre-med (antibiotics) for dental procedures?

☐ YES ☐ NO Are you allergic to any known materials resulting in hives, eczema, breathing problems, etc.?

☐ YES ☐ NO Have any wounds that healed slowly or presented other complications?

☐ YES ☐ NO **FOR WOMEN:** Are you pregnant? Due Date _____

☐ YES ☐ NO Do you have a history of fainting?

☐ YES ☐ NO Have you ever had any radiation therapy?

☐ YES ☐ NO Are you now taking drugs or medications?

CURRENT MEDICATION	REASON

DENTAL HISTORY

	YES	NO
How long since your last dental visit? _____		
When was your last COMPLETE dental exam? _____		
When was your last Full Mouth x-rays (16 small films), or Panorex (machine that rotates around your head)?_____		
Are you having any dental problems now? If so, what?_____	☐	☐
Do you have good dental health?	☐	☐
Do you wear dentures (full or partial)?	☐	☐
If so, do you like the fit & appearance of your present dentures?	☐	☐
Have you experienced any growths or sore spots in your mouth?	☐	☐
Do your gums bleed, feel tender or irritated?	☐	☐
If so, have you ever had any treatment for that condition?	☐	☐
Do you regularly use dental floss?	☐	☐
Are you HAPPY with the appearance of your teeth?	☐	☐
Do you have any discolored teeth that bother you?	☐	☐
Do you wish you had whiter teeth?	☐	☐
Would you like your smile to look better or different?	☐	☐
Any reaction or allergies to anesthetic (novocaine, lidocaine, carbocaine, etc.)?	☐	☐
Have you had prolonged bleeding following an extraction?	☐	☐
Are your teeth sensitive to hot, cold, sweets or pressure?	☐	☐
Are you aware of grinding or clenching of your teeth?	☐	☐
Do you experience headaches, earaches or neck pain (circle)?	☐	☐
Do you have loose, tipped or shifting teeth?	☐	☐
Have you ever worn braces on your teeth (orthodontics)?	☐	☐
Are you apprehensive about dental treatment?	☐	☐
Have you had GOOD or BAD (circle one) dental experiences in the past?	☐	☐
Is there any additional medical or dental information that we should know?	☐	☐

_____

_____

Name of previous dentist_____

Signature:_____ _____

Date:_____

MEDICAL AND DENTAL HISTORY

☐ **MEDICAL ALERT**

BRIGHTON DENTAL PLLC

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number: _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Dr. R. Ajay Dass 125 White Spruce Blvd. Rochester, NY 14623

Telephone: (585) 424-5660 Fax: (585) 424-1239 Email: Smile@bridentgroup.com

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

BRIGHTON DENTAL PLLC

125 White Spruce Blvd. Rochester NY, 14623

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of your Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign
Communications barriers prohibited obtaining the acknowledgement
Others (Please Specify)

_____

_____

_____

Brighton Dental, P.L.L.C

R. Ajay Dass, D.D.S.
Y. (Jay) Mruthyunjaya, B.D.S., M.P.H.
Vandana Nanavati, D.D.S.
Adam Chalom, D.D.S.

Dear Patient:

In an effort to reduce cost, increase efficiency and maintain a high level of professional care, we have created a financial policy that both patient and office personnel must adhere to.

Our office policy is as follows:

- As a courtesy, we will accept most dental insurance assignments and submit claims on your behalf. However, any deductibles and patient portion will be due in full at the time of your visit.

  Note: ***Although we will process your claims, it is the sole responsibility of the patient to satisfy any account balance in full for the service rendered. Amount not paid by the insurance for any reason becomes due and payable by the patient.***

- For services over $250.00 we expect 50% of the patient portion the fee at the beginning of the treatment and the balance at completion.
- We provide a 10% discount when paying at time of service in full by check or cash.
- We accept payment by **cash, check or credit card** (Visa, Mastercard, Discover or American Express)
- Inquire about our in-house insurance.
- For extensive treatment you can also apply for **3/6/12 month interest free** payment option.

If you have any questions regarding these financial policies, do not hesitate to speak to one of our business coordinators. We are here to help you in every way.

I understand and accept the above financial policy.

_____ _____

Patient or Responsible Party Brighton Dental Group, P.C.

Patient Name (Please Print)_____ Date _____

Address _____

125 WHITE SPRUCE BLVD. | ROCHESTER, NY 14623-1687 | PHONE 585-424-5660 | FAX 585-424-1239
e-mail: smile@bridentgroup.com | Web: www.brightondentalgroup.com