PATIENT REGISTRATION

Date_____ Cell Phone _____ Home Phone _____

Patient's Name_____ Birth Date_____ Age____ Preferred Name_____

Address _____

City _____ State____ Zip _____ Email Address_____

□ Single □ Married □ Widowed □ Divorced □ Separated Gender: □ M □ F Social Security #_____

Employed by_____ Position _____

Business Address_____ Business Phone _____

Spouse/Parent Name_____ Social Security # _____

Spouse/Parent Employed by_____ Position_____

Business Address_____ Business Phone_____

Who is responsible for this account?_____ Relationship to Patient_____

Birth date and Social Security # of person responsible for account _____/_____

Primary Dental Insurance Company_____ Group # _____

Secondary Dental Insurance Company_____ Group # _____

In case of emergency, who should be notified?_____ Phone_____

Whom may we thank for this referral?_____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance with_____

(Name of Insurance Company/ies)

And assign directly to Brite Family Dental all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

_____ _____

(Signature) (Date)

MINOR/CHILD CONSENT

I, the parent or guardian of_____ do hereby request and authorize the dental staff of

(Name of patient)

Brite Family Dental, Inc. to perform necessary dental services for my child, as indicated on an approved treatment plan, including but not limited to taking radiographs and administration of local anesthetic whether I am present or not when treatment is rendered. I also understand that I must update my child's health questionnaire either verbally or in writing prior to these appointments during which I may be absent.

_____ _____

(Signature) (Date)

(Rev.8/23)

Brite Family Dental

PATIENT'S NAME_____

HEALTH QUESTIONNAIRE ACKNOWLEDGEMENT AND CONSENT TO PROCEED: I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or medications can affect dental treatment, I understand the importance of and agree to notify the dentist of any changes at any subsequent appointment.

I authorize Dr. Scott A. Tracy and Dr. Kendell Davies or such associates or assistants as they may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to, bruising, hematoma, cardiac stimulation, and temporary or rarely, permanent numbness, and muscle soreness. I understand that it is possible for needles to break during the administration of local anesthetic and that surgical recovery of the needle may be necessary. Occasionally drops of local anesthetic may contact the eyes and facial tissues and cause temporary irritation. Dental materials and medications may trigger allergic or sensitivity reactions.

I understand that as part of the dental treatment, including preventive procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. After lengthy appointments, jaw muscles may also be sore or tender. Gums and surrounding tissues may also be sore or tender. Although rare, it is also possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases, sutures or additional treatment may be required.

I do understand that as part of dental treatment items including, but not limited to crowns, small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require bronchoscopy or other procedures to ensure safe removal.

I understand the need to disclose to the dentist any prescription drugs that are currently being taken or that have been taken in the past, such as Phen-Fen. I understand that taking the class of drugs prescribed for the prevention of osteoporosis, such as Fosamax, Boniva or Actonel, may result in complications of non-healing of the jaw bones following oral surgery or tooth extractions.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Signature:_____ Date:_____
(Patient, legal guardian or authorized agent of patient)

Witness:_____ Date: _____

(Rev. 8/23)