Bristol Family Dental, PC

815 Pine St. • Bristol, CT 06010--4448 (860)589-2794

Patient Information

Chart#: ____________
FOR OFFICE USE ONLY

Patient Name: ____________ * ____________ * ____ ____________
Last First MI Preferred Name

Title: ________ Gender:* ◯ Male ◯ Female Family Status:* ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date:* ________ Prev. Visit: ________ Email Address:
____

Phone: ________ * ________ ________ ____ Best time to call: ________
Home Mobile Work Ext

Address: ____________ * ____________
Address 1 Address 2

____________ * ______ * ____-____ *
City State Zip Code

Whom may we thank for referring you to our practice?

- ☐ Google Search
- ☐ Your insurance website
- ☐ Sign
- ☐ Facebook/Social Media
- ☐ Family/Friend (name below):
- ☐ Other (name below):

Name of person, office, or other source referring you to our practice:

____

Spouse or Responsible Party Information

The following is for:* ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name: ____________ * ____________ * ____ ____________
Last First MI Preferred Name

Title: ________ Gender:* ◯ Male ◯ Female Family Status:* ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date:* ________ Email Address: ____________

Phone: ________ * ________ ________ ____ Best time to call: ________
Home Mobile Work Ext

Address: ____________ * ____________
Address 1 Address 2

____________ * ______ * ____-____ *
City State Zip Code

Signature of patient, parent, or guardian (responsible party):

Signature ____________________ Date ________

Relationship to Patient: ____________

Primary Insurance Information

Primary Dental Insurance:

Name of Insured: ______________________ ______________________ ____
Last First MI

Insured's Birth Date: __________ ID #: ______________ Group #: __________

Insured's Address: ______________________ ______________________
Address 1 Address 2

______________________ ____ _____-____
City State Zip Code

Insured's Employer Name: ______________________

Employer Address: ______________________ ______________________
Address 1 Address 2

______________________ ____ _____-____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: ______________________

Insurance Address: ______________________ ______________________
Address 1 Address 2

______________________ ____ _____-____
City State Zip Code

Secondary Insurance Information

Secondary Dental Insurance:

Name of Insured: ______________________ ______________________ ____
Last First MI

Insured's Birth Date: __________ ID #: ______________ Group #: __________

Insured's Address: ______________________ ______________________
Address 1 Address 2

______________________ ____ _____-____
City State Zip Code

Insured's Employer Name: ______________________

Employer Address: ______________________ ______________________
Address 1 Address 2

______________________ ____ _____-____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: ______________________

Insurance Address: ______________________ ______________________
Address 1 Address 2

______________________ ____ _____-____
City State Zip Code

Response Date: __________

BRISTOL
FamilyDENTAL

Authorization and Consent for Services

I, ____________________________, hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect information has the potential of being hazardous to your health.

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

All emergency dental services, or any other dental services performed without previous financial arrangements, must be paid in full at the time of service.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I will be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on my dependent (if any).

A finance charge of 1% per month on any unpaid balance will be charged on all accounts exceeding sixty days. If legal or collection services are required to obtain payment, I understand that I will be responsible for all collection and legal costs associated with this debt.

*Cancellation Policy:

An appointment at Bristol Family Dental, is a reservation. If you are unable to keep your scheduled appointment, we require a 48 hour notice, or a fee will be assessed as follows:

- $50 will be charged for all appointments 1 hour or less. **PLEASE INITIAL__________**

- $100 will be charged for all appointments over an hour. **PLEASE INITIAL____________**

- We will require a deposit of $100 to reschedule any appointments with the doctor that are an hour and a half or longer. Your deposit will go towards your treatment. **PLEASE INITIAL__________**

*Payment options:

*Visa, MC, Amex, Disc, Cash, Check, Care Credit

* 5% courtesy is given if a multi-appointment treatment plan if paid in full at or before the first appointment. Cannot be combined with dental insurance.

*10% courtesy is given to seniors with no dental insurance or the membership plan, and only applies if paid in full.

Patient/Guardian Signature: ____ Date: ______/______/2023

BRISTOL
Family DENTAL

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ______________________________, have received a copy of this office's Notice of Privacy Practices.

I acknowledge the following party and or parties to be privy to my health information. Please state **name, relationship & best way to contact** the appropriate party.

1. ______________________________
2. ______________________________
3. ______________________________

____
Please Print Your Name

____
Signature

____
Date

* You may refuse to sign this acknowledgement *

For Office Use Only

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

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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Medical & Dental History Form

Patient Name: ____________ ____________ ___ ____________
Last First MI Preferred Name

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well-being.

What is the date (or approximate date) of your last medical exam? ____________

Your Primary Care Physician's name, address, & phone number:

____

____

Please indicate if you have experienced any of the following:

☐ Allergy- Anesthetic	☐ Allergy- Aspirin	☐ Allergy- Codeine	☐ Allergy- Foods
☐ Allergy- NSAIDs	☐ Allergy- Other	☐ Allergy- Pen/Amox	☐ Allergy- Sulfa Drugs
☐ Angina	☐ Artifical Heartvalve	☐ Asthma	☐ Blood Thinner Use
☐ Cancer	☐ Cold sores (Herpes)	☐ Diabetes	☐ Epilepsy/Seizures
☐ Glaucoma	☐ Heart attack	☐ High Blood Pressure	☐ High Cholesterol
☐ Kidney Disease	☐ Liver Disease	☐ Mental Health Care	☐ Oral Contraceptives
☐ Pacemaker	☐ Reflux/GERD	☐ Snoring	☐ Stroke
☐ Surgery history	☐ Vertigo		

Do you have any other health issues or allergies?

____

____

____

Please list any medications you are currently taking, one medication per line:

____

____

____

____

Have you been hospitalized within the last 5 years due to surgery or illness? ◯ Yes ◯ No

If yes, please explain: ____________

Have you had an orthopedic total joint replacement? ◯ Yes ◯ No

Have you taken, or are scheduled to take, antiresorptive agent (ie. Fosamax, Actonel, Boniva, Reclast, Prolia, Aredia, Zometa, XGEVA)?
◯ Yes ◯ No

Has any medical provider recommended you premedicate with antibiotics prior to dental appointments? ◯ Yes ◯ No

Do you use tobacco (smoking or chewing or vaping)? ◯ Yes ◯ No

Do you use marijuana? Medicinal or Recreational? ◯ Yes ◯ No

WOMEN ONLY: Are you pregnant? ◯ Yes ◯ No

If Yes, when is the due date? ____________________

Are you breastfeeding? ◯ Yes ◯ No

Dental History

What is the reason for your dental visit today?

____

____

When was your last dental visit and what was done? ____________________

If you could change anything about your mouth, teeth, or smile, what would it be? ____________________

How frequently do you brush your teeth?

◯ 2(+) a day ◯ Daily ◯ Weekly ◯ Seldom

How frequently do you floss your teeth?

◯ Daily ◯ 3-4 times per week ◯ Occasionally ◯ Never

Please mark any of the following to indicate Yes in response to the question:

- ☐ Do your gums bleed when you brush or floss?
- ☐ Do your teeth experience sensitivity to cold or hot temperatures or biting?
- ☐ Are any of your teeth currently causing you pain?
- ☐ Do you clench or grind your teeth (either consciously or during sleep)?
- ☐ Are any of your teeth loose, or are you concerned about any teeth loosening?
- ☐ Do you currently have any dental implants, dentures, or partials?
- ☐ Have you ever had complications following dental treatment?

If any of the previous questions are marked, please explain:

____

____

☐ **To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next dental appointment without fail. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.**

Signature of patient, parent, or guardian:

Signature ____ **Date** __________

Relationship to Patient:

____

____

Provider Signature:

Signature ____ **Date** __________

Response Date: __________