JESSICA H. BRIGATI, DDS, PLLC
FAMILY DENTISTRY

PATIENT INFORMATION FORM

If you are downloading and emailing this form, please save this file to your computer before filling it out.

About You

Last Name _____First _____Middle Initial _____

Name of Guardian if patient is a minor: _____

Circle one: ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. I prefer to be called: _____

Status: ☐ single ☐ married ☐ child ☐ other Gender: ☐ male ☐ female

Birth Date: ____/_____/____ SS#:_____-_____-_____ DL# __ __ __ __ __ __ __ __

Address: _____

City/State/Zip_____

Email Address: _____@_____

Home Telephone #_____ Work #_____ext. _____

Fax #: _____Pager #: _____Cell #: _____

Employer:_____ Position/Title_____ # of yrs_____

Business Address:_____

Spouse's Name _____ Work # : _____ext: _____

Other family members seen by us:*(name/ relation)*_____

Whom may we thank for referring you: _____

In case of Emergency contact: _____Relation:_____#:_____

Dental History

Name of Previous Dentist: _____ Phone#_____

Date of last dental visit: _____ Date of last cleaning: _____Date of last X-Ray_____

Have you worn braces? ☐ no ☐ yes If yes, Date removed: _____ Orthodontist's Name: _____

Are you currently wearing your retainer every night: ☐ Yes ☐ No, why? ☐ lost ☐ broke ☐ other

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Dental Insurance

Insurance Co. Name:_____ Group#: _____

Customer Service 1.800 or 1.888 Number: _____ *(located on your insurance card)*

Who is the insured member in you family? ☐ Yourself ☐ Spouse ☐ Other

Insured's DOB _____ Insured's SS#___ ___ ___ - ___ ___ - ___ ___ ___ ___

Insured's Employer: _____ Wk#: _____

Has the insured had previous dental care under this plan? ☐ No ☐ Yes → *Date of last dental appointment:* _____

Name of Previous Dentist: _____

Medical History:

Are you currently under the care of a physician? Physicians Name: _____Phone: _____

Date of Last exam: _____

Do you have a current medical problem? Y☐ /N☐ Explain? _____

_____

_____

Please list any prescription/over-the-counter drugs you are taking:

Name of Medication _____ dosage _____ for _____

Name of Medication _____ dosage _____ for _____

Name of Medication _____ dosage _____ for _____

Name of Medication _____ dosage _____ for _____

Name of Medication _____ dosage _____ for _____

For Women:

Y☐ N☐ Are you pregnant? Y☐ N☐ Nursing? Y☐ N☐ Using Birth Control Medication?

Y☐ N☐ Hormone Medication Y☐ N☐ Through Menopause Y☐ N☐ Abnormal Pap Smear Date:_____

CONTINUED ON NEXT PAGE

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Have you ever had any of the following diseases or medical problems?

Y☐ N☐ AIDS
Y☐ N☐ HIV Positive
Y☐ N☐ Allergies/Hay Fever
Y☐ N☐ Anemia
Y☐ N☐ Arthritis
Y☐ N☐ Artificial Joints or Prosthetics (circle)
(describe)_____
_____
_____
Y☐ N☐ Asthma : Inhaler?_____
Y☐ N☐ Biopsy what_____ when_____
Y☐ N☐ Cancer/Chemotherapy/Radiation
Y☐ N☐ Diabetes
Y☐ N☐ Is your blood sugar monitored daily
Y☐ N☐ Emphysema
Y☐ N☐ Epilepsy/Seizures
frequency _____
Y☐ N☐ Glaucoma/ Cataracts (circle one)
Y☐ N☐ Heart Murmur/Mitral Valve Prolapse
Y☐ N☐ Heart Problems/Chest Pains describe
_____
_____
Y☐ N☐ Hearing Problems (left or right ear)
Y☐ N☐ Sexually Transmitted Disease (STD)
Which One(s): _____

Y☐ N☐ Hepatitis A☐ B☐ C☐ (select one)
Y☐ N☐ HPV (Human Papillomavirus)
Y☐ N☐ High☐/Low Blood Pressure☐ (select one)
Y☐ N☐ Implants (cosmetic or other)
what kind _____*date*_____
Y☐ N☐ Kidney or Urinary Problems
Y☐ N☐ Pacemaker: Date of Implantation: _____
Y☐ N☐ Rapid weight gain or loss greater than 10 lbs
Y☐ N☐ Scarlet Fever☐ or Rheumatic Fever☐ (Select One)
Y☐ N☐ Shortness of Breath or Swollen Ankles (circle)
Y☐ N☐ Sinus Problems
Y☐ N☐ Stomach or Digestive Problems
Y☐ N☐ Stroke date _____
Y☐ N☐ Surgery within the last five years
what kind _____
Y☐ N☐ Thyroid Trouble
Y☐ N☐ Tobacco Useage *what form:* ☐*cigarettes*
☐*chewing* ☐ vaping/ e-cigarettes ☐ *other* _____
are you currently practicing the above *yes*☐ *no*☐
how long have you been practicing the above: _____
*how often do you practice the above*_____
Y☐ N☐ Active or Remote Tuberculosis (TB) (select one)
Y☐ N☐ Oral Ulcer☐ or Stomach Ulcer☐ (select one)
Y☐ N☐ Blood Disorder _____
_____

Have you ever had an undesirable or allergic reaction to: (please note the reaction at the lines at the bottom)?

Y☐ N☐ Aspirin Y☐ N☐ Sulfa Drugs Y☐ N☐ Dental Anesthetics Y☐ N☐ Nickel
Y☐ N☐ Latex Y☐ N☐ Penicillin / Antibiotics Y☐ N☐ Epinephrine Y☐ N☐ Other
Y☐ N☐ Codeine/ Valium/ Morphine/ Pain Medication

_____
_____

Please list any other medical condition(s) and/ or serious illnesses that we should be aware of:

_____
_____

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Dental Hygiene Questions

How often do you brush your teeth? ☐ 2x/day ☐ 1x/day ☐ _____

How often do you floss? ☐ 2x/day ☐ 1x/day ☐ _____

Are you happy with teeth and their appearance? ☐ Yes ☐ No

What, if anything would you change about your teeth/smile if you could? _____

Are you interested in learning about the latest techniques in improving your smile? ☐ Yes ☐ No

Do you suffer from frequent headaches? ☐ Yes ☐ No If yes, how often? _____

Signatures

By physically or electronically signing below, I agree that the information provided today is correct to the best of my knowledge. I understand it is my responsibility to inform this office of any changes in my medical status. I understand that this office will assist me in getting my insurance reimbursement, but I am financially responsible for all charges whether or not paid by insurance. Payment is due in full at time of treatment unless prior arrangements have been approved.

_____ Sign / Date Here
Patient/Parent Signature

By physically or electronically signing below, I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges to the extent permitted under applicable law, I authorize release of any information relating to any dental claims.

_____ Sign / Date Here
Patient/ Parent Signature

By physically or electronically signing below, I hereby authorize payment of dental benefits otherwise payable to me directly to Dr. Jessica H. Brigati, DDS, PLLC.

_____ _____ Sign / Date Here
Patient/ Parent Signature ***Date***

JESSICA H. BRIGATI, DDS, PLLC
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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: 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 share your privacy practices as described in our Notice of Privacy Practices. If we change our policy, we will issue a revised Notice of Privacy Practices, which contain the changes. The 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 a revision of our Notice, by contacting our business manager: LaShann Daniel or by emailing LaShann@brigatiDDS.com.

Right to Revoke: You 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 this revocation, and that we may decline to treat you or continue treating you if you revoke this consent

Section B: 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 physically or digitally 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 a personal representative on behalf of the patient signs this Consent, 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.

For Office Use Only

If the patient declines to sign this form please check this box here: □

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PATIENT RECORD OF DISCLOSURES

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected heath information (PHI). The individual is also provided the right to request confidential communication or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner. ***(Check and fill in all that apply):***

Work Telephone: _____

- ☐ O.K. to leave message with detailed information
- ☐ Leave a message with call back number only

Home Telephone: _____

- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call back number only

Cell Phone: _____

- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call back number only
- ☐ O.K. to text me with information

Written Communication

- ☐ O.K. to **e-mail** me at this address:_____@_____
- ☐ O.K. to mail to my home address
- ☐ O.K. to mail to my workplace
- ☐ O.K. to fax to this number: _____

Other Individuals Who Can Request Information About Me

- ☐ Name _____ Relationship _____
- ☐ Name _____ Relationship _____
- ☐ Name _____ Relationship _____
- ☐ Name _____ Relationship _____

JESSICA H. BRIGATI, DDS, PLLC
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GENERAL CONSENT

1. I hereby authorize Dr. Jessica H. Brigati, DDS, PLLC or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.

2. Upon such diagnosis, I authorize Jessica H. Brigati, DDS to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I consent to the use of appropriate medication and therapy as deemed necessary. I fully understand that using anesthetic embodies a certain risk.

I have read, understand and agree to this General Consent. By typing or signing your name below, you have reviewed and electronically or physically signed this form.

_____ _____
Signature ***Date:***

_____
Witness ***:***

_____
Parent or Responsible Party

_____
Relationship to Patient

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FINANCIAL POLICY FORM

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our FINANCIAL POLICY, which we require you read and sign prior to any treatment along with our demographic form, health/dental history forms.

FULL PAYMENT of your estimated portion of treatment fees is due at the time of service unless prior arrangements have been made. We accept cash, checks, Visa, MasterCard, Discover, American Express and CareCredit.

INSURANCE: Your insurance policy is a contract between you and your insurance company. Our treatment recommendations are not determined by your insurance coverage. We file your insurance as a courtesy. We may accept assignment of insurance benefits. However, we do require at least your estimated portion to be paid at the time of service. If after pending insurance pays there is still an outstanding balance, the balance is your responsibility. (We can only file and accept insurance if we have your correct information - it is your responsibility to keep us up to date on your insurance coverage). Please be aware of limitations that may define non-covered, reasonable and necessary fees, and or waiting periods as defined by your particular policy.

USUAL AND CUSTOMARY RATES: Our practice is committed to providing the best treatment for our patients and our fees are usual and customary for OUR office. Our fees are based on the education of our staff, the high quality of materials and labs used, state of the art equipment used and procedures performed. Should you accept treatment, you are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary fees or treatment.

IN AND OUT OF NETWORK BENEFITS: Our office is considered out-of-network with all insurance companies with the exception of Delta with whom we are considered premier providers and we adhere to only the premier contract policies. You are responsible for understanding the terms of your policy as relates to in and/or out of network providers. •

SECONDARY INSURANCE: Having more than one insurer does not necessarily mean that your services are covered at 100%. Secondary insurers will pay as a function of what your primary carrier pays. We will help you file your secondary insurance as a courtesy. You are responsible for any balances after your insurance(s) has made payment.

MINOR PATIENTS: The adults accompanying a minor and the parents (or guardians of the minor) are responsible for payment. For unaccompanied minor, non-emergency treatment will be denied unless prior payment arrangements have been made.

DIVORCE DECREE: This office is NOT a party to your divorce decree. Parents are responsible for their bill at the time of service. The financial responsibility for a minor rests with the adult accompanying the patient to each visit.

MISSED APPOINTMENTS: Our office tries to accommodate our patient's busy schedules. Appointments are by reservation only and we request cancellations to be at least 48 hours in advance. Please help us serve you better by keeping scheduled appointments. If an appointment is no showed or cancelled without giving us notice of 48 hours, we will charge you $55.00 after the second occurrence.

Thank you for reading our Financial Policy. *Please let us know if you have any questions or concerns.*

I have read, understand and agree to this Financial Policy. By typing or signing your name below, you have reviewed and electronically or physically signed our Financial Policy form.

_____ _____

Signature of Responsible Party ***Date:***