BRITT DENTAL CENTER
Confidential Patient Information

PATIENT

Name _____ ☐ Male ☐ Female
Last First Middle Preferred

Address _____
City State Zip

Home Phone _____ Cell Phone _____ Email _____

Do we have your permission to contact you via email or text message with appointment reminders and other office information? Email: ☐ Yes ☐ No Text: ☐ Yes ☐ No

Date of Birth _____/_____/_____ SSN _____-_____-_____

Emergency Contact _____
Name Phone Number Relationship

Place of Employment _____ Occupation _____

Has any member of your family previously been treated in our office? ☐ Yes ☐ No

If so, what is his/her name and relationship to you? _____

Do you have dental insurance? ☐ Yes ☐ No If yes, please provide us a copy of your most recent insurance card.

Are you interested in more information on our Britt Dental Care discount savings plan for you or your family as an alternative to dental insurance? ☐ Yes ☐ No

PERSON RESPONSIBLE FOR ACCOUNT ☐ Same as above

Name _____ Date of Birth _____/_____/_____ SSN _____-_____-_____

Place of Employment _____ Occupation _____

Business Address _____ Business Phone _____
City State

MEDICAL HISTORY

Physician's Name _____ Phone Number _____

Date of last complete physical: _____ Are you under a doctor's care now? ☐ Yes ☐ No

Please describe any current medical conditions: _____

_____

Please list any medications (with dosages) or vitamins you are currently taking: _____

_____

Are you pregnant? ☐ Yes ☐ No If you are pregnant, when is your due date? _____

Are you currently nursing? ☐ Yes ☐ No

(continued on reverse)

Are you allergic to any of the following? ☐ Penicillin ☐ Latex ☐ Other: _____

Do you have a history of endocarditis? ☐ Yes ☐ No

Have you received a prosthetic joint in the last 6 months? ☐ Yes ☐ No

Are you subject to prolonged bleeding? ☐ Yes ☐ No

Do you smoke or use tobacco in any form? ☐ Yes ☐ No Frequency: _____ Type: _____

Please CHECK if you have or have had any of the following:

☐ High Blood Pressure	☐ Fainting or Dizziness	☐ Liver Disease	☐ Thyroid/Parathyroid Disease
☐ Low Blood Pressure	☐ Swelling of Feet/Ankles/Hands	☐ Hepatitis A (infectious)	☐ Arthritis/Gout
☐ Rheumatic Fever	☐ Stroke	☐ Hepatitis B (serum)	☐ Epilepsy or Seizures
☐ Congenital Heart Lesion	☐ Diabetes	☐ Hepatitis C	☐ Acid Reflux
☐ Artificial Heart Valve	☐ Tuberculosis	☐ HIV Positive	☐ Hypoglycemia
☐ Heart Murmur	☐ Kidney Trouble	☐ Fever Blisters/Herpes	☐ Drug/Alcohol Abuse
☐ Shielded Pacemaker	☐ Lung Disease	☐ Cancer	☐ Psychiatric Care
☐ Unshielded Pacemaker	☐ Sleep Apnea	☐ Chemotherapy/ Radiation	
☐ Mitral Valve Prolapse			

Please describe any serious illness you have had not listed above: _____

DENTAL HEALTH

Why have you chosen our dental practice? _____

What is your reason for today's visit? _____

Previous Dentist _____ Date of last visit: _____ Need records transferred? ☐ Yes ☐ No

How important is it for you to keep your teeth for the rest of your life? ☐ Very ☐ Somewhat ☐ Not important

Have you ever had complications following dental treatment? _____

Have you ever received orthodontic treatment? ☐ Yes ☐ No Periodontal treatment? ☐ Yes ☐ No

Are you concerned about any of the following? ☐ Discolored teeth ☐ Discolored fillings

☐ Spaces between teeth ☐ Broken or chipped teeth ☐ Missing teeth ☐ Crowding or crooked teeth

☐ Loose teeth ☐ Joint/Jaw pain ☐ Other _____

Have you been told that you grind your teeth? ☐ Yes ☐ No Have you been told that you snore? ☐ Yes ☐ No

Do you have any other concerns not mentioned above? _____

_____

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.

_____ _____

Patient or Guardian's Signature Date

BRITT DENTAL CENTER

FAMILY, COSMETIC, AND IMPLANT DENTISTRY

RECORDS RELEASE

DATE: _____

PATIENT(S) NAME: _____ DOB: _____
_____ DOB: _____
_____ DOB: _____
_____ DOB: _____

TRANSFER TO:

Britt Dental Center
7780 Brier Creek Parkway Suite 120
Raleigh, NC 27617
(919)957-4500
info@brittdental.com **(preferred)**

TRANSFER FROM: _____
_____
_____

PLEASE INCLUDE:

- ☐ Most recent panorex (with date)
- ☐ Most recent bitewings (with date)
- ☐ Any periodontal treatment information
- ☐ Date of last cleaning

PATIENT/GUARDIAN SIGNATURE : _____

RELATIONSHIP: _____ Date: _____

BRITT DENTAL CENTER

FAMILY, COSMETIC, AND IMPLANT DENTISTRY

ACCOUNT RESPONSIBILITY

Payment is due at time of service rendered.

Insurance:
We file all insurance for you as a courtesy. If your insurance company fails to cover all benefits, you are responsible for the remaining balance. We do our best to provide an accurate estimate regarding the fees for service, however, that is just an estimate and not a final quote.

ASSIGNMENT OF BENEFITS

I certify that I, and/or my dependent(s), have insurance coverage with _____ [Name of insurance company(ies)] and assign directly to Dr. Ben H. Britt, Jr. and Dr. Jessica A. Forestier all insurance 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 authorize the use of my signature on all insurance submissions. The above-named doctors may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Broken Appointments:
Fees for missed appointments or appointments canceled or rescheduled within ***24 hours*** will be assigned as follows:

Exam and Cleaning appointments: $50.00
Restoration procedures/Whitening appointments: 50% of scheduled fee

IF YOU ARE MORE THAN 10 MINUTES LATE TO YOUR APPOINTMENT, YOU MAY BE ASKED TO RESCHEDULE

Signature acknowledges receipt and understanding of financial agreement. I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

Signature of Patient, Parent, Guardian, or Personal Representative DATE

Please print name of Patient, Parent, Guardian, or Personal Representative Relationship to Patient

BRITT DENTAL CENTER

FAMILY, COSMETIC, AND IMPLANT DENTISTRY

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

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.

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.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us a written notice of your revocation submitted to the Contact Person mentioned in our Notice. 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.

I have had full opportunity to read and consider the contents of this Consent for and 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.

Name of Patient _____

Signature of Patient _____ Date _____

I give permission for _____, my _____
(NAME) (RELATIONSHIP TO PATIENT)

to communicate with Britt Dental Center on my behalf.

Signature of Patient _____ Date _____