REGISTRATION AND HEALTH HISTORY

Date: _____ **Who may we thank for this referral?** _____

First Name: _____ M.I. ____ Last Name: _____ ☐ male ☐ female Date of Birth: _____ *(Enter as MM/DD/YYYY)* Age: ____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____ Social Security#: _____ *(Do NOT include dashes or spaces)*

Email Address: _____ Emergency Contact: _____ Emergency Phone: _____

Marital Status: ☐ Married ☐ Single Student: ☐ Full-time ☐ Part-time ☐ N/A Occupation: _____

What would you prefer to be called? _____

Family Physician: _____ Phone#: _____

(In order for us to process your dental claims, this section must be filled out in its entirety)

Dental Insurance Carrier: _____ ID#: _____ Group #: _____

Mailing address of Insurance: _____ City: _____ State: _____ Zip Code: _____

Employer of Insured: _____

Secondary Insurance: _____ Insured SS: _____ *(Do NOT include dashes or spaces)* Insured DOB: _____ *(Enter as MM/DD/YYYY)*

Relationship to Insured: _____

Employer: _____ Phone#: _____

Who is financially responsible for this account? _____ Phone#: _____

Please select Y = Yes or N = No if you have any of the following conditions:

☐Y ☐N - Rheumatic Fever
☐Y ☐N - Heart Disease
☐Y ☐N - Heart Murmur (or MVP)
☐Y ☐N - High Blood Pressure
☐Y ☐N - Tuberculosis
☐Y ☐N - Use Oral Contraceptives
☐Y ☐N - Artificial Joint / Heart Valve
☐Y ☐N - History of Endocarditis
☐Y ☐N - Thyroid Disease
☐Y ☐N - Anemia
☐Y ☐N - Asthma
☐Y ☐N - Diabetes
☐Y ☐N - Are you nursing
☐Y ☐N - Might you be pregnant
☐Y ☐N - Hepatitis Type: ☐ A ☐ B ☐ C
☐Y ☐N - Radiation Therapy: Head / Neck
☐Y ☐N - Seizure Disorder
☐Y ☐N - Kidney Disease
☐Y ☐N - Venereal Disease
☐Y ☐N - Bleeding Problems
☐Y ☐N - Cancer
☐Y ☐N - Aids/HIV
☐Y ☐N - Eating Disorders

Other conditions not listed: _____

Are you allergic to latex, soy or egg products? _____

List any antibiotics, anesthetics or other drugs you are allergic to: _____

List all prescription medications you are presently taking: _____

_____

Do you have any disease, organ transplant, or take any medication which may depress your immune system? _____

Do you have, or have you ever had clicking, popping or pain in your tempromandibular joints (TMJ)? _____

Have you been hospitalized in the past five years? ☐Yes ☐No If yes, why? _____

Do you take aspirin on a daily basis? ☐Yes ☐No If yes, why? _____

Are you under a physician's care presently? ☐Yes ☐No If yes, why? _____

Have you ever been a drug or substance abuser? ☐Yes ☐No Do you smoke? ☐Yes ☐No How much? _____

Is there anything you would like to discuss with the Doctor in private? _____

I attest that I understand and answered all the above questions honestly and completely. I understand that the doctor is basing his treatment on this information. I authorize the release of information to insurance carriers and other health care professionals who are involved in my care. I assign my insurance benefits to Briglia Dental Group unless otherwise indicated.

Signature: _____ **Date:** _____

*Your signature indicates you have received a copy of the HIPAA law and Dental Materials forms as well as releasing Dr. Ron Briglia to utilize any dental photographs for lecturing and educational purposes.

BRIGLIA
DENTAL GROUP

DENTAL HEALTH AND APPEARANCE

Reason for visit: _____ Approximate date of last dental visit: _____

What is your primary concern that you would like us to address first? _____

When would you like us to start treatment? _____

Have you ever had any serious problem associated with previous dental treatment or any dental emergencies? ☐Yes ☐No

If so, explain: _____

What, if anything, has happened in previous experiences at the dentist that was reason not to return? _____

_____

Do you ever feel (or have you ever been told) that you don't have fresh breath? _____

How often do you brush your teeth? ____ time(s) a _____ How often do you floss? ____ time(s) a _____

What type of brush do you use? ☐Manual ☐Powered

Do you avoid brushing any part of your mouth because of pain? ☐Yes ☐No If yes, what part? _____

Which foods cause you twinges of pain: ☐Hot ☐Cold ☐Sweet ☐Sour ☐None

Do your gums feel tender or swollen? ☐Yes ☐No

Do you chew on only one side of your mouth? ☐Yes ☐No If yes, explain: _____

Do you clench or grind your jaws while sleeping or during the day? ☐Yes ☐No Do your jaws ever feel tired? ☐Yes ☐No

COSMETIC/ESTHETIC EVALUATION

Are you happy with your smile? ☐Yes ☐No Please rate your smile from 1 to 10 (1 = I hate my smile, 10 = Awesome): _____

Would you like to have whiter teeth? ☐Yes ☐No

If you had a magic wand, what, if anything, would you change about your smile? _____

What (if any) personal or professional benefit might you gain if you had a gorgeous smile? _____

Do you have any special occasions coming up? _____

Would you like to improve your smile? Please select all that apply:

☐ Lighten all front teeth showing	☐ Rebuild fracture(s)	☐ Straighten rotation	☐ Eliminate dark or stained fillings
☐ Lighten single tooth	☐ Lengthen	☐ Straighten angulation	☐ Reduce gum showing in smile
☐ Close spaces between teeth	☐ Shorten	☐ Eliminate crowding	☐ Repair uneven edges

Please add anything you feel is important:

Our mission at Briglia Dental Group is to provide patients with exceptional, comprehensive dental care at every appointment. Through our team of highly qualified dentists and dental professionals we seek to produce quality dentistry and create positive long-term investments in our patients health, appearance, and smile

Warm Regards,
Dr. Ron Briglia & Team

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Full Name: _____ Telephone: _____ Social Security#: _____
(Do NOT include dashes or spaces)

Address: _____ City: _____ State: _____ Zip: _____

_____ (*Initial*) I agree to allow Dr. Briglia and Team to leave messages that include Protected Healthcare Information of the following: Please initial next to the applicable communication devices:

_____ Home # _____ ____Cell # _____ ____ Work # _____

_____ (*Initial*) No, I do not agree to allow Dr. Briglia and Team to leave messages that include Protected Healthcare information on my home, work and cell phone.

_____ (*Initial*) I agree to allow Dr. Briglia and Team to speak with only the following people regarding my Protected Healthcare Information.

List Name(s), relationship and phone number:

_____
(Print name) *(Relationship)* *(Phone number)*

_____
(Print name) *(Relationship)* *(Phone number)*

_____ _____ _____
Patient Name (*Please Print*) Patient Signature Date

☐ Patient Refused to Sign: Staff Name / Date: _____

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. We encourage you to read it carefully and completely before signing this Consent.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION CONT.

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 our office at 610-692-4440 or by mailing us at **600 East Marshall Street - Suite 201, West Chester, PA 19380.**

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 address above. Please understand that revocation of this Consent will not affect any action we took 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 healthcare 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:** _____

Please keep a version of this form for your records. You may either email the completed form to tcdkaren@yahoo.com, or print and bring to your first appointment.

OUR OFFICE POLICY REGARDING DENTAL INSURANCE

If we have received all of your insurance on the day of the appointment, we will be happy to file your claim for you. You must be familiar with your insurance benefits, as we will collect from you the estimated amount insurance is not expected to pay. By law your insurance company is required to pay each claim within 30 days of receipt. We file all insurance electronically so your insurance company will receive each claim within days of treatment. You are responsible for any balance on your account after 30 days, whether insurance has paid or not.

PLEASE UNDERSTAND that we file dental insurance as a courtesy to our patients. We do not have a contract with your insurance company, only you do. We are not responsible for how your insurance company handles its claims or for what benefits they pay on a claim. We can only assist you in estimating your portion of the cost of treatment, we at no time guarantee what your insurance will or will not do with each claim. We can also not be responsible for any errors in filing your insurance, once again we file claims as a courtesy to you.

Fact 1 – NO INSURANCE PAYS 100% OF ALL PROCEDURES
Dental insurance is meant to be an aid in receiving dental care. Many patients think that their insurance pays 90%-100% of all fees. This is not true! Most plans only pay between 50% - 80% of the average total fee. Some pay more, some pay less. The percentage paid is usually determined by how much you or your employer has paid for coverage or the type of contract your employer has set up with the insurance company.

Fact 2 – BENEFITS ARE NOT DETERMINED BY OUR OFFICE
You may have noticed that sometimes your dental insurer reimburses you or the dentist at a lower rate than the dentist's actual fee. Frequently, insurance companies state that the reimbursement was reduced because your dentist's fee has exceeded the usual, customary, or reasonable fee ("UCR") used by the company.

A statement such as this one gives the impression that any fee greater than the amount paid by the insurance company is unreasonable or well above what most dentists in the area charge for a certain service. This can be very misleading and is simply not accurate.

Insurance companies set their own schedules and each company uses a different set of fees they consider allowable. These allowable fees may vary widely because each company collects fee information from claims it processes. The insurance company then takes this data and arbitrarily chooses a level they call the 'allowable' UCR fee. Frequently this data can be three to five years old and these "allowable" fees are set by the insurance company so they can make a net 20%-30% profit.

Unfortunately, insurance companies imply that your dentist is "overcharging" rather than say that they are "underpaying" or that their benefits are low. In general, the less expensive insurance policy will use a lower usual customer or reasonable (UCR) figure.

MOST IMPORTANTLY, please keep us informed of any insurance changes such as a policy name, company address, or a change of employment.

BRIGLIA
DENTAL GROUP

2 Day Cancellation Policy

Office hours are by appointment only and we value your time. Appointment time is reserved for you alone. Like many offices, all appointments are confirmed by e-mail. When you receive your confirmation e-mail, **we ask that you click on the "Submit" button to confirm the appointment.** You can also confirm your appointment over the phone.

If you miss your appointment, cancel or change your appointment with less than 2 days notice, there will be a charge of $50.00.

This policy is in place out of respect for the doctor and other patients. Cancellations with less than 2 days notice are difficult to fill. By giving last-minute notice or no notice at all, you prevent someone else from being able to reserve that time.

By signing below, you acknowledge that you have read and understand the Cancellation Policy for Briglia Dental Group.

Thank You for your understanding and cooperation.

Printed Name _____ Signature _____

Date _____

Briglia Dental Group
Chester County Medical Center
600 East Marshall Street Suite 201
West Chester, PA 19380
Phone: 610-692-4440
Fax: 610-692-9277
www.BrigliaDentalGroup.com

Hours of Operation:
Monday: 8:00am – 5:00pm
Tuesday: 8:00am – 7:00pm
Wednesday: 8:00am – 5:00pm
Thursday: 8:00am – 5:00pm
Friday: By appointment only
Saturday: 8:00am – 2:00pm