Patient Information

Patient Name: _____ Date:_____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date:_____

Phone (Home): _____ (Work): _____ (Cell)_____

E-Mail address_____

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time ☐M ☐T ☐W ☐T ☐F ☐S

Address: _____
Street Apartment #

_____
City State Zip Code

Has any other member of your family been treated here before? Name _____

Relationship_____-

Health Information

Date of Last Dental Visit: _____ Reason for this visit:_____

Have you ever had any of the following? Please check those that apply:

☐ **AIDS / HIV**
☐ Allergies _____
_____
☐ Alzheimer's Disease
☐ Anemia
☐ Arthritis
☐ **Artificial Joints** (i.e.-hip, knee)
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dementia
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis A,B,C
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mitral Valve Prolapse
☐ Nervous Disorders
☐ Pacemaker
☐ Parkinson disease
☐ **Pregnancy**
Due date:_____
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ **Tuberculosis (TB)**
☐ Tumors
☐ Ulcers
☐ Venereal Disease

OTHER:
☐ _____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain:_____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain:_____
- Name of Physician: _____ Phone:_____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain:_____

Are you taking any type of blood thinner? (Coumadin, etc…….) ___Yes ___No

Are you taking any medication on a regular basis? ___Yes __No **If yes, please list all medications:**

_____

Are you allergic to **Codeine**? ___Yes ___No **Penicillin**? ___Yes ___No

May we contact you on your cell phone? Yes / No

To the best of my knowledge, all of the preceding answers and information provided are true and correct.

_____ Date: _____

Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other_____

Name of person or office referring you to our practice:_____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext:_____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #:_____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #:_____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Address: _____

_____

Glen J. Bridges, DMD
125 West Church St.
Jackson, Al. 36545

Consent for Services

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

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of three months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. I accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection fees (33.3%). I waive now and forever my right of exemption under the laws of the constitution of the State of Alabama and any other State.

In addition, I consent to the taking of photographs and x-rays before, during and after treatment, and to the use of the same by the doctor in scientific papers or demonstrations. The use of nitrous oxide can be used for anxiety during dental treatment if recommended by the Doctor or upon request of patient. I consent to treatment as recommended by Doctor. I understand if an appointment is broken, there will be at $30.00 fee.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

Privacy Practices
Dr. Glen Bridges

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 01/01/2014, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request.

You may request a copy of our Notice at any time.

Print Name:_____

Signature:_____

Date:_____

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
- ⇨ Communications barriers prohibited obtaining the acknowledgement
- ⇨ An emergency situation prevented us from obtaining acknowledgement
- ⇨ Other (Please Specify)

NON COVERED SERVICES

As your Dentist, I want to provide you with the best care possible. Sometimes there are services that I feel are necessary for the treatment of your condition and maintenance of good health are not covered by your dental benefits contract. You are expected to pay for those services in full. Let me reassure you that I will order only treatments that I feel are necessary for your dental health and care. In addition, some services may be recommended by me for cosmetic reasons. If you have any questions about whether or not a particular service is covered by your dental benefits contract, someone in our office will be happy to assist you. Thank you for your understanding.

Patient Signature Date

*_____

*_____

*I have read your policy and agree to pay for the services that are not covered by my contract as indicated by my signature for each date above.

Broken Appointment Policy

When you reserve a time with us please make every attempt to make your appointment. We do not "double book" as many offices do. This time is set aside specifically for you. Two days prior to your appointment you will receive an email, text message and a phone call. When you receive this message, please call, text or email us to confirm the time that you have already reserved with us. If we have not heard back from you 1-BUSINESS DAY prior to your reserved time, we may take your appointment off of our schedule.

We have a 1-BUSINESS DAY cancellation policy. If you need to change or reschedule your reserved time with us, please give us at least a 1-BUSINESS DAY notice so that we will be able to fill this time with others waiting for treatment. If your appointment time with us is on Monday, please confirm with us by Thursday, etc.

If you cancel, fail to show for your confirmed appointment, or you arrive excessively late and treatment cannot be completed as planned, we recover our lost opportunity and associated costs for having our Staff on standby with a Broken Appointment Fee ($30).

LATE ARRIVAL

If you are over 15 minutes late for your appointment, we reserve the right to reschedule your appointment for a later time. The Broken Appointment Fee of $30 will apply to this as well. Please understand that we strive to stay on time for your appointment as well as those patients that follow you. By signing below, you have read, and understand this agreement.

_____ _____

Patient/Guardian Signature Date