Welcome,

We are delighted to welcome you to our practice and are pleased that you chose us to serve your dental needs. We are serious about providing superior dental care at reasonable prices, and proud of our dedication to our patients. Our goal is to help you feel and look your very best through excellent dental care.

We would appreciate it if you would complete the Patient Information Form and Medical History Form before your arrival. Please remember to bring it with you at the time of your appointment along with your Dental Insurance card and List of Medications.

If you require Premedication for an artificial joint replacement or heart condition or a recommendation from your physician, please contact the office and see the Premed Link under “CARE INFO” on our website.

For driving directions to our office, click “MAP”.

Thanks again for choosing our dental practice.

Sincerely,

Dr. Bryington and Staff
**WELCOME...** My staff and I are pleased to welcome you to our office. We look forward to providing you and your family with the most modern dental care available. Our office can provide you with complete general dental service, from cleaning to cosmetic dentistry to full mouth reconstructive care.

**PATIENT INFORMATION**

<table>
<thead>
<tr>
<th>Name ________________________________</th>
<th>Preferred Name ________________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local Address ________________________</td>
<td>Other Address ________________________</td>
</tr>
<tr>
<td>City, State, Zip ______________________</td>
<td>City, State, Zip ________________________</td>
</tr>
<tr>
<td>Home Phone # _________________________</td>
<td>Sex: Male _______________ Female _______________</td>
</tr>
<tr>
<td>Work Phone # _________________________</td>
<td>Soc. Sec. # _________________________</td>
</tr>
<tr>
<td>Cell Phone # _________________________</td>
<td>Birth date _________________________</td>
</tr>
<tr>
<td>Email ______________________________</td>
<td>Marital Status _________________________</td>
</tr>
<tr>
<td>Driver’s License # ____________________</td>
<td>Spouse Name _________________________</td>
</tr>
<tr>
<td>If child: Parent/Guardian: ______________</td>
<td>Parent/Guardian #2 ______________________</td>
</tr>
</tbody>
</table>

**In Case of Emergency:**

<table>
<thead>
<tr>
<th>Name ______________________________</th>
<th>Phone # ______________________________</th>
</tr>
</thead>
</table>

Whom may we thank for referring you to our office?

**EMPLOYMENT**

<table>
<thead>
<tr>
<th>Patient/Parent Employer ______________________</th>
<th>Spouse/Parent Employer ______________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer Address ______________________________</td>
<td>Employer Address ______________________________</td>
</tr>
<tr>
<td>City, State, Zip ______________________________</td>
<td>City, State, Zip ______________________________</td>
</tr>
<tr>
<td>Phone # ______________________________________</td>
<td>Phone # ______________________________________</td>
</tr>
</tbody>
</table>

**DENTAL INSURANCE**

<table>
<thead>
<tr>
<th>Name of Dental Insurance Co. ______________________</th>
<th>Group # ______________________ Claims Telephone ______________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secondary Dental ______________________</td>
<td>Group # ______________________ Claims Telephone ______________________</td>
</tr>
</tbody>
</table>

**INSURED INFORMATION**

<table>
<thead>
<tr>
<th>Insured Name ______________________</th>
<th>Home Phone ______________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address __________________________</td>
<td>Work Phone _____________________</td>
</tr>
<tr>
<td>City, State, Zip __________________</td>
<td>Work Phone _____________________</td>
</tr>
<tr>
<td>SS# ______________________________</td>
<td>Date of Birth __________________</td>
</tr>
<tr>
<td>Insurance ID# _____________________</td>
<td>Employer Name __________________</td>
</tr>
<tr>
<td>Employer Name _____________________</td>
<td>Employer Name __________________</td>
</tr>
</tbody>
</table>
EMERGENCY CARE . . . We recognize that emergency situations do arise and we will do our best to respond promptly. If you do have a problem, please call us as early in the day as possible. For after hour emergencies call the office number for instructions.

PREVENTIVE CARE . . . Good dental health requires constant attention. Regular preventive health care is a sound investment. We urge you to do your share by brushing and flossing daily and visiting our office at the recommended intervals for routine preventive care. For recall visits you will be contacted by mail. Please telephone for an appointment when you receive this notice.

PAYMENT . . . We expect payment at the time of service. For your convenience MasterCard, Visa, Discover and Care Credit are accepted.

INSURANCE . . . As a service to you, our office will submit charges for service to your insurance company. However, we do consider the patient/guardian primarily responsible for the account. When insurance claims are preauthorized and benefits are assigned to us, the portion of the fee which is payable by the patient is due at the time of service. If insurance payment is not received within 30 days of the date of service, the patient will be responsible for the account balance at that time.

CONSENT FOR PROCEDURE

This is to certify that I, undersigned, consent to the performing of the dental procedures agreed to be necessary or advisable, including the use of local anesthetic as indicated and I will assume responsibility for fees associated with those procedures.

PATIENT/or Guardian Signature_________________________________   Date ________________________

PRIVACY POLICY NOTICE

Dear Patient:

Federal law requires us, as your health provider to make a copy of our Privacy Policy available to you. We are glad to have this opportunity to do so and to communicate to you our commitment to guard against inappropriate disclosure of your personal information.

We collect and use information necessary to provide you with dental health services. We collect and maintain information including your name, address, telephone number, age, medical history, insurance information and other pertinent information needed for your care. This information will not be disclosed to anyone except as permitted by law. When this information about you, as permitted by law, is shared, we protect it with a confidentiality agreement that obligates the recipient of the information to keep it confidential. This confidential information will be stored in a secure place, disposed of in a secure fashion and used only for the purpose for which it was provided.

I acknowledge that I have read the above office Privacy Policy and have had a copy of the office Privacy Policy made available to me.

PATIENT/or Guardian Signature_________________________________   Date ________________________
**MEDICAL HISTORY**

Drugs, pills or medications you are taking. Please list or provide copy: __________________________________________________

Name of Medical Doctor: ___________________________ Phone ___________________________

**DENTAL HISTORY**

Do you have any specific dental concerns? Please list:

- 1. When was your last dental exam?
- 2. When was your last full mouth x-ray taken?
- 3. Do you have pain in your jaw or near your ears?
- 4. Do you get lip sores (fever blisters, cold sores)?
- 5. Do you have any growths or sore spots in your mouth?
- 6. Does any part of your mouth hurt when clenched?
- 7. Have you ever had a problem with Novocaine or other local anesthetic?
- 8. Have you ever had an allergic reaction to local anesthetic?
- 9. Have you ever had any difficult extractions in the past?
- 10. Have you experienced prolonged bleeding after extraction?
- 11. Do your gums bleed?
- 12. Do you have a bad taste in your mouth or mouth odor?
- 13. Have you ever had instructions on the care of your mouth?
- 14. Do you chew on only one side of your mouth? If so, why?
- 15. Do you habitually clench or grind your teeth?
- 16. Is any part of your mouth sensitive to pressure, hot or cold? Where?
- 17. Do you have headaches that you associate with your teeth?
- 18. Do you like your smile?
- 19. Is there any other problem not covered?
- 20. When was your last cleaning?
- 21. How many times a day do you brush your teeth?
- 22. Do you floss daily? How often?
- 23. Do you use any oral rinses? What?
- 24. Do you smoke? Packs per day? How many years?
- 25. Do you use chewing tobacco or snuff?
- 26. Do you still have your wisdom teeth?
- 27. Have you had gum problems in the past?
- 28. Have you had gum surgery or treatment?
- 29. Have you ever had braces/orthodontic treatment?
- 30. Have you ever had TMJ treatment or problems?
- 31. Are your teeth sensitive?