For Office Use Only
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BRIGHT STAR DENTAL
New Patient Information

Date:_____

Name:_____***Date of Birth:***_____

Social Security#:_____***Home Phone #:***_____***Work #:***_____

Mailing Address:_____***City***_____***State***_____***Zip:***_____

E-Mail Address:_____***Cell#:***_____

Occupation:_____***Employed By:***_____***How Long?***_____

Spouse/Parent/Other:_____***Date of Birth:***_____***Cell#***_____

Address:_____***City:***_____***State:***_____***Zip:***_____***Home#***_____

Occupation:_____***Employed By:***_____***How Long?***_____***Work#:***_____

Who may we thank for referring you to our office?_____

Dental Insurance? Y N – Name of Insured:_____***SS# of Insured:***_____

Place of employment:_____***Date of Birth of Insured:***_____

Health History: ***Have you ever had:***

Y N Arthritis	*Y N Severe Headaches*	*Y N Lung Disease*
Y N Asthma	*Y N Heart Attack*	*Y N Rashes*
Y N Cancer	*Y N Heart Murmur*	*Y N Rheumatic Fever*
Y N Cold Sores/ Canker Sores	*Y N Heart Problems*	*Y N Stroke*
Y N HIV	*Y N Heart Surgery*	*Y N Any Surgeries: LIST below*
Y N Pacemaker	*Y N Hepatitis*	*Y N Thyroid*
Y N Diabetes	*Y N High Blood Pressure*	*Y N Tuberculosis*
Y N Epilepsy	*Y N Jaundice*	*Y N Tumor*
Y N Fainting Spells	*Y N Kidney Diseases*	*Y N Ulcers*
Y N Hay Fever	*Y N Latex Allergy*	*Y N Venereal Disease*

List Surgeries:_____

Y N Presently Pregnant ***Y N Trying to become pregnant*** ***Y N Taking Birth Control Meds***

Y N I am allergic to Costume Jewelry (list):_____

Y N I am allergic to a food, material, or medicine
If so, what:_____

Y N Name of Primary Physician:_____
I am under active treatment for:_____

Y N I am taking medications, drugs, vitamins, minerals, or supplements:
List:_____

Y N I prefer to be sedated and I am interested in taking medication that would help me be totally relaxed during my dental appointments.

Please read the following before signing:
To the best of my knowledge, all of the preceding answers ar true and correct. If I ever have any changes in my health, or if my medications change, I will inform the Doctor. I authorize the Doctor to perform any necessary dental treatment for my minor child or me. I understand that the details of the treatment will be provided for me, and I will be allowed to ask questions prior to actual treatment.

Possible risks and consequences include: Drug reactions and side affects, post- operative bleeding and/or pain, post-operative infection and/or bone inflammation, jaw joint malfunction and/or pain, need for root canal therapy after any filling, crown, partial crown, veneer or gum therapy, and/or loss of teeth. If any of these consequences occur, I understand that I am financially responsible for any additional treatment.

Possible Risks and Consequences of Dental Anesthesia
Possible risks and consequences include: pain, soreness, or stiffness in area of injection, prolonged or permanent numbness, hematoma, allergic reactions and side effects, dizziness, nervousness, and heart palpitations.
I understand that the practice of dentistry is not an exact science, and, as a result, no guarantees can be provided.

Financial and Insurance Information:
I understand that Bright Star Dental accepts most dental insurance. I understand that even if I have dental insurance, I am financially responsible for any and all fees for my treatment not covered by my dental insurance. I authorize Bright Star Dental to release any information to my insurance company that is needed to process a claim. I understand that payment is due at time of service. If I receive a dental exam and x-rays free of charge and choose to request my x-rays I will be responsible for the fee associated with the free services.

I give Dr. Gilbert and the Team at Bright Star Dental permission to respond to me on social media, including, but not limited to Google+, Facebook, Twitter, etc. I understand that if I would like to withdraw such permission, I will Let Bright Star Dental know in writing, and to the extent they can remove public responses, they will.

I understand that, due to the busy schedule and the high demand for Bright Star Dental's services, I will provide my credit card information to reserve an appointment date and time. If I fail to keep my appointment, I understand I will be charged a $100 non-refundable reservation deposit.

I authorize Bright Star Dental to use any and all models, radiographs, and photos for use in future lectures, presentations, publications and marketing materials including the internet.

Bright Star Dental. P.C. and Dr. Brian Gilbert and his associates will not refund any fees at any time for any procedures/treatment performed.

Limited Warranty:
If any crown, partial crown or veneer has a problem (unrelated to a patient's lack of home care, a traumatic injury or misuse of teeth) within 5 years after placement, we may repair it or replace it. This warranty does not apply to restorations placed on teeth with a root canal procedure. Depending of the circumstances, we may repair it or replace it at no charge, prorate the charge, and/or the patient may be responsible for any additional laboratory and/or material costs. If a patient has not kept on schedule with his/her recommended regular cleanings, annual fluoride treatments or periodontal maintenance appointment, this warranty does not apply. For this warranty to apply, any and all treatment planned for the same quadrant, as the warranteed tooth must be completed with in one year of placement of the crown/veneer.

Arbitration Agreement:
In an effort to control the increasing costs of dental care, any claims or disputes against this office shall be resolved by "binding arbitration." By signing this agreement, the patient agrees with the office of Bright Star Dental, PC and Brian J. Gilbert, D.D.S. that any dispute relating to dental or medical care services rendered for any condition, including any services rendered prior to the date this agreement was signed, and any dispute arising out of the diagnosis, treatment or care of the patient, including the scope of the arbitration clause and the arbitrability of any dispute, against whenever made, (including to the full extent permitted by applicable law third parties who are not signatories to this agreement (including associates), shall be resolved by binding arbitration by the American Arbitration Association, under the Code of Procedure then in effect. The patient understands that the result of this arbitration agreement is that claims, including malpractice claims he/she may have against the doctor, cannot be brought as a lawsuit in court before a judge or jury, an agrees that all such claims will be resolved as described in this section.

Consent for Treatment:
I have read the above information and have had an opportunity to ask questions. I understand that if I have any future questions, concerns, constructive criticism or complaints, it is my responsibility to contact Bright Star Dental at one of the numbers below, or in writing. You can reach the Doctor by the following means: e-mail: BrightStarDental@gmail.com
Office: (575)526-4334
Emergency: (575)202-9177

We require all patients to give our office no less than 2 business days notice for any cancellations, reschedules or changes in appointments. If we do not receive notice at least 2 business days prior to a scheduled appointment, a $50 short-notice cancellation/reschedule fee will be applied to the patient's account. ($100 for short-notice cancelled/rescheduled appointments with one of our doctors.) After 3 short-notice cancellations/reschedules/no shows by a patient, the patient will be dismissed from our practice.

_____ _____ _____

Patient or Guardian Signature ***Witness*** ***Date***