BRILLIANT
DENTISTRY

Please Help Us Understand You

Patient Name: ____ **Date______________________**

Our office is different in that we give our patients our full attention. We find out what is important to you and deliver what we promise. Please answer the following so we can understand you better.

In your own words how can we help you?

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Here are some of the services we provide.

I am interested in:

☐ **Nonsurgical Facelift** ☐ **TMJ Treatment** ☐ **Implants** ☐ **Smile Makeover**

☐ **Facelift Dentures** ☐ **Filling Upgrade** ☐ **Comfort Dentistry**

Brilliant Dentistry's model is to answer your questions as well as to allow you to see if we are the right Dentist for you. If you feel we are not the best Dentist for you, we will be happy to refer you to who we know is a good match for you. If you feel we can help you, we will take records, do a thorough examination, and give you specific options for your dental treatment.

Please let me know how you feel about the following:

How important is: dental health, prevention, dental cosmetics, and facial cosmetics?

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Patient Name ______________________ Date of Birth ______________________

Address ______________________ City/State/ZIP ______________________

Employer ______________________ Work Phone # ______________________

Home Phone # ______________________ Cell Phone # ______________________

Email ______________________ SSN ______________________

Marital Status ______________________ Spouse Name & DOB ______________________

Emergency Contact ______________________ Contact Phone # ______________________

Place a mark on "yes" or "no" to

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
AIDS/HIV	❑Yes	❑No	Fainting or dizziness	❑Yes	❑No	Tuberculosis	❑Yes	❑No
Anemia	❑Yes	❑No	Glaucoma	❑Yes	❑No	Tumor or growth on Head/Neck	❑Yes	❑No
Arthritis, Rheumatism	❑Yes	❑No	Heart Murmur	❑Yes	❑No	Sleep Apnea	❑Yes	❑No
Artificial Heart Valves	❑Yes	❑No	Heart Problems	❑Yes	❑No	Headaches	❑Yes	❑No
Artificial Joints	❑Yes	❑No	Hepatitis Type ________	❑Yes	❑No	Jaw Pain	❑Yes	❑No
Asthma	❑Yes	❑No	High Blood Pressure	❑Yes	❑No	Jaw Popping	❑Yes	❑No
Bleeding abnormally, with extractions or surgery	❑Yes	❑No	Kidney Disease	❑Yes	❑No	Limited Opening	❑Yes	❑No
			Liver Disease	❑Yes	❑No	Congested Ears	❑Yes	❑No
Blood Disease	❑Yes	❑No	Mitral Valve Prolapse	❑Yes	❑No	Dizziness	❑Yes	❑No
Cancer	❑Yes	❑No	Heart Attack	❑Yes	❑No	Ringing Ears	❑Yes	❑No
Chemotherapy	❑Yes	❑No	Pacemaker	❑Yes	❑No	Posture Problems	❑Yes	❑No
Circulatory Problems	❑Yes	❑No	Radiation Treatment	❑Yes	❑No	Clenching	❑Yes	❑No
Heart Lesions	❑Yes	❑No	Sinus Trouble	❑Yes	❑No	Grinding	❑Yes	❑No
Cortisone Treatments	❑Yes	❑No	Stroke	❑Yes	❑No	Facial Pain	❑Yes	❑No
Persistent cough	❑Yes	❑No	Swollen Feet or Ankles	❑Yes	❑No	Neck Ache	❑Yes	❑No
Diabetes	❑Yes	❑No	Swollen Neck Glands	❑Yes	❑No	Bell's palsy	❑Yes	❑No
Epilepsy	❑Yes	❑No	Thyroid Problems	❑Yes	❑No			

List any medications you are currently taking: Please include any blood thinning medications or aspirin?

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____

Are you allergic to any medications or other substances?

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Have you received or currently receiving medications for osteoporosis known as bisphosphonates for example Fosamax, Actonel, or Boniva?

❑Yes ❑No List Medication ______________________

Please list any major surgeries______________________

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Circle if: you have seen an Orthodontist, had your bite adjusted, had any bite related treatment or TMJ Joint Surgery?

Circle if: you have seen any of the following healthcare professionals: ENT, Neurologist, Chiropractor, or Massage Therapist.

Circle if: you snore, use a CPAP or have had a sleep study?

Have you ever had radiation treatment to the head and/or neck? ❑Yes ❑No

Do you use tobacco products? ❑Yes ❑No

Are you pregnant or nursing? ❑Yes ❑No

Do you take a premed antibiotic for dental appointments?

❑Yes ❑No List Medication______________________

Signature: ______________________ **Date:** ______________________

HEALTH INSURNACE PORTIBILITY AND ACCOUNTABILITY ACT (HIPAA)

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Purpose of consent: By signing this form, you will consent to our use and disclosure of your protected health information as described in our notice of privacy practices.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. A copy will be made available to you at your request. Our notice provides a description of our treatment, payment activities and healthcare operations, of the used and disclosures we may make of your protected health information, and of other important matters about your protected health information. You may obtain a copy of our Notice of Privacy Practices at any time by contacting us. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If changes are made, we will issue a revised Notice of Privacy Practices. Those changes may apply to any of your protected health information that we maintain.

Right to Revoke: You have the right to revoke this consent at any time by giving us written notice of your revocation. Please understand the revocation of this consent will affect any actions we took before receiving your revocation.

I have been given the full opportunity to read and consider the contents of Notice of Privacy Practices. I understand by choosing to accept the Consent form, I am giving my consent to your use and disclosure of my protected health information.

FINANCIAL AND TREATMENT POLICY

Brilliant Dentistry strives to ensure a clear understanding of your financial responsibility with respect to the services we provide. These policies apply to all procedures and services provided.

No Insurance

If you do not have insurance, we will collect in full at the time of service. Our practice offers payment options such as discounts and resources to obtain payment plans. Please see our staff for more information on these options.

Insurance

Claim Filing: As a courtesy to you, we will file your claim with your dental insurance company. Any payment that remains is your responsibility. We do not enter disputes over insurance benefits. We bill insurance in accordance with all federal, state and other contractual requirements in cases where we have an agreement or we are a participating provider. As a dental provider, we do not participate with or have the capabilities to submit claims to any medical insurance policies. We expect payment in full from you if your insurance company delays processing of your claim for over 60 days. You agree to be financially responsible for any portion of the charges incurred not covered by insurance policy. If your insurance company sends payments directly to you, it is your responsibility to submit payment to Brilliant Dentistry.

Down payments: We have carefully calculated down payments for any services that will be submitted your dental insurance. We require these payments at the time of service, and reserve the right to refuse treatment if payment is not provided.

Payments: We accept cash, check, Visa, MasterCard, Discover, American Express, Lending Club and CareCredit.

*There may be additional charges to your office visit if procedures completed changes during your visit.

Signature:______________________________ Date:____________________

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DENTISTRY

RELEASE OF DENTAL RECORDS FORM

I, ______________________________, hereby authorize the release of my dental records from

__________________________________ to Brilliant Dentistry.

Please send current radiographs to:
Brilliant Dentistry
7727 Flying Cloud Drive
Eden Prairie, MN 55344
P: (952) 944- 2052
F: (952) 944-7873
BrilDentistry@gmail.com

Printed Name(s): ________________________________

Date/s of Birth: ______________________

Signature: ______________________________ Date: ______________

Radiograph Dates:

Pan: __________ Bitewings: __________ Full Series: __________