



Ph. (575) 526-4334 • www.brightstardental.com • 2010 E. Lohman Ave. Ste. 1 Las Cruces, NM 88001

Welcome to Bright Star Dental

Our mission is to *set the standard for what exceptional dentistry can be.*

We believe dentistry should be comfortable, personalized, and focused on what matters most to you. Please take a few moments to help us better understand your goals and how we can serve you.

How Did You Hear About Us?

- | | |
|--|--|
| <input type="checkbox"/> Family or Friend: _____ | <input type="checkbox"/> Social Media |
| <input type="checkbox"/> Google Search | <input type="checkbox"/> Mailer or Advertisement |
| <input type="checkbox"/> Insurance Directory | <input type="checkbox"/> Other: _____ |

What brought you to our office today?

How have your past dental experiences been?

Is there anything that makes you nervous or uncomfortable about dental treatment?

If you could change anything about your teeth or smile, what would it be?

What Is Most Important to You? Please rank your top three priorities, with 1 being the most important.

- | | |
|----------------------|-----------------------------------|
| ___ Comfort | ___ Cost |
| ___ Appearance | ___ Completing Treatment Quickly |
| ___ Long-term Health | ___ Finding a Dentist I Can Trust |

Are you interested in learning more about? (Check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Cosmetic Dentistry / Smile Makeover | <input type="checkbox"/> Relief for Sensitive Teeth |
| <input type="checkbox"/> Dental Implants | <input type="checkbox"/> Botox, Wrinkle Reduction and/or Lip Augmentation |
| <input type="checkbox"/> Sedation Options for Anxiety-Free Visits | <input type="checkbox"/> Teeth Whitening |
| <input type="checkbox"/> Replacing Missing Teeth | <input type="checkbox"/> Straightening Teeth |
| <input type="checkbox"/> Gentle, Thorough Cleanings With Less Scraping | <input type="checkbox"/> TMJ or Jaw Pain Relief |
| <input type="checkbox"/> Same-Day Crowns | <input type="checkbox"/> Customized Home Care and Prevention Programs |
| <input type="checkbox"/> Reversing Early Cavities Without Drilling | <input type="checkbox"/> Dry Mouth or Bad Breath Solutions |
| <input type="checkbox"/> Gentle Laser Treatment Options | <input type="checkbox"/> OTHER: _____ |

Is there anything else you would like us to know?

Personal And Insurance Information:

Name: _____ Preferred Name: _____ Date of Birth: _____
Social Security #: _____ Home Phone #: _____ Work #: _____
Mailing Address: _____ City: _____ State: _____ Zip: _____
E-Mail: _____ Cell #: _____
Occupation: _____ Employed By: _____

Emergency Contact: _____ Relationship: _____ Cell #: _____
Address: _____ City: _____ State: _____ Zip: _____
Occupation: _____ Employed By: _____ Work #: _____

Primary Dental Insurance? Y N Name of Insured: _____ SS# of Insured: _____
Place of Employment: _____ DOB of Insured: _____
Secondary Dental Insurance? Y N Name of Insured: _____ SS# of Insured: _____
Place of Employment: _____ DOB of Insured: _____

Health History:

(Please check any of the following conditions you have now or have had in the past.)

- | | | |
|---|--|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Severe Headache | <input type="checkbox"/> Rashes |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cold Sores/ Canker Sores | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> HIV | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Tumor |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Presently Pregnant |
| <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Kidney Diseases | <input type="checkbox"/> Trying to Become Pregnant |
| <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Taking Birth Control Meds |
| <input type="checkbox"/> Mental Health Therapy | <input type="checkbox"/> Lung Disease | |

For Office Use Only:

I am under active treatment for: _____

List surgeries (and dates): _____

List allergies (to food, material or medicine): _____

List medications, drugs, vitamins, minerals, or supplements: _____

Preferred Pharmacy: _____ Physician Name(s) (if any): _____

Acknowledgement:

To the best of my knowledge, the information provided is true and complete, and I will notify the office of any changes

Patient Name Printed _____ Guardian Printed _____

Patient or Guardian Signature _____ Date _____

ARBITRATION AGREEMENT

This Arbitration Agreement (“Agreement”) governs the resolution of any dispute between the Patient and Bright Star Dental LLC, including its owners, employees, contractors, and affiliated providers. A copy of this Agreement is available electronically upon request.

1. Agreement to Arbitrate

Any claim, dispute, or controversy arising out of or relating to dental services rendered, including claims for professional negligence or malpractice, shall be resolved exclusively by binding arbitration and not by lawsuit in court.

2. Waiver of Jury Trial

By signing below, both parties knowingly and voluntarily waive their constitutional right to have any dispute decided in a court of law before a judge or jury.

3. Governing Law

This Agreement shall be governed by and interpreted under the Federal Arbitration Act (9 U.S.C. § 1 et seq.) and applicable New Mexico law.

4. Administration and Rules

Arbitration shall be administered by the American Arbitration Association (AAA) in accordance with its Consumer Arbitration Rules in effect at the time the claim is filed.

5. Scope and Delegation

The arbitrator shall have exclusive authority to resolve any dispute relating to the interpretation, applicability, enforceability, or formation of this Agreement, including any claim that all or part of this Agreement is void or voidable.

6. Remedies

The arbitrator may award any remedy that would have been available in a court of law.

7. Collection Actions Exception

Notwithstanding any other provision of this Agreement, Bright Star Dental LLC may pursue collection of unpaid balances, fees, or other amounts owed by the Patient through small claims court, magistrate court, district court, collections proceedings, or other lawful means without first submitting such claims to arbitration.

8. Severability

If any provision of this Agreement is found to be unenforceable, the remaining provisions shall remain in full force and effect.

9. Mutuality

This Agreement applies equally to claims brought by the Patient or by Bright Star Dental LLC.

BY SIGNING THIS AGREEMENT, THE PATIENT ACKNOWLEDGES THAT HE OR SHE HAS READ THIS AGREEMENT, UNDERSTANDS THAT ANY DISPUTE WILL BE RESOLVED BY BINDING ARBITRATION, AND VOLUNTARILY WAIVES THE RIGHT TO A TRIAL BY JUDGE OR JURY.

Patient Name (Printed): _____

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Consent and Financial Policies

Please read each section carefully and place your initials in the space provided to indicate your understanding and agreement.

1. General Consent to Examination and Treatment

I authorize the licensed dental professionals employed by or contracted with Bright Star Dental to perform dental examinations, radiographs, photographs, diagnostic procedures, and dental treatment after discussing their recommendations with me and answering my questions.

Patient Initials: _____

2. No Guarantee of Results

I understand that dentistry is not an exact science. While every effort will be made to achieve the best possible result, no guarantees or warranties have been made regarding the outcome of any treatment.

Patient Initials: _____

3. Insurance and Financial Responsibility

I understand that dental insurance is a contract between me and my insurance company. Any estimate of insurance benefits is not a guarantee of payment.

I understand that I am financially responsible for all charges incurred for my treatment, regardless of insurance coverage. Payment is due at the time services are rendered unless other arrangements have been made in advance.

Patient Initials: _____

4. Appointment Cancellation Policy

I understand that appointments reserved for me are valuable and that late cancellations may prevent other patients from receiving care.

I agree to provide at least two business days' notice if I need to cancel or reschedule an appointment. If I fail to provide adequate notice, a short-notice cancellation fee may be charged to my account.

Current fees are:

- \$50 for hygiene appointments
- \$100 for doctor appointments

Patient Initials: _____

Acknowledgment and Signature

I have read and understand the policies above. I have had an opportunity to ask questions, and I agree to these terms.

Patient/Guardian Name Printed: _____

Patient/Guardian Signature: _____ Date: _____

Staff Witness: _____ Date: _____