Sandy Lake Dental & Orthodontics

Patient Information:

Patient's Name: _____
Last First Middle Preference

Birthdate: _____ Male/Female: _____ Marital Status: _____

Social Security #: _____ Driver's License #: _____ State: _____

Address: _____
Street Apt. # City State Zip

*(Please provide **all** telephone numbers to contact you. There may be times when we need to reach you on short notice.)*

Home: _____ Work: _____ ext _____ Cell: _____

Email Address *(optional)*: _____ Other: _____

Insured's Name: _____
Last First Middle Preference

Social Security #: _____ Birthdate: _____ Insured's Employer: _____

Insurance Co.: _____ Group #: _____ Insurance Phone #: _____

Insurance Address: _____
Street Apt. # City State Zip

Spouse's Name: _____ Birthdate: _____ Social Security #: _____

Spouse's Employer: _____ Spouse's Work Ph: _____

Is an immediate family member a patient here: _____ Name: _____

How did you hear about us? _____

Responsible Party Information:

Self: _____ Other: _____
Last First Middle

If "Other," please complete: Relationship to Patient: _____

Birthdate: _____ Social Security #: _____ Driver's License #: _____

Address: _____
Street Apt. # City State Zip

Home Ph: _____ Work Ph: _____

Emergency Contact Information:

Name of nearest relative not living with you: _____ Phone: _____

Address: _____
Street Apt. # City State Zip

Patient's Signature: _____ Date: _____

Parent/Guardian signature if patient is a minor: _____

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Patient Health History

1. Are you experiencing pain or discomfort? ..... Y N
2. Are you in good health? ..... Y N
3. Has there been a change in your general health within the past year? ..... Y N
4. Are you under the care of a physician? ..... Y N

   If so, what condition is being treated? _____

   Physician's Name: _____ Phone #: _____

   Address: _____
5. Have you been hospitalized or had a serious operation or illness within the past 5 years? ..... Y N
6. Do you have or have you had any of the following diseases or problems? Please circle:

AIDS/HIV Positive	Epilepsy/Seizures	Nervousness
Allergies or Hives	Fainting/Dizzy Spells	Pain in Jaw Joints
Anemia	Glaucoma	Plastics
Angina Pectoris	Hay Fever	Psychiatric Treatment
Arthritis	Heart Attack/Disease	Rheumatic Fever
Artificial Joint	Heart Failure	Rheumatism
Artificial Heart Valve	Heart Murmur	Scarlet Fever
Asthma	Heart Pacemaker	Sickle Cell Disease/Traits
Blood Transfusion	Heart Surgery	Sinus Trouble
Bruise Easily	Hepatitis A (Infectious)	Stroke
Chemotherapy (Cancer, Leukemia)	Hepatitis B (Serum)	STD or VD (Syphilis, Gonorrhea)
Cold Sores/Fever Blisters	High/Low Blood Pressure	Thyroid Disease
Congenital Heart Defects/Lesions	Kidney Trouble	Tuberculosis (TB)
Cortisone Medicine	Latex	Ulcers/Colitis
Cough	Liver Disease	Yellow Jaundice
Diabetes	Metals	X-Ray or Cobalt Treatment
Emphysema	Mitral Valve Prolapse	

7. Are you taking any drug, medicine or herbal supplement? ..... Y N

   If so, what: _____
8. Are you allergic or have you reacted adversely to any drugs or medicines? ..... Y N

   If so, which drugs? _____

Aspirin	Erythromycin	lidocaine or Marcaine	Scopolamine
Codeine	Local Anesthetic	Penicillin	Sleeping Pills
Darvon	Nembutal/Seconal	Percodan	Tetracycline
Demoral	Nitrous Oxide	Other Antibiotics	Valium

9. Have you had previous skin reactions to jewelry or know of an allergy to any metal? ..... Y N
10. Have you had any serious trouble associated with any previous dental treatment? ..... Y N
11. Have you had abnormal bleeding associated with previous extractions, surgery, or trauma? ..... Y N
12. Do you have a disease, condition, or problem not listed above that you think I should know? ..... Y N

    If yes, please explain: _____
13. **FOR WOMEN ONLY: ARE YOU PREGNANT?** ..... Y N

    If YES, what month? _____ Are you taking birth control pills? ..... Y N
14. Is there anything about your smile you don't like such as discolored teeth, crooked teeth, unsightly silver fillings, etc.? ..... Y N
15. Our doctors are accomplished cosmetic dentists. Would you like current information on smile improvement procedures they perform, such as bleaching, porcelain veneers, and tooth-colored restorations? ..... Y N

CONSENT: The undersigned hereby authorizes Doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (Name of Patient) _____ and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk.

PATIENT _____ DATE _____ DOCTOR _____

PARENT OR RESPONSIBLE PARTY _____ RELATIONSHIP TO PATIENT _____

Sandy Lake Dental & Orthodontics

Consent for Use and Disclosure of Health Information

SECTION A: PATIENT GIVING CONSENT

Name: _____ Social Security #: _____

Address: _____

Please list ALL telephone numbers where we can contact you: _____

_____

Please list the names of ALL people (e.g. spouse, parents, etc.) you authorize us to release your health information to, including copies of your records if needed: _____

_____

E-mail: _____

SECTION B: TO THE PATIENT — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and health care operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and health care operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or continue treating you if you revoke this Consent.

SIGNATURE:

I , _____ , have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, please complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

You are entitled to a copy of this consent after you sign it. Include completed consent in the patients chart

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Sandy Lake Dental & Orthodontics

Office Policies and Procedures

Financial Policy

Payment for services rendered is due the day of treatment. We do our best to provide you with an accurate *estimate* of what your insurance is expected to pay based upon information you and your insurance provides us. Occasionally the insurance company will deny, delay, or reduce payment based upon their specific criteria relating to your individual policy. Any remaining balance not paid by insurance within 45 days will be the patient's responsibility. Balances extending after 90 days may be sent to an outside collection agency.

Appointment Scheduling/Confirmation Policy

We will preschedule your next appointment with your consent according to recommended recall frequencies or next phase of treatment requirements. However, we *require* a verbal re-confirmation of *every* appointment within 24-72 hours to reserve your individual appointment time. Without this confirmation your appointment may be cancelled and given to another patient.

Broken Appointment/Short Cancellation Policy

We understand that emergencies rarely occur which may preclude you from keeping your scheduled appointment. However, cancellations or no-shows without proper notice make it difficult to fill the appointment time that was reserved for you. If you no-show or cancel your appointment without a proper 24 hour notice you will be charged a $50 broken appointment fee--Saturday appointments will incur a $75 broken appointment fee.

Warranty Policy

We are pleased to offer a generous warranty on our treatment. We offer a 5 year warranty on crowns, onlays, and bridges. We offer a 3 year warranty on composite fillings, night-guards and appliances. In order for the warranty to remain in effect, the patient must keep up with recommended cleanings at *our office* without exception. The warranty will apply to defects in materials only and the patient may be required to pay for lab costs associated with replacement. The warranty may be modified at the office's discretion.

If there are any questions regarding office policies or procedures please contact the front office staff. By signing below you agree to abide by our office policies.

Patient Signature _____ Date _____