1 About You

Today's Date:

Last Name:_____ First Name:_____

I prefer to be called:_____ Gender:_____

Birthday:_____ Age:_____

Address:_____ City:_____

State:_____ Zip Code:_____

Home Phone:_____ Cell Phone:_____

SSN:_____ Marriage Status:_____

DL#:_____ Email:_____

Employer:_____ Occupation:_____

Address:_____ City:_____

State:_____ Zip Code:_____

Length of employment:_____ Work Phone:_____

Previous/Present Dentist:_____ Last Visit:_____

Whom may we thank for referring you?:_____

☐ Social Media ☐ Insurance ☐ Internet/Google ☐ Family/Friend/Co-Worker

Do you have other family members seen by us?:_____

2 Spouse Information

His/Her name:_____ Employer:_____

Work Phone:_____ SSN:_____

Birthdate:_____ DL#:_____

3 Emergency Contact

His/ Her Name:_____ Relation:_____

Work Phone:_____ Home Phone:_____

4 Dental Insurance

Primary Carrier	Secondary Carrier
Insurance Co. Name:_____	Insurance Co. Name:_____
Telephone:_____	Telephone:_____
Insured's Name:_____	Insured's Name:_____
Relation:_____	Relation:_____
Insured's Birthdate:_____	Insured's Birthdate:_____
Insured's ID#:_____	Insured's ID#:_____
Group/ Policy #:_____	Group/ Policy #:_____
Insured's Employer:_____	Insured's Employer:_____

5 Medical History

Do you have a personal Physician?_____ Physician's name:_____

Phone:_____ Last visit date:_____

Are you currently under the care of this Physician?_____

If Yes, please explain:_____

Your current physical health is?_____

Are you currently pregnant/breastfeeding?_____

Are you taking any prescription / over the counter or herbal supplement drugs? If yes, please list

_____

_____

Has your doctor ever told you that you require an antibiotic pre-med prior to dental treatment? *Yes No

*If Yes, what antibiotic was prescribed? _____

Do you smoke or use tobacco in any form?_____

5 (Medical History Continued)

Have you ever taken Phen-Fen? (Also known as Redux or Ponclimin) If Yes, when?_____

Have you ever had Osteoporosis or a bone disorder, and received any bisphosphonate drugs? (EX: Fosamax, Boneva, Skelid, Actonel, or Diodronel)_____

Have you ever taken IV drugs for Metastatic bone cancer? (EX: Zomet or Aredia)_____

Have you ever suffered from Congenital Heart disease?
Bacterial Endocarditis, or Atrial Septal Malformation?_____

Please list any medical condition(s) that you have ever had:_____

Have you ever had any of the following diseases or medical problems?			
_____Yes _____No	Abnormal Bleeding	_____Yes _____No	Herpes/Fever Blisters
_____Yes _____No	Alcohol/Drug Abuse	_____Yes _____No	High Blood Pressure
_____Yes _____No	Anemia	_____Yes _____No	HIV+/AIDS
_____Yes _____No	Arthritis	_____Yes _____No	Hospitalized for any **Reason***
_____Yes _____No	Artificial Bones/Joints/Valves	_____Yes _____No	Kidney Problems
_____Yes _____No	Asthma	_____Yes _____No	Liver Disease
_____Yes _____No	Blood Transfusion	_____Yes _____No	Low Blood Pressure
_____Yes _____No	Cancer/ Chemotherapy	_____Yes _____No	Lupus
_____Yes _____No	Colitis	_____Yes _____No	Pacemaker
_____Yes _____No	Congenital Heart Failure	_____Yes _____No	Psychiatric Problems
_____Yes _____No	Diabetes	_____Yes _____No	Radiation Treatment
_____Yes _____No	Difficulty Breathing	_____Yes _____No	Rheumatic/Scarlet Fever
_____Yes _____No	Emphysema	_____Yes _____No	Seizures
_____Yes _____No	Epilepsy	_____Yes _____No	Shingles
_____Yes _____No	Fainting Spells	_____Yes _____No	Sickle Cell Disease
_____Yes _____No	Frequent Headaches	_____Yes _____No	Sinus Problems
_____Yes _____No	Glaucoma	_____Yes _____No	Stroke
_____Yes _____No	Hay Fever	_____Yes _____No	Thyroid Problems
_____Yes _____No	Heart Attack	_____Yes _____No	Tuberculosis (TB)
_____Yes _____No	Heart Surgery	_____Yes _____No	Ulcers
_____Yes _____No	Hemophilia	_____Yes _____No	Venereal Disease
_____Yes _____No	Hepatitis	***Reason**	

Are you allergic to any of the following?			
_____Yes _____No	Aspirin	_____Yes _____No	Latex
_____Yes _____No	Codeine	_____Yes _____No	Penicillin
_____Yes _____No	Dental Anesthetics	_____Yes _____No	Tetracycline
_____Yes _____No	Erythromycin	_____Yes _____No	Sulfa
_____Yes _____No	Jewelry/Metals	***Other**	

6 Dental History

Why have you come to the dentist today?	
Are you currently in pain?	_____Yes _____No
Have you ever had a serious/difficult problem associated with any previous dental work?	_____Yes _____No
Do you have or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)?	_____Yes _____No
Your current dental health is:	____Good____ Fair____ Poor
Do your gums ever bleed?	_____Yes _____No
How many times a day do you brush?	
How often do you floss?	

What would you like to change about your smile? ☐Nothing, I am happy with my smile

☐Color ☐Bite ☐Chipped Teeth ☐Spaces ☐Crowding ☐ Smile Makeover ☐ Missing Teeth ☐ Whiter Teeth

7 Sleep History

Do you snore or have you been told you snore?	_____Yes _____No
Do you feel rested after a night's sleep?	_____Yes _____No
Have you been diagnosed with sleep apnea?	_____Yes _____No
Do you wear a C-PAP?	_____Yes _____No
Have you worn a C-PAP in the past?	_____Yes _____No
Have you been recommended to wear a C-PAP?	_____Yes _____No
Have you had a sleep study or been recommended to have one done?	_____Yes _____No

8 Confirmation

☐ I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Payment is due in full at time of treatment unless prior arrangements have been approved.

Our office is HIPAA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

_____ _____

Signature Date

OFFICE POLICIES

Thank you for choosing S.A.H. Dentistry as your dental health care provider. We are committed to giving you comfortable, quality treatment. Thank you for completing a medical history form, so that we can give you the best care possible. We now want to provide you with information regarding our office policies, including payment, insurance and appointment information.

Payment information:

- Payment is expected in full at time of visit
- We gladly accept Cash, Check, MasterCard, Visa, Discover, and American Express
- We participate with Care Credit, a third party financing company

Please check the box if you would like more information about our third party financing option:

☐ I would like more information about Care Credit

Do you have insurance?

- We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company.
- As a courtesy to you, we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits will determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible. If your insurance company has not made payment within 60 days, we will ask you to contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
- We ask that you pay the deductible and co-payment. This is the **estimated** amount, not covered by your insurance company. You may pay this by cash, check, credit card or third party financing at the time we provide the service to you.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

Appointment reminders:

- Our office may attempt to contact you via text and/or phone to confirm your upcoming appointment. We understand that unforeseen circumstances happen from time to time, however we ask that you **please contact our office at least 2 business days in advance should there be a change in your schedule.**

We are pleased to have you as a patient of our practice and look forward to taking care of your smile!

Consent:

I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered. I further understand that a finance, rebilling, collection charge and/or attorney fee will be added to any overdue balance. By signing below, you are authorizing us to call you at any number you provide including calls to mobile/cellular or similar devices for any lawful purpose. You agree to any fees or charges that you may incur for an incoming call from us, and/or outgoing calls to us, to or from any such number, without reimbursement from us.

_____ _____

Signature Date

S.A.H Dentistry

Your Privacy Is Important To Us

Acknowledgement of Receipt of Notice of Privacy Policies

I, _____ (Patient's Name) understand that as part of my health care, S.A.H. Dentistry originates and maintains health records by describing my health history, symptoms, examinations, test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided with and understand that S.A.H. Dentistry's Notice of Privacy Practices provides a complete description of the uses and disclosures of my health information.

I understand that:

_____(Initials) I have the right to review S.A.H. Dentistry's Notice of Privacy Practices prior to signing this acknowledgement.

_____(Initials) I **DO NOT** wish to receive a copy of this Dental Practice's HIPPA Notice of Privacy Practices.

_____(Initials) S.A.H. Dentistry may contact me via mail, home phone, cellular phone, email to remind me of appointments.

Signature of Patient X_____

Date: _____/_____/_____

Please list authorized persons with whom we may discuss your Protected Health Information (PHI) in addition to custodial parents and legal guardians:

1._____ Added/Removed Date_____/_____/_____

2._____ Added/Removed Date_____/_____/_____

3._____ Added/Removed Date_____/_____/_____

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FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but it could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barrier prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify)_____

Staff personnel's initials _____