SUNNYSIDE
FAMILY DENTISTRY

Welcome. Thank you for trusting us at Sunnyside Family Dentistry to help you maximize your oral health. We are committed to providing every adult and child with the highest quality of care in the most gentle, efficient manner. To help us serve you to the best of our ability, please fill out these forms as accurately as possible. Thank you! We're glad you're here.

ABOUT YOU

Name _____

Preferred Name _____

Date of Birth _____

☐ Male ☐ Female ☐ Transgender

Address _____

City _____ State ____ Zip _____

Email _____

Mobile # _____ Home # _____

☐ Single ☐ Married ☐ Divorced

☐ Separated ☐ Widowed

How did you hear about our office?

_____

Employer _____

Employer # _____

Present Position _____

Length of Employment _____

Work Address _____

City _____ State ____ Zip _____

IN CASE OF AN EMERGENCY, PLEASE NOTIFY:

Name _____

Relationship_____

Mobile # _____ Home # _____

INSURANCE

Insurance Company _____

Phone # _____

Subscriber ID # _____

Group # _____

Address _____

City _____ State ____ Zip _____

Insured's Name _____

Insured's Birth Date _____

Insured's Employer _____

Insured's Social Security # _____

If you have secondary insurance, please let a team member know

ACCOUNT INFO

PERSON RESPONSIBLE FOR ACCOUNT

Name _____

Relation _____ Birth Date _____

Mobile # _____ Home # _____

Email _____

Billing Address _____

City _____ State ____ Zip _____

_____
Patient Name

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MEDICAL HISTORY

Date of last health exam _____

What was this exam for? _____

How would you describe your health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Yes ☐ No

If yes, nature of care: _____

Primary Provider Name _____

Primary Provider Phone # _____

ANY ALLERGIES TO THE FOLLOWING:

Latex	☐
Aspirin, Ibuprofen, Tylenol	☐
Codeine, Valium, Other Sedative	☐
Dental Anesthetic/Epinephrine	☐
Penicillin, Amoxicillin	☐
Erythromycin	☐
Tetracycline	☐
Jewelry/Metals	☐

Other _____

MEDICATION LIST

	Name	Dose	Frequency	Reason For Taking
1)				
2)				
3)				
4)				
5)				
6)				
7)				
8)				

For the following questions circle yes or no. Your answers are for our records only and will be confidential. Please note that during your initial visit you may be asked some questions about your responses. This will help our team best determine if there are any necessary adjustments to your dental care based on your overall health.

Abnormal Bleeding	Yes	No	Colitis	Yes	No
Alcohol/Drug Abuse	Yes	No	Congenital Heart Defect	Yes	No
Anemia	Yes	No	Diabetes	Yes	No
Arthritis	Yes	No	Difficulty breathing	Yes	No
Artificial bones/joints/valves	Yes	No	Emphysema/COPD	Yes	No
Asthma	Yes	No	Epilepsy	Yes	No
Cancer/Chemotherapy	Yes	No	Fainting Spells	Yes	No

Frequent Headaches	Yes	No	Pacemaker	Yes	No
Glaucoma	Yes	No	Psychiatric Condition	Yes	No
Heart Attack	Yes	No	Radiation Treatment	Yes	No
Heart Murmur	Yes	No	Rheumatic/Scarlet Fever	Yes	No
Heart Surgery	Yes	No	Seizures	Yes	No
Hemophilia	Yes	No	Shingles	Yes	No
Hepatitis	Yes	No	Sickle Cell Disease	Yes	No
Herpes	Yes	No	Sinus Problem	Yes	No
High Blood Pressure	Yes	No	Stroke	Yes	No
HIV or AIDS	Yes	No	Thryoid Condition	Yes	No
Hospitalized for any reason	Yes	No	Tuberculosis (TB)	Yes	No
Kidney Problems	Yes	No	Ulcers	Yes	No
Liver Disease	Yes	No	Venereal Disease	Yes	No
Low Blood Pressure	Yes	No	Other Conditions: _____		
Mitral Valve Pre-lapse	Yes	No	_____		

WOMEN ONLY

Are you pregnant?	Yes	No
Are you on birth control?	Yes	No
Are you a nursing mother?	Yes	No

HAVE YOU EVER TAKEN THE FOLLOWING DRUGS?

Fen-phen (weightloss)	Yes	No
Bisphosphonate drugs such as Fosamax, Reclast, Prolia	Yes	No
Tobacco/Recreational Drugs	Yes	No

DENTAL HISTORY

Reason for seeking dental care at this time _____

Date of last dental visit _____ Reason? _____ Date of last X-Rays _____

Former dentist _____ City/State _____

Reason for finding a new dentist _____

How often do you: **Brush** _____ times per _____ **Floss** _____ times per _____

Have you had any difficulty with dental work in the past? _____

Do you have, or have you ever had any of the following?

☐ Aching or sensitive teeth	☐ Broken filling	☐ Areas of food traps	☐ Unfavorable dental experience
☐ Sensitive/bleeding gums	☐ Loose teeth	☐ Difficulty opening wide	☐ Growths or lesions in your mouth
☐ Broken or missing teeth	☐ Bad Breath	☐ Clicking/Popping in jaw	☐ Swollen glands
☐ Grinding or clenching	☐ Cold Sores	☐ Jaw pain or tiredness	☐ Dry mouth
☐ Swelling/lumps in mouth	☐ Gum infection	☐ Orthodontic treatment	☐ Other _____

If you could change your smile, what would you change?

☐ Remove unsightly fillings	☐ Straighten teeth	☐ Change shape of teeth	☐ Close gaps between teeth
☐ Replace missing teeth	☐ Whitening	☐ Make teeth same color	☐ Other _____

By signing below, I certify that all the above information is complete and accurate.

_____	_____	_____
Patient Name (Printed)	Patient Signature	Date
_____	_____	_____
Doctor Name (Printed)	Doctor Signature	Date

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MISSED APPOINTMENT AGREEMENT

We make every effort to value your time and we schedule your appointment time just for you.

It is our philosophy to continue to put our patients first and to make your experience a positive one.

It is our policy for you to give us 48 hours' notice if you need to change an appointment, and for you to call and speak directly with a staff member as our answering machine does not accept cancellations.

We will not charge you for your first missed appointment. However, if you miss an appointment for a second time, we reserve the right to charge a $50 missed appointment fee, and instead of rescheduling we will put you on a call list and notify you of a same day appointment opening.

Thank you for allowing us to share our missed appointment policy with you and please let us know if you have any questions. We are committed to your oral health and keeping your scheduled appointments allows us to be better partners in your dental care.

_____ _____

Patient Signature Date

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FINANCIAL RESPONSIBILITY

The doctors and all of our staff are committed to giving you superior dental care and we want you to feel as comfortable as possible throughout your treatment. This includes understanding your treatment plan, as well as our financial policy. Carefully read the following, then let us know if you have further questions.

Many people think if they have an employer provided benefit plan (insurance), it is the benefit plan that owes the doctor for their services. This is not the case. The benefit plan contract is between the patient, the employer, and the benefit plan company. As a courtesy to our patients, we'll bill your benefit plan, however, the responsibility for payment will remain with you. In order for us to bill your benefit plan, you must supply us with complete information about your benefit plan, including any necessary forms, group numbers, phone numbers, and addresses.

Most dental benefit plans do not cover 100% of the cost of your treatment. Patients are expected to pay the estimated non-covered portion at the time of service. If your benefit plan has not paid within 60 days of treatment, you will need to pay your account in full to this office. We will then reimburse you if and when your benefit plan has paid. This office can make no guarantees of the benefit plan's estimate of payment. This office does not absolve the patient of full responsibility for the charges in full for treatment rendered.

An often misunderstood term used by many dental benefit companies is "Usual, Customary and Reasonable Fee Schedule (UCR)." This is an arbitrary fee ceiling at which the benefit plan will stop reimbursement. After this ceiling, coverage for a particular procedure will cease. Again, this has nothing to do with the fee we charged, but with the level of coverage negotiated by the employer and benefit plan company.

Patients who do not participate with a benefit plan are expected to pay fees at the time of service unless prior arrangements have been made.

Our fees are on file with Oregon Dental Service. We accept Visa, MasterCard, Discover American Express cash or check.

All accounts over 60 days will be assessed 1.5% interest per month (18% APR).

There will be a $25.00 fee charged for all returned checks. If unable to keep your appointments, kindly give us 48 hours' notice. Otherwise, we reserve the right to charge $35.00 for time reserved.

You will need to provide our office with your Social Security number and health insurance card (if applicable) unless your total charge is paid in cash at the time of service. Treatment may be postponed if the above are not furnished by the patient or responsible party.

I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections on any amount owed on this or subsequent visits, the undersigned agrees to pay for all legal costs and expenses, including reasonable attorney fees. I hereby authorize the office to release information necessary to secure payment.

_____

Patient's Signature (or Responsible Person, if patient is a minor) Date

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AUTHORIZATION & DISCLOSURE (HIPAA)

CREDIT POLICY & FEES DISCLOSURE

ASSIGNMENT OF INSURANCE BENEFITS

AUTHORIZATION TO RELEASE INFORMATION

FINANCIAL RESPONSIBILITY

Truth-In-Lending Disclosure: In accordance with the Federal Truth-In-Lending Act, we are providing the following information about our credit and fee policy:

1. Patient Portion is due at the time of service.

2. Balances extended beyond 60 days from date of the first billing will be subject to a finance charge of 1.5% per month (annual rate of 18%).

3. There will be a $30.00 fee charged for cancellations with less than 24 hour notice.

4. There will be a $25.00 fee charged for all returned checks.

Assignment of Insurance Benefits: I hereby authorize SUNNYSIDE FAMILY DENTISTRY to submit claims to my insurance carrier for all services rendered. I direct third party payers to issue payment directly to SUNNYSIDE FAMILY DENTISTRY.

Authorization to Release Information: I authorize the release of any information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

Financial Responsibility: I understand that it is my responsibility to provide complete, accurate, and timely information on my insurance coverage(s). In the event that my insurance coverage does not pay, for any reason, I understand that I will be financially responsible for the dental services received.

Authorization to Perform Procedures: I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICIES OF THIS DENTAL OFFICE.

I UNDERSTAND THAT IAM RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT.

_____

Print Full Name (Patient or Responsible Person, if patient is a minor) Date of Birth

_____

Signature Date

Authorization valid until specifically revoked in writing