WELCOME TO SANDY DENTAL. We're so glad you're here! If you have any questions or concerns as you fill this out, please feel free to ask us!

ADD US TO YOUR CONTACTS: Make sure you don't miss important notifications! Check out our contact information at the bottom of this page.

*Please write clearly and in print. The **responsible party** is the person responsible for the patient.*

PATIENT INFORMATION

First Name | Middle Initial

Last Name

Preferred Name | Preferred Salutation: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.

Are you: ☐ Under 18 ☐ Responsible Party

Address

City | State | Zip Code

Home Phone | Cell Phone

Work Phone | Ext.

Birth Date | Sex: ☐ Male ☐ Female

Marital: ☐ Married ☐ Single ☐ Widowed ☐ Separated ☐ Divorced

Social Security # | Driver's License #

Email

How can we reach out to you? Check all that apply.
☐ email ☐ text ☐ phone calls

ADDITIONAL INFORMATION

How did you hear about us?
☐ Patient ☐ Social Media ☐ Insurance ☐ Other

Who can we thank for your referral?

Are any of your family members patients with us? ☐ Yes ☐ No

Please list their name(s)

RESPONSIBLE PARTY

Full Name (First and Last)

The Patient is your:
☐ Spouse ☐ Child ☐ Other:

Address

Home/Work Phone | Cell Phone

Birth Date | Sex: ☐ Male ☐ Female

Social Security # | Driver's License #

Email

How can we reach out to you? Check all that apply.
☐ email ☐ text ☐ phone calls

PRIMARY INSURANCE INFORMATION

Do you have dental insurance? ☐ Yes ☐ No

Policy Holder's Full Name (if different from patient)

The Insured is your:
☐ Self ☐ Spouse ☐ Child ☐ Other

Policy Holder's Birth Date & Social Security #

Member ID Number

Employer

Employer's Address

Name of Insurance Company

Address of Insurance Company

Signature of Patient and/or Responsible Party: _____ Date: _____

MEDICAL HISTORY

If yes, please provide additional information in each field:

Do you have a primary physician? List his/her name and contact details.	☐ Yes	☐ No	
Are you currently being treated for a specific condition?	☐ Yes	☐ No	
Have you ever been hospitalized or had any serious illness or major operation?	☐ Yes	☐ No	
Are you taking any medications, pills, drugs, or controlled substances?	☐ Yes	☐ No	
Do you take, or have you taken, Phen-Fen or Redux?	☐ Yes	☐ No	
Have you ever taken any medications containing bisphosphonates (such as Fosamax, Boniva, Actonel, Zometa, Didronel, Aredia, Skelid, Reclast)?	☐ Yes	☐ No	
Do you have, or have had, a head, neck, or jaw injury(ies)?	☐ Yes	☐ No	

Are you: ☐ Pregnant/trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives? Due Date:

Are you allergic to any of the following?

☐ Asprin	☐ Erythromycin	☐ Latex	☐ Codeine	☐ Barbiturates (Sleeping Pills)	☐ Local Anesthetics
☐ Metal	☐ Penicillin	☐ Iodine	☐ Sulfa Drugs	☐ Acrylic	☐ Epinephrine

Other Allergies? ☐ Yes ☐ No If yes, please tell us what you're allergic to:

Do you have, or have you had, any of the following? Circle the conditions you have or have had and scratch out those you don't.

AIDS/HIV Positive	Chest Pains	Frequent Cough	High Blood Pressure	Atherosclerosis	Stomach/Intestinal Disease
Alzheimer's Disease	Cold Sores/Fever Blisters	Frequent Headaches	High Cholesterol	Bronchitis	Stroke
Anaphylaxis	Congenital Heart Disorder	Genital Herpes	Hives or Rash	Dry Mouth/Sjorgern's	Swelling of Limbs
Anemia	Convulsions	Glaucoma	Hypoglycemia	Lupus	Thyroid Disease
Angina	Yellow Jaundice	Heart Attack/Failure	Irregular Heartbeat	Unusual Weight Loss	Tumors or Growths
Arthritis/Gout	Rheumatic Heart Disease	Heart Murmur	Kidney Problems	Radiation Treatments	Ulcers
Artificial Heart Valve	Alcohol Addiction	Heart Pacemaker	Leukemia	Renal Dialysis	Autoimmune Disease
Artificial Joint	Cortisone Medicine	Heart Trouble/Disease	Liver Disease	Rheumatic Fever	Uses Bisphosphonates
Asthma	Diabetes	Anorexia/Bulimia	Low Blood Pressure	Rheumatism	Gag Reflex
Blood Disease	Drug Addition	Joint Replacement	Lung Disease	Scarlet Fever	Mental Health Problems
Blood Transfusion	Easily Winded	Sexually Transmitted Illness	Mitral Valve Prolapse	Shingles	Uses Blood Thinners
Breathing Problems	Emphysema	Hemophilia	Osteoporosis	Sickle Cell Disease	Uses Methotrexate
Bruise Easily	Epilepsy or Seizures	Hepatitis A	Pain in Jaw Joints	Sinus Trouble	
Cancer	Excessive Bleeding	Hepatitis B or C	Parathyroid Disease	Spina Bifuda	
Chemotherapy	Fainting Spells/Dizziness	Herpes	Psychiatric Care		

Do you have or have had any condition not listed above? ☐ Yes ☐ No Is there anything you would like to make us aware of? ☐ Yes ☐ No

If you answered yes to the above two questions please provide additional details here. Or, if you have further comments, please write them here:

DENTAL HISTORY

If yes, please provide additional information in each field:

Are you visiting us for a specific concern or problem (e.g. tooth ache)?	☐ Yes	☐ No	
When was the last time you visited a dental professional?	☐ Yes	☐ No	

In the following list, please circle those items relevant to you and scratch out those which aren't:

Gums Bleed	Sensitivity to Cold	Mouth Ulcers	Grind or Clench Teeth	Smoke Cigarettes	Unpleasant Odor in Mouth
Periodontitis	Sensitivity to Sweets	Cold Sores	Chew Tobacco	Vape	Use Dentures
Sensitivity to Heat	Fever Blisters	Sores on Lips or Mouth	Smoke Tobacco	Unpleasant Taste in Mouth	Have Implants

CORONAVIRUS

Do you have, or have you recently had (in the last 24-72 hours) any fever, shakes, cough, shortness of breath, runny nose, or other flu-like symptoms? Does anybody in your household have or has had the above symptoms? ☐ Yes ☐ No

Have you or has anybody in your household tested positive for Covid-19 in the last 2-4 weeks? ☐ Yes ☐ No Date of positive result:

EMERGENCY CONTACT

Contact's Full Name:

Relationship to Patient: Phone Number:

PREFERRED PHARMACY

Pharmacy's Name (e.g. CVS):

Address:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Name of Patient and/or Responsible Party: _____

Signature of Patient and/or Responsible Party: _____ Date: _____

MEDIA RELEASE CONSENT

Sandy Dental is pleased to participate in social media outlets such as Facebook, Instagram, YouTube, Google+, etc. Through these venues, we share staff pictures, office updates, new contests, and other fun and helpful information updates that may benefit our patients. With the expressed permission of our patients, we are pleased to share posts welcoming new patients to our practice, congratulating patients completing their treatment, and posting photos of our patient's beautiful new smiles.

I hereby agree and give my permission for Sandy Dental, Inc., and their respective dentists (hereby referred to as Sandy Dental) to use pictures of my smile, both before and after, in the capacity of case presentation. I understand that my photos, both before and after, may be used in:

Social media posts (Instagram, Facebook, etc.), company website, as well as in-office photography, and in a compilation book for case presentation. I understand that these photos will not be used for any other commercial purposes without my written consent.

By designating the appropriate box below, I grant my permission in the following manner:

- ☐ I authorize and permit Sandy Dental to use my smile photos, full-face photos, first name and a brief story about my smile in all forms of media release as outlined above.
- ☐ I authorize and permit Sandy Dental to use my smile photos, full-face photos, and first name but no brief story about my smile in all forms of media release as outlined above.
- ☐ I authorize and permit Sandy Dental to use only my smile photos, but not my first name in all forms of media release as outlined above.

Patient Name (please print): _____

Patient Signature: _____ Date: _____

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

Representative's Name (please print): _____

Relationship to Patient: _____

Representative's Signature: _____ Date: _____

ZERO TOLERANCE POLICY

Please note that Sandy Dental, Inc. operates a **ZERO TOLERANCE** policy. Any patients who commit an act of violence against any member of staff or other patient, or behave in such a way that any such person(s) fears for their safety, will be documented. Any such incidents will be reported to the police immediately, and the patient's elected treatment will be terminated.

Expected Standards of Behavior: Sandy Dental, Inc. practices have a duty to provide a safe and secure environment for staff, patients and visitors. Violent or abusive behavior will not be tolerated, and decisive action will be taken to protect staff and patients.

The following are examples of **unacceptable** behavior on Practice Premises:

- Theft
- Threats or threatening behavior
- Violence
- Excessive noise (e.g. recurrent loud or intrusive conversation, shouting, or phone use)
- Threatening or abusive language involving swearing or offensive remarks
- Derogatory racial or sexual remarks
- Malicious allegations relating to members of staff, other patients or visitors
- Taking alcohol or drugs on practice premises
- Drug dealing on practice premises
- Willful damage to practice property

Patient/Representative Name: _____

Patient/Representative Signature: _____ Date: _____

COMMUNICATION CONSENT FORM

This form is used to obtain your consent to communicate with you by email or text regarding your Protected Health Information.

Sandy Dental, Inc. offers patients the opportunity to communicate by email or text. Transmitting patient information by email or text has a number of risks that the patient should consider before granting consent to use email or text for these purposes. We will use reasonable means to protect the security and confidentiality of email or text information sent and received. However, we cannot guarantee the security and confidentiality of email or text communication and will not be liable for inadvertent disclosure of confidential information. I understand that I can change my mind and revoke or provide consent later.

I consent to: ☐ Email ☐ Text ☐ Both Email and Text ☐ None, neither Email nor Text

I acknowledge that I have read and fully understood this consent form. I understand the risks associated with communication of email or text between Sandy Dental, Inc. and me and consent to the conditions outlined herein. Any questions I may have had were answered.

Patient/Representative Name: _____

Patient/Representative Signature: _____ Date: _____

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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 healthcare operation.

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 healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. 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. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting us by phone or email.

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

I have had full opportunity to read and consider the contents of this Consent and 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.

Patient Name (please print): _____

Patient Signature: _____ Date: _____

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

Representative's Name (please print): _____

Relationship to Patient: _____

Representative's Signature: _____ Date: _____

FINANCIAL POLICY

Thank you for choosing Sandy Dental. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of our mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment options you may choose from: Cash, Money Order, Visa, MasterCard, Amex, Discovery and Care Credit Healthcare Financing Company.

- **Returned checks incur a $25.00 fee**

Financing with Care Credit: Care Credit offers payment plans that allow you to pay over time with no interest. They provide convenient, low monthly payments with no annual fees or prepayment penalties*. Financing your treatment through Care Credit allows you to begin improving your oral health immediately. Please visit their website, ***www.CareCredit.com*** for more information, to check your eligibility, and to apply for financing.

*Interest, payments, and penalties are subject to changes at Care Credit's discretion and based on available promotions. It is your responsibility to carefully review the terms and conditions of any financing plan.

Please Note: Sandy Dental, Inc. requires payment prior to beginning your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case. For patients with dental insurance, we are happy to work with your carrier to maximize your benefits. We will help you process your insurance claim for a refund so long as we have your complete information request. Reimbursement from the insurance company will come directly from the insurance company. All charges are your responsibility whether your insurance company(ies) does not pay. Note that not all benefits are covered in your contract(s), some insurance companies select certain benefits that are not covered. Many Insurance policies have co-payments for services with a deductible. These should be canceled at the time you complete treatment. If your insurance does not pay your balance in full within 30 days after your treatment, we ask for your cooperation in contacting the insurance to expedite their payments.

Broken Appointments: If you cannot keep your appointment, please provide 24 hours advance notice so that our other patients may make use of the available time.

- **A $25.00 fee will be applied to patients who miss or cancel more than 1 appointment without 24 hours notice.**

Patient Record Request: If you wish to request your dental records, please inform the office manager and fill out a Patient Record Request form. Records will be provided to the patient within 7-14 business days.

- **Cost of records are $15.00**

I acknowledge that I have read and fully understood the Financial Policy of Sandy Dental, Inc. and consent to the conditions herein.

Patient/Representative Name: _____

Patient/Representative Signature: _____ Date: _____