Please write clearly and in print.

*The **responsible party** is the person responsible for the patient (for example, if the patient is underage or has a diagnosis which prevents him or her from making medical desicions).*

PATIENT INFORMATION

First Name | Middle Initial

Last Name

Are you: ☐ Under 18 ☐ Responsible Party

Do you have dental insurance? ☐ Yes ☐ No

Address

City | State | Zip Code

Home Phone | Cell Phone

Sex: ☐ Male ☐ Female

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

Birth Date | Social Security #

Email

How can we reach out to you? Check all that apply.

☐ email ☐ text ☐ phone calls

RESPONSIBLE PARTY

First Name | Middle Initial

Last Name

Sex: ☐ Male ☐ Female | Birth Date

Home Phone | Cell Phone

The Patient is your:

☐ Spouse ☐ Child ☐ Other:

HOW DID YOU HEAR ABOUT US?

☐ Patient ☐ Social Media ☐ Insurance ☐ Other

Who can we thank for your referral?

FAMILY UNIT

List the name(s) and relationship of your family and/or partner below. This helps us keep track of family units.

Full Name / Relationship

1.

2.

3.

4.

PREFERRED PHARMACY

Pharmacy's Name (e.g. CVS) | Pharmacy's Phone Number

Pharmacy's ***EXACT*** Address | City | State | Zip Code

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? Check all that apply.

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

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? Check all that apply.

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

Do you have or have had any condition that isn't included in this list? ☐ 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

In the following list, please check all that applies.

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

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

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

Name: Relationship to Patient: Phone Number:

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:

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

I acknowledge that I have been provided with SANDY DENTAL, INC., "Notice of Privacy Practices"., and I am giving my consent for the use and disclosure of Protected Health Information as required and / or permitted by law.

Patient Name (please print): _____

Patient Signature: _____ Date: _____
(or legal representative; proof may be requested)

Rev.09/19

EMAIL/TEXT MESSAGE TO MOBILE PHONE CONSENT FORM

Purpose: This form is used to obtain your consent to communicate with you by email/ mobile text messaging regarding your Protected Health Information. SANDY DENTAL, INC., (SD) offers patients the opportunity to communicate by email/mobile text messaging. Transmitting patient information by email/mobile text messaging has a number of risks that patients should consider before granting consent to use email/mobile text messaging for these purposes. SD will use reasonable means to protect the security and confidentiality of email/mobile text messaging information sent and received. However, SD cannot guarantee the security and confidentiality of email/mobile text messaging communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication of email/mobile text messaging between SD and I, and consent to the conditions outlined herein. Any questions I may have had were answered.

PATIENT ACKNOWLEDGMENT & AGREEMENT

My Consented Email Address is*: _____

My Consented Mobile Number For Text Messaging is*: _____

Patient Signature: _____ Date: _____

IN CASE OF EMERGENCY:** *Please call 911 or proceed to the nearest emergency room.* ***Do not use this way of communication for that purpose.

Rev.09/19

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

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 Zero Tolerance Policy and the Financial Policy of Sandy Dental, Inc. and consent to the conditions herein.

Patient Name (please print): _____

Patient Signature: _____ Date: _____

(or legal representative; proof may be requested)