Sones Family Dental, LLC

New Patient Registration

Today's Date: _____

Patient's Name_____

Sex: M F

Birthdate: _____ Age: _____

Home Address_____

City_____State_____ZIP_____

Single_____ Married_____ Separated_____ Widow_____

Soc. Sec.#_____

Home Ph#_____Cell Ph#_____

E-mail Address_____

Your Employer_____

Work Ph#_____

If patient is a minor, we need: Mother's DOB_____Father's DOB_____

Person responsible for account_____ Relationship: _____

Name of Spouse (parent if minor) _____

Spouse (parent's) Soc. Sec#_____

Spouse (parent's) Employer_____

Work Ph#_____Cell Ph#_____

Emergency Contact Information: Name, Telephone #, and Address:

_____

_____

Reason for this visit: _____

How did you hear about our office

_____

Do you have dental insurance? Y N Dental insurance subscriber: _____

Dental insurance company name? _____

Dental History

Patient's Name: _____

Please circle any of the following problems that apply to you.

-Sensitivity (hot, cold, sweet, pressure) YES NO
Where? UR LR UL LL
-Headaches, ear aches, neck pain YES NO
-Jaw joint pain YES NO
-Teeth or fillings breaking YES NO
-Grinding or Clenching teeth YES NO
-Bleeding, swollen or irritated gums YES NO
-Loose, tipped or shifting teeth YES NO
-Bad Breath YES NO

Do you have or had any of the following?

-Dentures YES NO
-Partial Dentures YES NO
-Braces YES NO
-Periodontal(gum) treatments YES NO

Please share the following dates:

-Your last cleaning _____/_____
-Your last oral cancer screening _____/_____
-Your last complete X-Rays _____/_____

Name of previous Dentist_____
City_____State_____
Phone #_____

If you could whiten your teeth for a cost anyone could afford, would you do it? YES NO

Do you smoke or use chewing tobacco?YES NO
How much? _____How long? _____

If I could change my smile, I would:

-make it whiter YES NO
-make it straighter YES NO
-close spaces YES NO
-Replace black metal fillings with tooth colored restorations YES NO
-Repair chipped teeth YES NO
-Replace missing teeth YES NO
-Replace old crowns that don't match YES NO
-Have a smile makeover YES NO

On a scale of 1-5, with 5 being the highest rating:

How important is your dental health to you?
1 2 3 4 5

Where would you rate your current dental health?
1 2 3 4 5

Where do you want your dental health to be?
1 2 3 4 5

What is the most important thing to you about your future smile and dental health?
_____

What is the most important thing to you about your dental visit today? _____

Medical History

Please circle any of the following problems/conditions that apply to you:

AIDS	Y	N	Dizziness	Y	N	HIV positive	Y	N	Scarlet Fever	Y	N
Allergies	Y	N	Drug Addiction	Y	N	**Hemophilia**	Y	N	Seizures	Y	N
Anemia	Y	N	Emphysema	Y	N	**Joint Infection**	Y	N	Sinus Problems	Y	N
Angina(chest pain)	Y	N	Epilepsy	Y	N	Kidney Disease	y	N	Sleep Apnea	Y	N
Artificial Heart Valve	Y	N	**Infective Endocarditis**	Y	N	Liver Disease	Y	N	Stomach Issues	Y	N
						Low Blood Press	Y	N	Stroke	Y	N
Artificial Joints	Y	N	**Heart Attack**	Y	N	Mitral Valve Prolapse	Y	N	Thyroid Disease	Y	N
Bisphosphonates	Y	N	**Heart Disease**	Y	N				Tuberculosis	Y	N
Cancer	Y	N	Heart Murmur	Y	N	Pacemaker	Y	N	Ulcers	Y	N
Chemotherapy	Y	N	Heart Surgery	Y	N	**Pregnant Currently**	Y	N	Radiation	Y	N
Congenital Heart Defect	Y	N	High/Low Blood Pressure	Y	N	Respiratory Issues	Y	N	Rheumatism	Y	N
						Rheumatic Fever	Y	N	Other_____		

Are you allergic or have you reacted adversely to any of the following medications? Circle all that apply

Aspirin Darvon Nitrous Oxide Percodan **Latex** Local Anesthetic Tetracycline Valium Codeine Erythromycin
Penicillin Sulfa Other_____

Have you ever taken any of the following medications? Circle all that apply

Actonel Zometa Boniva Aredia Fosamax
Herbal Supplements Reclast

Are you under a physician's care? What for?
_____
_____

Family Physician_____
Phone #_____

What medications are you currently taking? _____
_____

Sones Family Dental, LLC

Madison County Veterans Assistance Commission

Are you a veteran? Y N

Would you be interested in releasing your information to the Veterans Assistance Commission of Madison County to see if you qualify to receive dental benefits for you and your family?

Y N

Address: _____ City: _____

State: _____ Zip: _____

Home Number: _____

Cell Number: _____

Patient Signature **Print Name and Date**

Sones Family Dental, LLC

Financial Policy

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health. The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment. Please note that payment of your bill is considered part of your treatment. Payment is due at the time service is provided. **Our office accepts cash, personal checks, MasterCard, Visa, and Discover. If the amount is not paid in full at time of service a 1.5% finance charge per month will be applied to your account (15% APR).** Outside financing is available upon request and approval. Please note that returned checks will be subject to additional fees. **In the case it becomes necessary for our office to enlist a collection service and/or legal assistance; you will be responsible for any collection and/or legal charges up to 35%.**

Do you have insurance?

-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.

-All charges you incur are your responsibility regardless of your insurance coverage. 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. Our office is not a party to that contract.

-Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

-We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.

-We ask that you pay the deductible and copayment, which is the estimated amount not covered by your insurance company, by cash, check, MasterCard, Visa, or Discover at the time we provide the service to you.

-Insurance payments are ordinarily received within 30 days from the time of filing. If your insurance company has not made payment within 30 days, we will ask that you 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 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.

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care of our financial policy.

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 unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge and/or attorney fee will be added to 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.

_____Patient Signature (parent if child)

_____Date

Sones Family Dental, LLC

Dental Treatment Consent Form

Patient Name(s):

_____

Date: _____

The purpose of this form is to clarify basic expectations of patients during and after dental treatment at Sones Family Dental, and to clarify some basic dental risks and/or complications that can occur during and after dental treatment. This is not an all-inclusive list of risks/complications; any questions will gladly be answered by the dentist and staff. Thank you for choosing Sones Family Dental for all your dental needs!

Dental Anesthetics

I understand dental anesthetics are given to numb regions where dental procedures are to be performed. In the event that anesthetic is administered, the patient may accidentally bite, scratch, chew, or suck on his/her lip, cheek, tongue, or surrounding tissues causing damage or injury to the patient. Eating is not recommended until the numbness has worn off.

Some common complications that can arise during and after anesthetic is administered include, but are not limited to, pain, swelling, and bruising.

Some of the rare, but more serious complications include, but are not limited to, permanent anesthesia/numbness/abnormal sensation of the areas anesthetized, as well as allergic life threatening reactions resulting in emergency situations.

Alterations in Dental Treatment

I understand that treatment options may change during the course of patient care due to conditions discovered during treatment that were not evident during examination.

I also understand that in this event, I will be notified of such changes before proceeding with dental treatment.

I understand that such changes may include, but are not limited to, a referral to a specialist, such as an endodontist (nerve therapy specialist), a periodontist (gum specialist), or an oral surgeon when and if needed. I understand that such referral is left to the discretion of the attending dentist.

I understand the provisions of this informed consent as described and have no further questions.

Patient Signature **Patient name and Date (Please Print)**

Sones Family Dental LLC

Cancellation and No-Show Policy

Office hours are by appointment and we do value your time. This office is a private practice dental office and not a dental "clinic." Appointment time is reserved for you alone. Where appropriate, we prefer to schedule longer appointments so we can complete as much needed dental treatment as possible during one appointment. We feel this type of scheduling will cause minimal disruption to your daily schedule and will provide efficiency in completing your dental care. When you make an appointment, please be sure that you will be able to keep it. Morning appointments may be best for more complicated procedures.

Emergencies and unforeseen patient treatment problems may arise, causing schedule changes. Emergencies are unexpected and seem to come at the most inconvenient times. If you have a dental emergency that needs immediate attention, we will always offer to see you at once. We expect that other patients who might be slightly inconvenienced by this will be understanding of the situation. At some point, they may need the same courtesy too!

Like many offices, this office does call to confirm your appointment. Please make a note of any dental appointments we have scheduled in a place where you will be easily reminded. If you cannot make an appointment as scheduled, please notify the office. There will be a charge of $25 per 30 minutes of scheduled time for a broken appointment or cancellation with less than 48hrs notice for your appointment. If our staff is successful in filling your appointment time with another patient, there will be no broken appointment charge.

If you have any questions about our appointment cancellation and no-show policy, please feel free to ask us.

Thank you for choosing SonesFamily Dental for all your dental needs.

_____ _____

Patient Signature **Patient Name and Date Please Print**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

**** You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

Purpose: This form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself.

I, _____, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

_____ {Please Print Name}	_____ Relationship
_____ {Please Print Name}	_____ Relationship
_____ {Please Print Name}	_____ Relationship

Patient Signature: _____ Date: _____

For Office Use Only

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

- □ Individual refused to sign
- □ Communications barriers prohibited obtaining the acknowledgement

- □ An emergency situation prevented us from obtaining acknowledgement
- □ Other (Please Specify)