Patient Name: ____ Date: ___________________
First Middle In. Last

Address: _____________________________________ City: _____________ State: _____ Zip: _______

Home Phone: ________________ Work Phone: ________________ Other Phone: _________________

Patient Date of Birth: ___________ Patient Social Security #: ______________ Status: M S W D

Patients Employer ____

E-Mail Address ______________________________ Please circle contact preference: E-Mail / Phone
(Appointment Reminders)

RESPONSIBLE PARTY / INSURANCE INFORMATION

Name of Parent / Subscriber: ____

Date of Birth: ________________ Social Security #: ___________________ WK phone: ____________

Employer: __________________________________ Insurance Name: _________________________

Group #: ____________________________ Phone #: _____________________ Other Insurance: Y N

Referral Information

Whom may we thank for referring you to our practice? Another patient, friend another patient, relative (Name)________________________________ Yellow Pages Newspaper Work Postcard Insurance Location Other

CONSENT FOR SERVICES AND USE AND DISCLOSURE OF HEALTH INFORMATION
As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. Regardless of any dental insurance a patient may have, the full treatment fees are the responsibility of the patient, not the insurance company or the practice. Full payment of our fees is due at or before the time of treatment. A full explanation of our office policies is included in this packet for your review.
I grant my permission to your assignee, to telephone me at home or at my work to discuss matters related to this form. I have read this form, agree to its terms, and certify I've provided all information completely and accurately.

___________________________________ Date _______________ Relationship to Patient ____________
Signature of patient, parent or guardian

___________________________________ Date _______________ Relationship to Patient _____________
Signature of guarantor of payment/responsible party

I, ______________________ (please print name) have been provided with the Notice of Privacy Practices provided by this office. I give my consent to this office for use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Signature: ____ **Date:** _________________

Though dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Have you ever had any of the following? Please check those that apply:

AIDS / HIV positive	Epilepsy	Liver Disease
Allergies	Excessive Bleeding	Mental Disorders
Alzheimer's Disease	Fainting spells/dizziness	Nervous Disorder
Anaphylaxis	Frequent cough	Pacemaker
Anemia	Glaucoma	Psychiatric Care
Angina	Headaches	Radiation Treatment
Arthritis/ Gout	Head Injuries	Renal Dialysis
Artificial Heart Valve	Heart Attack/Heart Failure	Respiratory Problems
Artificial Joints	Heart Disease	Rheumatic Fever
Asthma	Heart Murmur	Rheumatism
Blood Disease	Hemophilia	Sickle Cell Disease
Blood Transfusion	Hepatitis	Sinus Problems
Cancer	Herpes	Stomach Problems
Chemotherapy	High Blood Pressure	Stroke
Chest Pains	Hives/Rash	Thyroid Disease
Congenital Heart Disorder	Irregular Heart Beat	Tuberculosis
Convulsions	Jaundice	Tumors/Growths
Diabetes	Kidney Disease	Ulcers
Drug Addiction	Leukemia	Venereal Disease
Emphysema		Other

1) Please list all medications you are taking:____
   ____
2) Are you allergic to any of the following?
   Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Other:
   ____
3) Do you have any medical conditions for which you must take antibiotics prior to dental appointments?
   No Yes:____
4) Have you ever had any complications following dental treatment? No Yes
   If yes, please explain:____
5) Have you ever been admitted to the hospital, had a major operation, or needed emergency care during
   the past two years? If yes, please explain:____
6) Are you now under the care of a physician? No Yes
   If yes, please explain:____
   Name of Physician:______________________________Phone #:__________________________
7) Do you use tobacco? No Yes
8) Do you use controlled substances? No Yes
9) Do you have any health problems that need further clarification? No Yes
   If yes, please explain:____

*Women: Are you: Pregnant/Trying to get pregnant? Nursing? Taking Oral Contraceptives?

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

____ ________________________

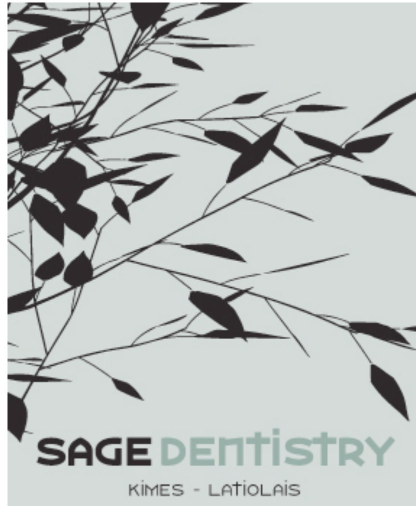
Signature of patient, parent or guardian Date

DENTAL HISTORY

Date of most recent dental exam: __________________ Date of most recent x-rays:_____________________
Date of most recent treatment other than cleaning: __________________
I routinely see my dentist every: ___3mo ___4mo ___6mo ___12mo ___Not routinely
How would you rate the condition of your mouth? ___ Excellent ___Good ___Fair ___Poor
Previous Dentist: ___________________________________
May we request records from your previous dentist to help us facilitate your care? ___ YES ___NO

Please answer YES or NO to the following	**YES**	**NO**
Personal History:		
1. Are you fearful of dental treatment? Scale of 1 to 10 (very) ___________________	____	____
2. Have you had an unfavorable dental experience?	____	____
3. Have you ever had complications from past dental treatment?	____	____
4. Have you ever had trouble getting numb or reactions to local anesthetic?	____	____
5. Did you ever have braces, orthodontic treatment or had your bite adjusted?	____	____
6. Have you had any teeth removed?	____	____
Smile Characteristics:		
7. Is there anything about the appearance of your teeth that you would like to change?	____	____
8. Have you ever whitened (bleached) your teeth?	____	____
9. Are you self conscious about your teeth?	____	____
10. Have you been disappointed with the appearance of previous dental work?	____	____
Bite & Jaw Joint:		
11. Do you/would you have any problems chewing gum?	____	____
12. Do you/would you have any problems chewing bagels or other hard foods?	____	____
13. Have your teeth changed in the last 5 years, become shorter, thinner or worn?	____	____
14. Are your teeth crowding or developing spaces?	____	____
15. Do you have more than one bite or do you clench (squeeze) to make your teeth fit together?	____	____
16. Do you have problems with sleep or wake up with an awareness of your teeth?	____	____
17. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	____	____
18. Do you have tension headaches or sore teeth?	____	____
19. Do you wear or have you ever worn a bite appliance?		
Airway:		
20. Have you been diagnosed with sleep apnea or participated in a sleep study?	____	____
21. Do you have restless sleep, wake up feeling unrested, or feel tired during the day?	____	____
22. Do you snore or have you been told you stop breathing in your sleep?	____	____
Tooth Structure:		
23. Have you had any cavities within the past 3 years?	____	____
24. Do you have a dry mouth?	____	____
25. Are any teeth sensitive to hot, cold, biting or sweets?	____	____
26. Have you ever had a toothache, cracked filling, broken, chipped or cracked tooth?	____	____
27. Do you avoid brushing any part of your mouth?	____	____
28. Do you feel or notice any holes (i.e. pitting) in your teeth?	____	____
Gum & Bone		
29. Have you ever been diagnosed or treated for periodontal (gum) disease?	____	____
30. Have you ever experienced gum recession?	____	____
31. Is there anyone with a history of periodontal disease in your family?	____	____
32. Do your gums bleed when brushing, flossing or eating?	____	____
33. Are your teeth becoming loose?	____	____
34. Have you ever noticed an unpleasant taste or odor in your mouth?	____	____
35. Have you experienced a burning sensation in your mouth?	____	____

Patient Signature (or responsible party): ___________________________________ Date: ___________________



Office Procedures and Protocol

Our team would like to extend a warm welcome to you. We realize you choose where you go for your health needs, and we are honored to have you in our office. Our goal is to provide you with honest, caring dental excellence in an exceptionally comfortable and professional environment. We are always looking for ways to improve your experience in our office, and we welcome your feedback. In order to provide you with excellent service and to avoid any misunderstandings, we feel it is important our patients be clearly informed of our office policies.

Payment options: All fees, services and treatment will be explained to you prior to each appointment. Your payment in full is due at or before the time of your appointment. For your convenience, we accept all major credit cards, cash and checks.

Financial policies: All account balances are considered past due after 30 days. All overdue account balances after 30 days will begin accruing additional finance charges each month. A $30.00 service fee will be added for any returned checks, and this fee plus the original amount of the check may be recovered electronically. After a returned check, only cash or credit cards will be accepted for payment, and appointments must be paid for in advance.

Financing options: We wish for all our patients to have access to the care they need. We are proud to help make this possible by offering financing (in many cases, interest-free) through our partnership with CareCredit. We're happy to provide you with more details if you're interested.

Appointment policy: Your appointment is reserved especially for you. Broken appointments represent a cost to you, to us, and to our other patients who are waiting for care. Please call our office during business hours (Mon-Thurs. 7:30am-4:00pm) with 48 hours of notice to cancel and reschedule any appointments. Of course we understand emergencies do occur. However, excessive abuse of this policy (more than twice) will result in additional charges to your account, requiring payment in full for appointments before any new appointments can be made, or dismissal from the practice.

We kindly ask that parents please accompany any children under the age of 16 to all dental appointments and remain in the office for the entire appointment.

Initials: ________________

<u>Patients with dental insurance:</u> We do work with many insurance companies, however we are an out-of network-provider and we do not participate with insurance networks of any kind. At your request, we will research your plan to the best of our ability in order to present you with an **ESTIMATE** of what your insurance might cover. We have two options available for you to choose from: **Please circle desired option.**

1) You can pay us for our services in full at or before the appointment time. We will then provide you with the insurance claim, filled out completely by our staff (including all details and codes for dental procedures) for you to mail to the insurance company for reimbursement.
2) You can pay us only that portion we estimate will not be covered by insurance at or before your appointment time. We will allow your outstanding balance at no additional charge for thirty (30) days while we seek payment of your balance from the insurance company on your behalf. If the balance is still outstanding at thirty (30) days, we will require your payment in full at which time you can seek reimbursement from your insurance company.

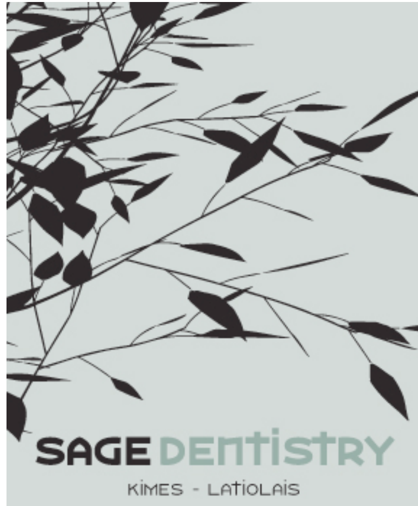
Secondary Insurance: We recognize some patients are covered by two dental insurance companies. We are happy to file your secondary insurance as a courtesy to you. When we file your secondary insurance we will request that they reimburse you directly. We will collect your estimated portion based on your primary insurance coverage.

A friendly note about insurance: Your insurance plan was negotiated between you/your employer and the insurance company, and coverage often changes from year to year. There are thousands of plans and therefore it is impossible for us to know exactly what your insurance **MIGHT** pay. Account balances are the responsibility of each patient, not our office or the insurance company.

Thank you for taking the time to read and accept our policies. Please always let us know if there is anything we can do to better serve you. We greatly appreciate your understanding and cooperation!

Agreement: I, _________________________, have read and understand the above policies, and agree to their terms.

Signature: _____________________________________ **Date:** ___________________



GENERAL MEDIA RELEASE FORM

Patient Name: ____

In connection with dental services and/or treatment being rendered, I give permission for photographs to be taken of me, with the following stipulations:

1. The photographs shall be made by my dentist, a professional photographer, or technician under their direction.
2. The photographs shall be used for medical records or as educational materials as deemed appropriate by my dentist.
3. I will not be identified by name other than for medical records purposes.
4. Photographs may be retouched in any way the professional staff considers desirable.

Please initial all that apply:

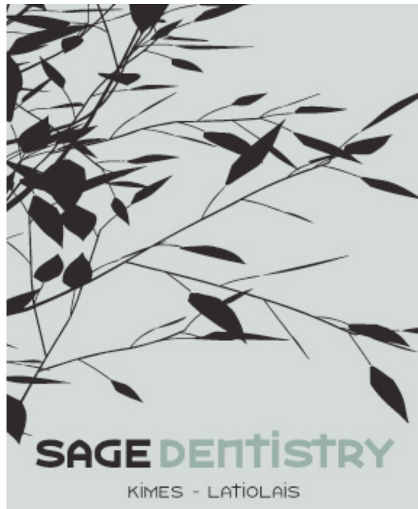
______ I understand and hereby consent to the above.

______ I give additional consent for my photos to be used for marketing purposes, including on the Sage Dentistry website. I understand that my identity will not be disclosed without further consent.

______ I understand that Sage Dentistry promotes their practice through Social Media. I consent to the use of photographs of me engaging in day to day operations at Sage Dentistry. I understand that I might be identified by first name only, and that my privacy will be protected as per HIPAA regulations.

___________________________________ ___________________________________
Patient's signature Date

____
Relationship to Patient, if other than self



RECEIPT OF NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

<u>**You May Refuse To Sign This Acknowledgement**</u>

I, ____________________________________, have been provided with a copy of this office's Notice of Privacy Practices.

____
Print Name

____
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

___ Communication barriers prohibited obtaining the acknowledgement

___ An emergency situation prevented us from obtaining acknowledgement

___ Other (Please specify)

____