## Referral Information

How did you find us? ☐ Patient/Friend - Name: _____

☐ Insurance Provider List ☐ Internet Search ☐ Mailer ☐ Facebook ☐ Other _____

## Patient Information

Patient Name: _____ Date: _____

Last First MI

Parent/Guardian (if under 18): _____

Sex: ☐ Male ☐ Female Status: ☐ Married ☐ Single ☐ Child ☐ Partner ☐ Other

Social Security #:_____ Date of Birth: _____

Phone (cell):_____ (home): _____ (work): _____Ext:_____

Preferred Telephone: ☐ Cell ☐ Home ☐ Work

Email:_____ May we email/text you appointment reminders? ☐ Yes ☐ No

Address: _____

Street Apartment #

_____

City State Zip Code

Employer: _____ Occupation: _____

Emergency Contact: _____

Name Phone Relationship

## Spouse or Responsible Party Information

The following is for: ☐ Patient (skip this section) ☐ Policy Holder (complete this section) ☐Other (complete this section)

Patient Name: _____ Date: _____

Last First MI

Social Security #:_____ Date of Birth: _____

Phone (cell):_____ (home): _____ (work): _____Ext:_____

Address: _____

Street (if different from patient's) Apartment #

_____

City State Zip Code

## Insurance Information ☐ Self Pay / No Insurance

Policy Holder: _____ Patient's Relation: _____

Birth Date: _____ Social Security #: _____

Insurance Company: _____ Employer: _____

ID#: _____ Group #:_____

## Consent for Services

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. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____

**Signature of patient, parent or guardian**

# HEALTH HISTORY

Patient First Name | MI | Last Name | Birthdate | Sex ☐ Male ☐ Female

**GENERAL HEALTH QUESTIONS**

1. Have you had any serious illness, operations or hospitalizations? ☐ Yes ☐ No

2. Are you under a physician's care at this time? ☐ Yes ☐ No

Name, address and phone # of physician:

**Do you have or did you ever have any of the following?**

**Cardiovascular Health**

3. High blood pressure ☐ Yes ☐ No
4. Angina or heart attack ☐ Yes ☐ No
5. Chest pain on physical exertion ☐ Yes ☐ No
6. Coronary artery blockage or treatment (bypass, stent, etc.) ☐ Yes ☐ No
7. Heart valve problem or replacement ☐ Yes ☐ No
8. Heart murmur ☐ Yes ☐ No
9. Heart disease, problem or treatment ☐ Yes ☐ No
10. Rheumatic fever ☐ Yes ☐ No
11. Past use of Fen-Phen ☐ Yes ☐ No
12. Irregular heart beat or pacemaker ☐ Yes ☐ No
13. Difficulty breathing when lying down ☐ Yes ☐ No
14. Stroke ☐ Yes ☐ No
15. Low blood pressure ☐ Yes ☐ No

**Respiratory Health**

16. Asthma ☐ Yes ☐ No
17. Emphysema or respiratory problems ☐ Yes ☐ No
18. Chronic sinus problems ☐ Yes ☐ No
19. Tuberculosis or persistent cough ☐ Yes ☐ No

**Endocrine/Blood/Immune Health**

20. Diabetes ☐ Yes ☐ No
21. Frequent thirst or frequent urination ☐ Yes ☐ No
22. Thyroid problems ☐ Yes ☐ No
23. Abnormal bleeding, bruise easily ☐ Yes ☐ No
24. Hemophilia ☐ Yes ☐ No
25. Anemia/blood disease ☐ Yes ☐ No
26. Cancer ☐ Yes ☐ No
27. Radiation therapy/chemotherapy ☐ Yes ☐ No
28. HIV infection/AIDS ☐ Yes ☐ No
29. Cold sores/canker sores ☐ Yes ☐ No
30. Organ transplant ☐ Yes ☐ No
31. Blood transfusion ☐ Yes ☐ No

**Muscular-Skeletal/CNS/Mental Health**

32. Joint replacement ☐ Yes ☐ No
33. Arthtritis ☐ Yes ☐ No
34. Osteoporosis ☐ Yes ☐ No
35. Fainting spells or dizziness ☐ Yes ☐ No
36. Seizures ☐ Yes ☐ No
37. Numbness or muscle weakness ☐ Yes ☐ No
38. Multiple sclerosis ☐ Yes ☐ No
39. Mental retardation ☐ Yes ☐ No
40. Dementia/Alzheimer's disease ☐ Yes ☐ No
41. Anxiety/Nervousness ☐ Yes ☐ No
42. Mental health treatment ☐ Yes ☐ No

**Gastro-Intestinal/Genito-Urinary Health**

43. Hepatitis (A, B, C or other) ☐ Yes ☐ No
44. Liver disease ☐ Yes ☐ No
45. Kidney disease/dialysis ☐ Yes ☐ No
46. Stomach trouble/ulcers ☐ Yes ☐ No
47. Sexually transmitted disease ☐ Yes ☐ No

**Medication Allergies and Other Allergies**

48. Penicillin or other antibiotics ☐ Yes ☐ No
49. Sulfa drugs ☐ Yes ☐ No
50. Dental antesthetic ☐ Yes ☐ No
51. Aspirin ☐ Yes ☐ No
52. Codeine/narcotics ☐ Yes ☐ No
53. Iodine ☐ Yes ☐ No
54. Latex products ☐ Yes ☐ No
55. Metals/nickels/jewelry ☐ Yes ☐ No
56. Other: ☐ Yes ☐ No

**Females Only**

57. Are you pregnant? ☐ Yes ☐ No
58. Are you nursing now? ☐ Yes ☐ No
59. Do you take birth control pills? ☐ Yes ☐ No

**Medications**

60. Are you taking any prescription medications, over the counter medications or herbal medicines? ☐ Yes ☐ No

If so, please list them and the dose taken:

61. Do you or have you used bisphosphonate medication (Fosomax, Actonel, Boniva, Skelid, Didronel, Aredia, Zometa, Bonefos)? ☐ Yes ☐ No

**Social**

62. Do you use tobacco? ☐ Yes ☐ No Quantity _____ Per Day
63. Do you use alcohol? ☐ Yes ☐ No Quantity _____ ☐ Per Day ☐ Per Week
64. Do you use recreational drugs? ☐ Yes ☐ No Quantity _____ Per Day
65. Do you have any other medical conditions not already listed above? ☐ Yes ☐ No

Please list:

I hereby certify that I have read the foregoing and filled out this questionnaire completely. I have advised you of all medical problems of which I am aware. I further certify that I, the unsigned, consent to the performing of x-rays and examination.

Signature of PATIENT or GUARDIAN _____ Date _____

Signature of DENTIST _____ ID# _____ Date _____

**UPDATE** Have there been any changes in your medical history, including any medications that you take, since you last completed this form? ☐ Yes ☐ No

Signature of PATIENT or GUARDIAN _____ Date _____

Signature of DENTIST _____ Date _____

# Sunrise Family Dentistry

## Written Financial Policy

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

**Payment Options:**

You can choose from:

- Cash, Visa, MasterCard, American Express, Discover Card or (Checks for existing patients)

- Convenient Monthly Payment Options from CareCredit

**Patients that have no insurance:**

Payment in full is due at the time service is rendered. We also offer an in-office Savings Plan to all of our patients.

**Patients who have dental insurance coverage that pays the office:**

All charges incurred are the responsibility of the patient or their guarantor, NOT the insurance company. 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 the insurance company. Our office is not a party to that contract. Our office does not guarantee that your insurance company will assist with payment for any dental treatment. If your claim is not paid within 60 days, denied, or paid at a lesser amount, you will be responsible for paying the full amount at that time. Our practice will not enter into a dispute with your insurance company over any claim, although we will provide necessary documentation your insurance company requests to sort out any confusion or questions that may arise. It is your responsibility to resolve any type of dispute over payments made or not made by your insurance company to our practice.

We always recommend treatment based on our patient's dental needs, not based on insurance coverage, which is inadequate with some dental plans. We estimate what the insurance will pay based on information they have provided us, which is almost always generalized information. What the insurance actually pays will be determined when they process the claim. The estimated patient portion is due and payable at the start of treatment and if the insurance pays less than estimated, we will bill the remainder to the patient or guarantor with the expectation that the full balance will be paid in full within 20 days.

**Please note:**

Sunrise Family Dentistry requires payment at the beginning of your treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.

A fee of $50 is charged for patients who miss or cancel without a 24-hour notice.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print) Date