

Welcome to **Plaza Dental**

Chart #:
FOR OFFICE USE ONLY

PATIENT REGISTRATION

PATIENT INFORMATION

Patient's Name: _____ **Date:** _____
Last, First MI (Preferred Name)

Address: _____
Street Apartment #

City State Zip Code

Email: _____ **Gender:** Male Female **Family Status:** Single Married Child

Social Security #: _____ **Medicaid ID:** _____ **Birth Date:** _____

Drivers License # _____ ****Office Use only: Copy in file?** Yes No

****HIPAA**:** Do we have permission to leave appointment, billing or dental information on your answering machine, voicemail or e-mail at the following numbers? Please check "Yes" or "No" for each contact number.

DO YOU NEED COMMUNICATION ASSISTANCE Yes Please explain _____
 NCAN (No communication Assistance needed)

Home Phone: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Best time to call: _____
Work Phone: _____ Ext: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Best time to call: _____
Cell Phone: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Best time to call: _____
Cell Text Message: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	
E-mail: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Fax: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	

RESPONSIBLE PARTY/GUARANTOR INFORMATION

Only if the person responsible for this account is NOT the patient, complete the following information for the Guarantor:

Guarantor Name: _____

Relationship to Patient: Self Spouse Child Other _____

Gender: Male Female **Family Status:** Married Single Divorced Child Other _____

Address: _____
Street City State Zip Code

Social Security #: _____ **Birth Date:** _____

Drivers License # _____ ****Office Use only: Copy in file?** Yes No

Phone Numbers: Home: _____ Work: _____ Ext: _____
Cell: _____ Fax: _____ E-mail: _____

Employer Name: _____ **Occupation:** _____

Employers Address: _____
Street City State Zip Code Phone

REFERRAL INFORMATION

How did you learn about, or who referred you to, our dental office? Patient/friend Our Staff, Another Dental Office,
 Yellow Pages, Insurance Plan, Newspaper, TV, Website, Newsletter, School, Your employer
 Direct Mail Postcard Other _____

Name of person or dental or medical office who referred you: _____
Please indicate your preferred dentist or hygienist in our office: _____

INSURANCE INFORMATION

Primary Insurance

Name of Primary Subscriber/Insured: _____ Is the insured a patient? Yes No

Relationship to Patient: Self Spouse Child Other _____
Last First MI

Insured's Social Security # _____ Birth Date: _____ Date Employed _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____ Work Phone: _____ Ext _____

Address: _____
Street City State Zip Code

Insurance Carrier/Plan Name: _____ Insurance Group #: _____ Insurance ID#: _____

Insurance Company Address: _____
Street City State Zip Code Phone

Medical Insurance

Name of Primary Subscriber/Insured: _____ Is the insured a patient? Yes No

Relationship to Patient: Self Spouse Child Legal Guardian Other _____
Last First MI

Insured's Social Security # _____ Birth Date: _____ Date Employed _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____ Work Phone: _____ Ext _____

Address: _____
Street City State Zip Code

Insurance Carrier/Plan Name: _____ Insurance Group #: _____ Insurance ID#: _____

Insurance Company Address: _____
Street City State Zip Code Phone

Reviewed by: _____ Date: _____

Dentist's Signature

TERMS AND CONDITIONS OF SERVICE

In consideration of all services provided by Sage Dental Group of Florida, PLLC, and its affiliated dental practices doing business as Sage Dental and their employees and contractors, or by Sage Dental Group of Georgia, LLC, and its affiliated dental practices and their employees and contractors (individually and collectively, the "Dental Group"), the undersigned hereby acknowledges and agrees on behalf of himself or herself, and on behalf of his or her children, dependents, and other persons for whom he or she serves as guarantor (collectively, "Dependents"), with the following terms and conditions of service:

Medical Information. The undersigned hereby certifies that all information provided to the Dental Group is true, correct and complete and agrees to promptly inform the Dental Group of any changes in any information (including regarding any Dependent). The Dental Group is authorized to use and disclose to any insurance, billing, management or processing company, agency or organization any health care information and medical records relating to the undersigned or any Dependent to obtain payment for services, determine insurance benefits, or otherwise as required by law. The Dental Group is authorized to contact the undersigned at any telephone number provided above (unless otherwise revoked in writing) to discuss this form and any billing, treatment, or other matter related to any dental treatment (including for any Dependent).

Treatment; Informed Consent. The undersigned authorizes the Dental Group and any treating dentist, hygienist, and staff member to perform all treatment described in any treatment plan (and including all other services determined by such dentist to be necessary or appropriate in connection with such treatment plan) accepted by undersigned for himself or herself or any Dependent. Dentistry is a biological procedure and not an exact science; therefore, despite the highest standard of care, no guarantee is or can be given by the Dental Group or any dentist or any other person employed or contracted by the Dental Group regarding any treatment or the results that may be obtained. The patient must comply with all specified appointments, procedures, and continuing care, and failure to do so will adversely affect the patient's treatment often necessitating additional required treatment (or retreatment) with additional fees. Failure to show within 15 minutes of the scheduled time for, or provide at least 48 hours advance notice of cancellation of, any appointment for any reason will result in a broken appointment fee. The Dental Group does not exercise control over the professional services of any of its treating dentists; therefore, the undersigned shall solely hold the treating dentist responsible for any treatment performed (including, without limitation, treatment provided under the treating dentist's supervision) and agrees to hold harmless the Dental Group and its interest holders, members, managers, officers, directors, owners, affiliates, employees, agents, contractors, and all other persons and entities under common control or ownership with the Dental Group. **Fees in treatment plans for non-insurance/discount plan patients are only valid for 30 days; all insurance/discount plan fees are subject to change at any time based upon changes in plan fee schedules or to correct errors.**

Financial Responsibility; Insurance. **THE UNDERSIGNED PATIENT AND GUARANTOR ASSUME FULL RESPONSIBILITY FOR PAYMENT OF ALL FEES AND CHARGES FOR ALL SERVICES OF THE DENTAL GROUP, WHETHER OR NOT COVERED BY INSURANCE. THE PATIENT'S PORTION OF ALL FEES (INCLUDING ALL DEDUCTIBLES AND CO-PAYS) IS DUE AND PAYABLE IN FULL AT THE TIME SERVICES ARE PERFORMED.** For treatment involving multiple appointments, such as a crown, root canal, denture, or implant, the entire patient portion is normally due when treatment is started. Any special financial arrangements must be made before treatment is started. All insurance, discount plans and discount coupons must be presented before treatment is started. The Dental Group submits insurance claims solely to primary dental insurance for patients' convenience and does not assume responsibility for the processing of such insurance or failure of insurance to pay for any reason. Dental insurance rarely covers all fees; estimated or preauthorized insurance benefits are not guaranteed. The undersigned agrees to pay promptly on demand any balance not paid by insurance within 60 days after the date of service. A service charge of 1½% per month (18% per annum) is charged on all balances more than 30 days past due. Insurance balances are considered past due if not paid within 60 days of the date of service. The undersigned shall pay all costs incurred by the Dental Group relating to collection of any unpaid or delinquent balance (including, without limitation, attorneys and collection agency fees, court costs, paralegals) whether or not suit is filed. The Dental Group reserves the right to terminate or deny any treatment if the patient's account is delinquent.

Assignment of Benefits; Authorization and Release. The undersigned hereby certifies that all insurance coverage described above is current and valid and assigns directly to the Dental Group all insurance benefits covering the undersigned or any Dependent for all services rendered. The undersigned hereby agrees that his or her signature below will be maintained "on file"; the Dental Group is authorized to use such signature on all applicable insurance claims and submissions. If any insurance payment is made to the undersigned, he or she shall immediately remit such payment to the Dental Group.

Notice of Privacy Practices. The undersigned has reviewed a copy of the Dental Group's Notice of Privacy Practices effective April 14, 2003, as amended.

I have read the above terms and conditions of service by the Dental Group and understand and accept such terms:

Signature of Patient, Parent, Legal Guardian,
Health Care Proxy or Surrogate, or Power of Attorney

Date signed: _____

Printed name of Patient, Parent, Legal Guardian,
Health Care Proxy or Surrogate, or Power of Attorney

Relationship to Patient: _____ Date signed: _____

Signature of Witness

Date signed: _____

Printed name of Witness

HIPAA COMPLIANCE

Patient Consent to Receive Mail and/or Telephone Messages

Patient's Name: *(Please print)*

LAST NAME FIRST NAME MIDDLE

1. Do we have your permission to send recall/treatment appointment reminders to your home? Yes _____ No _____

2. Do we have your permission to leave the following information on your home answering machine or voice mail?

Appointment Information	Yes _____	No _____
Billing Information	Yes _____	No _____
Dental/Medical Information	Yes _____	No _____

3. Do we have your permission to leave the following information on your work answering machine or voice mail?

Appointment Information	Yes _____	No _____
Billing Information	Yes _____	No _____
Dental/Medical Information	Yes _____	No _____

4. Do we have your permission to send the following information to your e-mail address provided to us on your patient registration form?

Appointment Information	Yes _____	No _____
Billing Information	Yes _____	No _____
Dental/Medical Information	Yes _____	No _____

5. Do we have your permission to send the following information to your cell phone number (including text messages) provided to us on your patient registration form?

Appointment Information	Yes _____	No _____
Billing Information	Yes _____	No _____
Dental/Medical Information	Yes _____	No _____

6. Do we have your permission to send the following information to your fax machine at the number provided to us on your patient registration form?

Appointment Information	Yes _____	No _____
Billing Information	Yes _____	No _____
Dental/Medical Information	Yes _____	No _____

7. I hereby give permission to share any information concerning me with the person(s) named below:

Name: _____ Name: _____

DATE: _____

SIGNED: _____

WITNESS: _____

Print Name: _____

Print Name: _____

Relationship to Patient: Self _____ Spouse _____ Parent _____ Child _____ Legal Guardian _____ Other: _____

Health History Form

Email: Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name:			Home Phone: <i>Include area code</i>		Business/Cell Phone: <i>Include area code</i>				
<i>Last</i>	<i>First</i>	<i>Middle</i>	()		()				
Address:			City:		State: Zip:				
<i>Mailing address</i>									
Occupation:			Height:		Weight:				
					Date of Birth: Sex: M F				
SS# or Patient ID:		Emergency Contact:		Relationship:		Home Phone: <i>Include area code</i> Cell Phone: <i>Include area code</i>			
				()		()			
If you are completing this form for another person, what is your relationship to that person?									
<i>Your Name</i>				<i>Relationship</i>					
Do you have any of the following diseases or problems:				<i>(Check DK if you Don't Know the answer to the the question)</i>				Yes No DK	
Active Tuberculosis.....								□ □ □	
Persistent cough greater than a 3 week duration.....								□ □ □	
Cough that produces blood.....								□ □ □	
Been exposed to anyone with tuberculosis.....								□ □ □	
If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.									

Dental Information *For the following questions, please mark (X) your responses to the following questions.*

Yes No DK			Yes No DK		
Do your gums bleed when you brush or floss?.....□ □ □			Do you have earaches or neck pains?.....□ □ □		
Are your teeth sensitive to cold, hot, sweets or pressure?.....□ □ □			Do you have any clicking, popping or discomfort in the jaw?.....□ □ □		
Is your mouth dry?.....□ □ □			Do you brux or grind your teeth?.....□ □ □		
Have you had any periodontal (gum) treatments?.....□ □ □			Do you have sores or ulcers in your mouth?.....□ □ □		
Have you ever had orthodontic (braces) treatment?.....□ □ □			Do you wear dentures or partials?.....□ □ □		
Have you had any problems associated with previous dental treatment?.....□ □ □			Do you participate in active recreational activities?.....□ □ □		
Is your home water supply fluoridated?.....□ □ □			Have you ever had a serious injury to your head or mouth?.....□ □ □		
Do you drink bottled or filtered water?.....□ □ □			Date of your last dental exam:		
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY			What was done at that time?		
Are you currently experiencing dental pain or discomfort?.....□ □ □			Date of last dental x-rays:		
What is the reason for your dental visit today?					
How do you feel about your smile?					

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

Yes No DK			Yes No DK		
Are you now under the care of a physician?.....□ □ □			Have you had a serious illness, operation or been hospitalized in the past 5 years?.....□ □ □		
Physician Name: Phone: <i>Include area code</i>			If yes, what was the illness or problem?		
()					
Address/City/State/Zip:			Are you taking or have you recently taken any prescription or over the counter medicine(s)?.....□ □ □		
			If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:		
Are you in good health?.....□ □ □			_____		
Has there been any change in your general health within the past year?.....□ □ □			_____		
If yes, what condition is being treated?			_____		

Date of last physical exam:			_____		

Medical Information Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

<p><i>(Check DK if you Don't Know the answer to the question)</i></p> <p>Do you wear contact lenses?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Date: _____ If yes, have you had any complications? _____</p> <p>Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia®, Zometa®, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Date Treatment began: _____</p>	<p>Do you use controlled substances (drugs)?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Do you use tobacco (smoking, snuff, chew, bidis)?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>If so, how interested are you in stopping? Circle one: VERY / SOMEWHAT / NOT INTERESTED</p> <p>Do you drink alcoholic beverages?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>If yes, how much alcohol did you drink in the last 24 hours? _____</p> <p>If yes, how much do you typically drink in a week? _____</p> <p>WOMEN ONLY Are you:</p> <p>Pregnant?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Number of weeks: _____</p> <p>Taking birth control pills or hormonal replacement?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Nursing?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
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<p>Allergies. Are you allergic to or have you had a reaction to: To all yes responses, specify type of reaction.</p> <p style="text-align: right;">Yes No DK</p> <p>Local anesthetics <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Aspirin <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Penicillin or other antibiotics <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Barbiturates, sedatives, or sleeping pills <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Sulfa drugs <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Codeine or other narcotics <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	<p style="text-align: right;">Yes No DK</p> <p>Metals <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Latex (rubber) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Iodine <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Hay fever/seasonal <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Animals <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Food <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Other <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
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Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

<p style="text-align: right;">Yes No DK</p> <p>Artificial (prosthetic) heart valve..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Previous infective endocarditis..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Damaged valves in transplanted heart..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Congenital heart disease (CHD)</p> <p> Unrepaired, cyanotic CHD..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p> Repaired (completely) in last 6 months..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p> Repaired CHD with residual defects..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	<p style="text-align: right;">Yes No DK</p> <p>Autoimmune disease..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Rheumatoid arthritis..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Systemic lupus erythematosus..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Asthma..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Bronchitis..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Emphysema..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Sinus trouble..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Tuberculosis..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Cancer/Chemotherapy/ Radiation Treatment..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Chest pain upon exertion..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Chronic pain..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Diabetes Type I or II..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Eating disorder..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Malnutrition..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Gastrointestinal disease..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>G.E. Reflux/persistent heartburn..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Ulcers..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Thyroid problems..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Stroke..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	<p style="text-align: right;">Yes No DK</p> <p>Glaucoma..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Hepatitis, jaundice or liver disease..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Epilepsy..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Fainting spells or seizures..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Neurological disorders..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p> If yes, specify: _____</p> <p>Sleep disorder..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Do you snore?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Mental health disorders..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p> Specify: _____</p> <p>Recurrent Infections..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p> Type of infection: _____</p> <p>Kidney problems..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Night sweats..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Osteoporosis..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Persistent swollen glands in neck..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Severe headaches/ migraines..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Severe or rapid weight loss..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Sexually transmitted disease.. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Excessive urination..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
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Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?.....

Name of physician or dentist making recommendation: _____ Phone: *Include area code*
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Do you have any disease, condition, or problem not listed above that you think I should know about?.....

Please explain: _____

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: _____ Date: _____

Signature of Dentist: _____ Date: _____

Comments: _____

FOR COMPLETION BY DENTIST
