**Patient Information**

Name: ________________________________________ Preferred Name: __________________________

Title: Dr. Mr. Mrs. Ms.

Gender Identity: Male Female Other Preferred Pronouns: _____________________________

Date of Birth: _____________________ Social Security Number: ________________________________

Street Address: _______________________________________________________ Apt #: ____________

City, State, Zip: _________________________________________________________________________

Relationship Status: Single Married Widowed Spouse's Name: ____________________________

Employer: _____________________________ Email: __________________________________________

Home Phone: _________________ Cell Phone: _________________ Work Phone: _________________

Preferred Contact Method: Text Message Email Phone - ( Cell Home Work )

Emergency Contact: _________________________________ Contact Phone: _____________________

**New Patients** – Whom may we thank for referring you to our practice? _____________________________

**Dental Insurance Information**

Employee/Subscriber Name: _______________________________ Subscriber ID #: _________________

Self Spouse Child Other: _____________________ Date of Birth: _____________________________

Group/Employer Name: _________________________ Group Number: ____________________________

Insurance Company Name: ________________________________ Phone: _________________________

Claims Mailing Address: _____________________________________________________________________

Is patient covered by additional insurance? Yes No

I authorize release of any information concerning my/my child's healthcare recommendations and treatment for the purpose of evaluation and administering claims for insurance benefits.

I authorize payment of insurance directly to Sapon & Swisher Dental.

I understand my dental benefits may be less than the fees for dental services and insurance may not pay the fee charged in full.

I understand I am responsible for and agree to pay the total fees for my/my child's dental treatment.

I agree to pay applicable deductibles and estimated co-payments on the date the dental services are rendered. I understand not all dental treatment may be covered by my insurance plan and I agree to pay for any non-covered services on the date dental services are rendered.

I agree to pay the total cost of dental services rendered on the date of service if I/my child do not have dental insurance benefits.

**I have read and understand all the information on this form.**

Patient/Guardian Signature: ______________________________________ Date: ___________________

## Medical History

Although 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.

Are you under a physician's care now?

○ Yes ○ No If yes ______________________________________________

Have you ever been hospitalized or had a major operation?

○ Yes ○ No If yes ______________________________________________

Have you ever had a serious head or neck injury?

○ Yes ○ No If yes ______________________________________________

Are you taking any medications, pills or drugs (including vitamins or supplements)?

○ Yes ○ No If yes ______________________________________________

______________________________________________________________

Have you ever taken Fosamax, Boniva, Prolia or any other medications containing bisphosponates?

○ Yes ○ No If yes ______________________________________________

Are you on a special diet?

○ Yes ○ No If yes ______________________________________________

Do you use tobacco? (Which type, how often?)

○ Yes ○ No If yes ______________________________________________

Do you use controlled substances?

○ Yes ○ No If yes ______________________________________________

**Women**: Are you…

○ Pregnant? ○ Trying to get pregnant? ○ Nursing? ○ Taking oral contraceptives?

Are you allergic to any of the following?

○ Aspirin ○ Penicillin ○ Codeine ○ Acrylic

○ Metal ○ Latex ○ Sulfa Drugs ○ Local Anesthetics

○ Other: ______________________________________________________

SAPON & SWISHER
DENTAL

Do you have, or have you had, any of the following? **If YES, please describe in COMMENTS below.**

| Condition | | Condition | | Condition | | Condition | |
|---|---|---|---|---|---|---|---|
| Abnormal Bleeding | ○ Yes ○ No | Congenital Heart Disorder | ○ Yes ○ No | Hemophilia | ○ Yes ○ No | Recent Weight Loss | ○ Yes ○ No |
| Acid Reflux/GERD | ○ Yes ○ No | Congestive Heart Failure | ○ Yes ○ No | Hepatitis A | ○ Yes ○ No | Renal Dialysis | ○ Yes ○ No |
| AIDS/HIV Positive | ○ Yes ○ No | Cortisone Medicine | ○ Yes ○ No | Hepatitis B | ○ Yes ○ No | Rheumatic or Scarlet Fever | ○ Yes ○ No |
| Alzheimer's Disease | ○ Yes ○ No | Dementia | ○ Yes ○ No | Hepatitis C | ○ Yes ○ No | Rheumatism | ○ Yes ○ No |
| Anaphylaxis | ○ Yes ○ No | Diabetes | ○ Yes ○ No | Herpes | ○ Yes ○ No | Seasonal Allergies | ○ Yes ○ No |
| Anemia | ○ Yes ○ No | Drug Addiction | ○ Yes ○ No | High Blood Pressure | ○ Yes ○ No | Shingles | ○ Yes ○ No |
| Angina/Chest Pain | ○ Yes ○ No | Dry Mouth | ○ Yes ○ No | High Cholesterol | ○ Yes ○ No | Sinus Trouble | ○ Yes ○ No |
| Arthritis | ○ Yes ○ No | Eating Disorder | ○ Yes ○ No | Hives or Rash | ○ Yes ○ No | Sleep Apnea | ○ Yes ○ No |
| Artificial Heart Valve | ○ Yes ○ No | Emphysema | ○ Yes ○ No | Hypoglycemia | ○ Yes ○ No | Stroke | ○ Yes ○ No |
| Artificial Joint | ○ Yes ○ No | Epilepsy/Seizures | ○ Yes ○ No | Kidney Problems | ○ Yes ○ No | Thyroid Disease | ○ Yes ○ No |
| Asthma | ○ Yes ○ No | Fainting Spells/Dizziness | ○ Yes ○ No | Liver Disease | ○ Yes ○ No | Tonsilitis | ○ Yes ○ No |
| Autoimmune Disease | ○ Yes ○ No | Frequent Headaches | ○ Yes ○ No | Low Blood Pressure | ○ Yes ○ No | Tuberculosis | ○ Yes ○ No |
| Blood Disease | ○ Yes ○ No | Glaucoma | ○ Yes ○ No | Mental Health Condition | ○ Yes ○ No | Tumors/Growths | ○ Yes ○ No |
| Blood Transfusion | ○ Yes ○ No | Hearing Impaired | ○ Yes ○ No | Mitral Valve Prolapse | ○ Yes ○ No | Ulcers | ○ Yes ○ No |
| Bruise Easily | ○ Yes ○ No | Heart Attack/Failure | ○ Yes ○ No | Osteoporosis | ○ Yes ○ No | Sexually Transmitted Disease | ○ Yes ○ No |
| Cancer | ○ Yes ○ No | Heart Murmur | ○ Yes ○ No | Pain in Jaw Joints | ○ Yes ○ No | Yellow Jaundice | ○ Yes ○ No |
| Chemotherapy | ○ Yes ○ No | Heart Pacemaker | ○ Yes ○ No | Psychiatric Care | ○ Yes ○ No | | |
| Cold Sores | ○ Yes ○ No | Heart Trouble/Disease | ○ Yes ○ No | Radiation Treatments | ○ Yes ○ No | | |

Have you ever had a serious illness not listed above?

○ Yes ○ No   If yes ______________________________________________________

Comments:

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 that dental office of any changes in medical status.

______________________ ________________________________ ____________

Patient Name   Signature of Patient, Parent or Guardian   Date

# HIPAA Consent Form

Patient Name: ____________________________________________

## HIPAA – Notice of Privacy Practice

HIPAA is a federal law developed to provide a standard for the protection of your health information. The purpose of the Notice of Privacy Practice is to explain how Sapon & Swisher Dental may use or disclose your health care information. The Notice also explains the rights that you are guaranteed under HIPAA regulations.

Though Sapon & Swisher Dental has always taken great care to protect the integrity and confidentiality of your health care information, we are now required by the HIPAA Privacy Rule to distribute this notice to you and obtain acknowledgement that you have received the Notice.

Signing below indicates that you acknowledge that the Notice of Privacy Practice is available by request. If you have any questions, please contact our HIPAA Compliance Officer listed:

Mary Yowell, Compliance Officer
434-973-1222
80 Whitewood Rd.
Charlottesville, VA 22901

I hereby acknowledge that I have received a copy of Sapon & Swisher Dental Notice of Privacy Practices.

______________
Initials of Patient/Guardian

## Permission to Share Medical Information

My medical information may be obtained and exchanged verbally to: _______________
**Typically, a family member, spouse, or friend that is allowed to receive information about your appointments or treatment.

______________
Initials of Patient/Guardian

## Permission to Bill Insurance

All professional services rendered are charged to the patient. Necessary forms will be completed by the office of Sapon & Swisher Dental to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage.
I understand my signature authorizes releasing of the information of the insurer or agency given to Sapon & Swisher Dental for participating health insurance plans.

Signature: ____________________________________________ Date: ______________

# FINANCIAL AGREEMENT

Thank you for choosing Sapon & Swisher Dental as your dental care provider. We are committed to the success of your treatment. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy. We require you read and sign prior to any treatment.

**INSURANCE:**
Dental insurance is a contract between the patient and the insurance company. At no time should insurance benefits compromise your doctor's diagnosis, treatment recommendations, or affect your choice of treatment. **Sapon & Swisher Dental is not responsible for knowing the specifics of your dental coverage.** Real time benefits are subject to your eligibility, plan limitations, deductibles, and annual maximums at the time the claim is processed.

Any treatment provided may not be covered by your insurance. Please know that we file your claim(s) with your insurance company as a courtesy to you, to limit financial responsibility. However, our practice has a contractual obligation with your insurance company to collect what they have indicated is your responsibility. Should you receive a bill from us regarding your visit here, we recommend you contact your insurance company for more detail. They will have information regarding your policy's specific guidelines and limitations.

_______ **initials**

**PAYMENT:**
Full payment is due at the time of service.
If insurance benefits apply, estimated patient copayments and deductibles are due at the time of service. We accept all forms of payment – cash, check, Apple pay, VISA, MasterCard, Discover, and Care Credit.
Check policy: If your check is returned for any reason, a $30 fee will be charged.

**RECORDS TRANSFER:**
Please ensure your x-rays have been transferred to our office prior to your appointment. If x-rays are treatment planned and completed at our office but were rendered at another office, they may not be covered by your insurance again. You will be responsible for the cost of these services.

**MISSED APPOINTMENTS:**
We believe everyone's time is valuable. When you break an appointment or cancel within 24 hours of your appointment, it impacts our staff and our other patients. Please help us serve all our patients by keeping scheduled appointments.
If we are unable to confirm your appointment within 24 hours, your appointment will be automatically cancelled.
**The missed appointment fees are as follows:**
**$30 fee** for hygiene appointments
**$60 fee** for restorative appointments
**All fees must be paid prior to rescheduling your appointment.**

**DELINQUENT ACCOUNTS:**
If your balance is 90 days past due, your account will be turned over to Collections. You will not be reappointed and/or any future appointments will be canceled until the balance has been paid through the collection agency.

**I have read, understand, and agree to the terms and conditions of this Financial Agreement.**

________________________________ ________________________
Patient/Guardian Signature Date