Welcome to
Sunshine Dental!

Please complete this information to the best of your ability.
(PLEASE PRINT)

Patient's #______________________

Patient's Last Name ______________________ First Name ______________________ Middle Initial __________
Home Address ______________________ Apt.# ______ City ______________ State ______________
Zip Code __________ Home Phone ______________________ Work Phone ______________________
Date of Birth ____________ Sex: M ☐ F ☐ Social Security No. ______________ Driver's License No. ______________
Place of Employment ______________________ Employment Address ______________________
City ______________________ State ______________ Zip Code __________
Emergencies: Name and phone number of next closest relative to patient: Name ______________ Phone ______________

If the patient is not responsible for payment of this account please complete the following information.

Responsible Person's Last Name ______________________ First Name ______________ Middle Initial __________
Home Address ______________________ Apt.# ____ City ______________ State ______ Zip __________
Home Phone ______________________ Work Phone ____________ Social Security No. __________.
Driver's License No. ______________ Relationship to Patient. __________ Place of Employment ______________
Employment Address ______________________ City ______________ State ____ Zip __________

Whom may we thank for referring you to Sunshine Dental? ***(PLEASE CIRCLE)***

Yellow Pages T.V. Guide Passing By Radio Newspaper Word of Mouth Billboard Television Mailer

Other: ______________________

MEDICAL HISTORY

• HOW IS YOUR GENERAL HEALTH:
☐ Excellent ☐ Good ☐ Fair ☐ Poor

• Is your blood pressure:
☐ High ☐ Low ☐ Normal

• Are you allergic to:
☐ Penicillin ☐ Codeine ☐ Novocaine

	YES	NO
•Are you taking any medication?	☐	☐
If yes, how long? ______________________		
•If female, are you pregnant?	☐	☐
If yes, how long? ______________________		
•Are you taking birth control pills?	☐	☐
•Do you have night sweats?	☐	☐
•Are you subject to prolonged bleeding?	☐	☐

HAVE YOU HAD OR EVER BEEN TREATED FOR:	YES	NO
•Hepatitis A or B	☐	☐
•Epilepsy / Convulsions	☐	☐
•Kidney Problems	☐	☐
•Diabetes	☐	☐
•Heart Trouble	☐	☐
•Artificial Joint	☐	☐
•Tuberculosis	☐	☐
•Alcoholism	☐	☐
•Venereal Disease	☐	☐
•Rheumatic Fever	☐	☐
•**HIV**	☐	☐

•Others not listed: ______________________
____

Is there anything in your medical history that we should be aware of? If yes, what? ______________________
____
Name and address of physician: ______________________
Are you currently under his treatment? Yes _____ No_____

DENTAL HISTORY

What is the reason for you visit? ______________________
Do your teeth ache? Yes______No______ If yes, where? Upper_____ Lower _____ Left _____ Right_____
How long has your problem existed? ______________________
Have you have an oral exam in the last six (6) months? Yes_____ No_____
Have you had full mouth X-rays in the last six (6) months? Yes _____ No_____
Have you had your teeth cleaned in the last six (6) months? Yes_____ No_____
Have you ever had any serious problems associated with dental treatment? Yes_____ No_____
If yes, explain: ______________________
Pharmacy phone number: ______________________
Do you have dental insurance? Yes_____ No_____ If yes, we are happy to accept your dental benefits as payment for dental care. However, you are required to provide us with a completed dental insurance claim form before we can accept it as payment.
Do you have major medical insurance? Yes_____ No_____

We have a payment plan for everyone. Ask your treatment counselor for details.

I verify that the above information is correct and agree to pay either 1 1/2 % per month or 18% interest per year on any of my charges that are not paid within 30 days from the date of treatment. Signature of patient or legal guardian if patient is a minor (ages 1-18).

Date ______________________ ***Signature*** ______________________

Sunshine Dental
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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}

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)

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CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I, the undersigned, hereby execute this **Consent for Purposes of Treatment, Payment, and Healthcare Operations** (this “Consent") as written evidence of my consent to the use or disclosure of my protected health information (as defined below) by **Sunshine Dental** for the purpose ol diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of **Sunshine Dental**. I understand that diagnosis or treatment of me by **Sunshine Dental** may be conditioned upon execution of this Consent.

I understand that my “protected health information" for purposes of this Consent is health information, including demographic information, that: (i) is created or received by **Sunshine Dental**; (ii) relates to my past, present, or future physical or mental health or condition, the provision of health care to me, or the past, present or future payment for the provision of health care to me; and (iii) identifies me or for which there is a reasonable basis to believe the information can be used to identify me.

Right to Review Notice of Privacy Practices

I understand I have a right to review **Sunshine Dental's** Notice of Privacy Practices prior to signing this document for a more complete description the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of **Sunshine Dental**. A copy of **Sunshine Dental's** Notice of Privacy Practices has been offered to me. The Notice of Privacy Practices describes The Notice of Privacy Practices for **Sunshine Dental**. This Notice of Privacy Practices also describes my rights and **Sunshine Dental's** duties with respect to my protected health information.

I understand that **Sunshine Dental** reserves the right to change its privacy practices that are described in the Notice of Privacy Practices and by executing this consent, I agree that **Sunshine Dental** has informed me that the terms of the Notice of Privacy Practices may change and that I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Right to Request Restriction

I understand I have the right to request that **Sunshine Dental** restrict how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations and that **Sunshine Dental** is not required to agree to the restrictions that I may request. However, if **Sunshine Dental** agrees to a restriction that I request, the restriction is binding on **Sunshine Dental**.

Right to Revoke Consent in Writing

I understand that I have the right to revoke this consent, in writing, at any time, except to the extent that **Sunshine Dental** has taken action in reliance on this consent.

____

Signature of Patient or Personal Representative

____

Name of Patient or Personal Representative

____

Date

____

Description of Personal Representative's Authority

Insurance and Financial Policy

At **Sunshine Dental**, we believe that you deserve the best care. That's why we always present you with the best dental solution possible to treat your personal situation. Each year we provide outstanding dental care to hundreds of patients. Some have dental benefits but some don't. If you have dental benefits, congratulations! You are very fortunate,. Here are some important things you should know:

Initial

_______ ■ Your dental benefits are based upon a contract made between your employer and an insurance company. **If you have any questions regarding your dental benefits, please contact your employer or insurance company directly. Dental benefit plans will never pay for completion of your dental care. It is only meant to assist you**.

_______ ■ We currently accept all private care insurance plans (plans that do not require you to select a dentist from a list or require our office to accept a reduced fee for service). This means that we work with literally thousands of companies. Although we can maintain computerized histories of payment by a given company, they do change; therefore it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is **ONLY AN ESTIMATE**. If you would like to know your insurance benefit, we will be happy to file a "pre-treatment authorization" with your insurance company prior to treatment. Keep in mind this is not a guarantee of coverage. This does delay treatment but will give you the exact out of pocket figures you may require.

_______ ■ We will bill your insurance as a courtesy. If insurance does not pay within 90 days, **Sunshine Dental** reserves the right to request payment in full for services from you and let you collect the insurance funds that are due to you. This is rare but it is important that you recognize that the insurance you have is a legal contract between YOU and your insurance company. Our office is not, and cannot be a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.

_______ ■ **Sunshine Dental** does require payment in full for your portion at the time of service. We accept MasterCard, Visa, American Express, Discover, cash and checks (for existing patients with established payment history). If you are in need of an extended finance option, we also work with CareCredit, who offers 3, 6, 12 or 18 month "same as cash" or longer terms with an interest bearing charge designed to meet your treatment plan needs on approved credit.

_______ ■ A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require **at least 24 hour** notice to avoid a **$35/hour cancellation fee** (emergencies are an exception).

_______ ■ In the event of an emergency after regular business hours, a **$55 emergency fee** will be charged for established patients in addition to the necessary treatment fees. Patients who are not established in the practice will be charged **$125 after hours emergency fee**.

I agree with the above conditions.

Print Name:____ Date:___________________

Patient/Parent Signature: ____