

“Get to Know You” Form

We are very happy to have you join our practice. WELCOME!
To our doctors, treatment is more than a great plan and excellent care. We want to get to know you and your family. The better we know each other, the more you will learn about your treatment. We hope you look forward to your appointments as much as we look forward to seeing you!

Please, help us get to know you better:

Nickname? _____

Other family members treated by us? _____

Who may we thank for referring you? _____

Spouse Name? (If applicable) _____

Where does your Spouse work? What job does your Spouse do?

Do you like or play any sports, musical instruments? _____

Do you have any pets? _____

Any great news that you'd like to share with us? _____

Previous Dentist? _____

Please bring this form to your first appointment, thank you!

REGISTRATION FORM

(Please Print)

Today's date:							
PATIENT INFORMATION							
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar	
Home phone () -		Cell phone ()		Birth date: / /		Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Drivers License #		Email Address @			Work phone ()		
Street address:		City:		State:		ZIP Code:	
Referred to clinic by (please check one box):				<input type="checkbox"/> Dr.		<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Hospital
<input type="checkbox"/> Family	<input type="checkbox"/> Friend NAME:	<input type="checkbox"/> Close to home/ work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Walk-IN		<input type="checkbox"/> Online	

- Purpose of initial visit?

- How long since you last dental visit?

- What was done at the time?

- Have you ever had any problems or complications with previous dental treatment?

- Do you have any questions or concerns?

- Do you have an FSA account? _____

Employment Information

Employer Name: _____ Occupation _____

Are you insured with thru this employer? _____ If so, what is the insurance companies name _____

Phone Number () _____ Name of subscriber (if different from patient) _____

Social Security # _____ necessary for insurance purposes only

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 and 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 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 reimburse full payment to patient. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that the fee estimate listed for this dental care can only be extended for a period of 30 days 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 days of billing if credit shall be extended. I further agree that the reasonable values of said services shall be as billed unless objected to, by me in writing, within the time for payment thereof. I further agree that waiver of any breach of any time or condition here under 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.

Sunrise Dental Center has permission to use diagnostic and treatment photographs and models of the patient for the purpose of scientific articles, seminars and presentations.

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.

Signature of patient, parent, guardian or responsible party

Date

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

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, please explain: _____
- Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____
- Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____
- Are you taking any medications, pills, or drugs? Yes No If yes, please explain: _____
- Do you take, or have you taken, Phen-Fen or Redux? Yes No _____
- Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No _____
- Are you on a special diet? Yes No
- Do you use tobacco? Yes No
- Do you use controlled substances? Yes No

Women: Are you Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?
 Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa drugs
 Other If yes, please explain: _____

- Do you have, or have you had, any of the following?
- | | | | |
|--|--|--|---|
| AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No | Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No | Hemophilia <input type="radio"/> Yes <input type="radio"/> No | Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No |
| Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No | Diabetes <input type="radio"/> Yes <input type="radio"/> No | Hepatitis A <input type="radio"/> Yes <input type="radio"/> No | Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No |
| Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No | Drug Addiction <input type="radio"/> Yes <input type="radio"/> No | Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No | Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No |
| Anemia <input type="radio"/> Yes <input type="radio"/> No | Easily Winded <input type="radio"/> Yes <input type="radio"/> No | Herpes <input type="radio"/> Yes <input type="radio"/> No | Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No |
| Angina <input type="radio"/> Yes <input type="radio"/> No | Emphysema <input type="radio"/> Yes <input type="radio"/> No | High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No | Rheumatism <input type="radio"/> Yes <input type="radio"/> No |
| Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No | Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No | High Cholesterol <input type="radio"/> Yes <input type="radio"/> No | Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No | Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No | Hives or Rash <input type="radio"/> Yes <input type="radio"/> No | Shingles <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Joint <input type="radio"/> Yes <input type="radio"/> No | Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No | Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No | Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No |
| Asthma <input type="radio"/> Yes <input type="radio"/> No | Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No | Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No | Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No |
| Blood Disease <input type="radio"/> Yes <input type="radio"/> No | Frequent Cough <input type="radio"/> Yes <input type="radio"/> No | Kidney Problems <input type="radio"/> Yes <input type="radio"/> No | Spina Bifida <input type="radio"/> Yes <input type="radio"/> No |
| Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No | Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No | Leukemia <input type="radio"/> Yes <input type="radio"/> No | Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No |
| Breathing Problem <input type="radio"/> Yes <input type="radio"/> No | Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No | Liver Disease <input type="radio"/> Yes <input type="radio"/> No | Stroke <input type="radio"/> Yes <input type="radio"/> No |
| Bruise Easily <input type="radio"/> Yes <input type="radio"/> No | Genital Herpes <input type="radio"/> Yes <input type="radio"/> No | Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No | Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No |
| Cancer <input type="radio"/> Yes <input type="radio"/> No | Glaucoma <input type="radio"/> Yes <input type="radio"/> No | Lung Disease <input type="radio"/> Yes <input type="radio"/> No | Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No |
| Chemotherapy <input type="radio"/> Yes <input type="radio"/> No | Hay Fever <input type="radio"/> Yes <input type="radio"/> No | Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No | Tonsillitis <input type="radio"/> Yes <input type="radio"/> No |
| Chest Pains <input type="radio"/> Yes <input type="radio"/> No | Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No | Osteoporosis <input type="radio"/> Yes <input type="radio"/> No | Tuberculosis <input type="radio"/> Yes <input type="radio"/> No |
| Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No | Heart Murmur <input type="radio"/> Yes <input type="radio"/> No | Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No | Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No |
| Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No | Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No | Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No | Ulcers <input type="radio"/> Yes <input type="radio"/> No |
| Convulsions <input type="radio"/> Yes <input type="radio"/> No | Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No | Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No | Venereal Disease <input type="radio"/> Yes <input type="radio"/> No |
| | | | Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No |

Have you ever had any serious illness not listed above? Yes No _____

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 the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____



Office Policy

Dear Patients,

Thank you for choosing Sunrise Dental as your family dental provider. We look forward to providing you high quality dental care at an affordable price.

When scheduling your appointments, we are making a commitment to you. Please remember that we have reserved a special time for you. If you find a need to reschedule your appointment, we ask for a minimum of 48 hours notice. Failed appointments and canceled appointments without 48 hour notice are subject to a \$25.00 fee.

NO CHECKS accepted for 1st time visits.

Checks returned for insufficient funds are subject to a \$35.00 fee. This fee is enforced to cover our bank charges. Please let us know if special arrangements must be made.

Patient portion is due at time of service. Please bring your co-payment with you. You will be asked to leave up to a \$100 deposit if we are unable to verify coverage with your dental insurance at time of your visit.

We bill your insurance as a courtesy to you. If any amounts are denied or not covered, the balance owing is your responsibility. Your estimated patient portion for services is based upon the information provided by your insurance company, and is expected on the day treatment is rendered. Please ask for an estimate, if one has not already been given to you.

Thank you again for your understanding and care with helping to keep our facilities safe and clean and helping us to provide you with the best possible dental care.

Patient Signature: _____ Date: _____

Print Name: _____