**Patient Information: (confidential)**

First Name**:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI: \_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apt:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Reason for Today’s Visit:**

General Visit Emergency Whitening Botox Invisalign Other

Last Visit to the Dentist (Date): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Office/Dentist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any Negative Dental Experience? (Optional) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have Dental Insurance?**

Yes No

**Dental Insurance Information:**

Self Other

Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Secondary Insurance (if any):** Self Other

Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**For the following questions, please circle yes or no, whichever applies.**

**No Yes Are you in good health?**

**No Yes Are you currently under the care of a physician?**

 **Physician’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**No Yes Have you had any serious Illness, operation or been hospitalized?**

 **Please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you have or have you had any of the following disease or problems?**

**No Yes Rheumatic fever or rheumatic heart disease**

**No Yes Congenital health lesions? Heart murmur?**

**No Yes Artificial bones / Joints**

**No Yes Heart attack/ Stroke / Pacemaker**

**No Yes Kidney problems**

**No Yes Diabetes**

**No Yes Tuberculosis**

**No Yes Thyroid problems**

**No Yes Epilepsy / Seizures/ Fainting spells**

**No Yes Ulcers / Colitis**

**No Yes Asthma / Arthritis**

**No Yes High / Low blood pressure**

**No Yes Experience pain / Discomfort in your joints**

**No Yes Psychiatric problems**

**No Yes Hepatitis**

**No Yes HIV Positive**

**Are you presently taking any medications? If so, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Are you allergic or have reacted adversely to:**

**No Yes Penicillin, Erythromycin, Amoxicillin or other antibiotic**

**No Yes Sulfa drugs**

**No Yes Codeine or other narcotics**

**No Yes Aspirin**

**No Yes Local anesthetics**

**No Yes Other \_\_\_\_\_\_\_\_\_\_\_**

**Women**

**No Yes Are you taking birth control pills?**

**No Yes Are you pregnant? Month#\_\_\_\_\_\_\_**

**No Yes Are you nursing?**

**To the best of my knowledge, the information given today is correct and it is my responsibility to inform this office of any changes in my medical stats. I authorize the dental staff to perform the necessary dental services that I may need. I understand that payment is due in full at time of treatment unless prior arrangements have been approved.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of patient / legal guardian Date**

**Patient’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Financial Policy**

**Thank you for choosing Sahara Dental for your treatment. Our goal is to provide you with the best possible dental care and help you to maintain your teeth for a lifetime. Out office manager will be available to discuss your insurance, financial or care credit needs, if necessary. We accept personal checks, as well as MasterCard and Visa for your convenience.**

**As a matter of courtesy to our patients, we will bill your insurance carrier. We will submit the original insurance claim and follow-up claim if necessary; however, you are responsible for the entire bill. If your insurance carrier does not remit payment within 60 days from the time the claim has been submitted, the balance will due in full from and you should contact your insurance carrier to find out why payment has been has been delayed. If there are any payments made our your insurance carrier in excess of the estimated balance, we will refund the credit amount owed to you, unless you ask us to retain the balance for your immediate dental treatment.**

**A monthly billing fee of 1.5% interest will be charged to your account for any balance due over 60 days. We require a 48 hour notice prior to your appointment if you are unable to keep it. A fee of $50.00 may be charged for broken appointments.**

**The fee listed is applicable if treatment is commenced within 60 days.**

**I completely understand the financial policy as stated above and as such. I agree that the total cost of the treatment is my responsibility.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient or Guardian Signature Date**

**Office Manager Date**

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

**\*You may refuse to sign this acknowledgement**

**(Please print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ has received a copy of the office’s notice of privacy practices.**

**Signature**

**Date**

**For office use only**

**We attempted to obtain written acknowledgment of receipt of our Notice of Privacy but acknowledgment could not be obtained because:**

**\_\_\_\_ Individual refused to sign**

**\_\_\_\_ Communication barriers prohibited obtaining the acknowledgment**

**\_\_\_\_ An emergency situation prevented us from obtaining acknowledgement**

**\_\_\_\_ Other (please specify)**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Reason for today’s visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How did you hear about our office? Select all that apply.**

* **Google**
* **Facebook**
* **Twitter**
* **Instagram**
* **Snapchat**
* **Insurance company**
* **Groupon**
* **Event**
* **Door sign**
* **Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Referred by a friend/family member**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

* **Referred by a doctor/dentist \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**