SUNSET HILLS DENTAL, L L C

www.mysunsethillsdental.com
11810 Gravois Rd | . • ST. LOUIS, MO 63127-1888 (314)842-5000

Welcome to our Practice

The following is for: ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name: _____ **Phone:** _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ _____ _____ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Whom may we thank for referring you to our practice?

_____

In an emergency who should be notified? Please enter Name and Phone number below:

_____

_____

Primary Dental Insurance:

Name of Insured: _____ _____ ___
Last First MI

Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Insurance Authorization:

☐ **By checking this box,**
I authorize my insurance to pay my benefits directly to the dentist for all services rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges, whether or not paid by insurance.

Secondary Dental Insurance

Name of Insured: _____ _____ ___
Last First MI

Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Medical History

- ☐ *Pre-Med - Amox
- ☐ *Pre-Med - Other
- ☐ Allergy - Codeine
- ☐ Allergy - Penicillin
- ☐ Anxiety
- ☐ Asthma
- ☐ Cancer
- ☐ Drug Addiction
- ☐ Fainting
- ☐ Hepatitis
- ☐ HIV
- ☐ Mental Disorders
- ☐ Other
- ☐ Respiratory Problems
- ☐ Stomach Problems
- ☐ Tumors
- ☐ *Pre-Med - Amox
- ☐ ADD/ADHD
- ☐ Allergy - Erythro
- ☐ Allergy - Sulfa
- ☐ Art. Heart Valve
- ☐ Autism
- ☐ Depression
- ☐ Eating Disorder
- ☐ Glaucoma
- ☐ Herpes/HPV
- ☐ Jaundice
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Rheumatic Fever
- ☐ Stroke
- ☐ Ulcers
- ☐ *Pre-Med - Amox
- ☐ Alcoholism
- ☐ Allergy - Hay Fever
- ☐ Allergy-Other
- ☐ Arthritis
- ☐ Autoimmune Disease
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Head Injuries
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Organ Transplant
- ☐ Pregnancy
- ☐ Rheumatism
- ☐ Thyroid disease
- ☐ *Pre-Med - Clind
- ☐ Allergy - Aspirin
- ☐ Allergy - Latex
- ☐ Anemia
- ☐ Artificial Joints
- ☐ Blood Disease
- ☐ Dizziness
- ☐ Excessive Bleeding
- ☐ Heart Disease
- ☐ High cholesterol
- ☐ Liver Disease
- ☐ Osteoporosis
- ☐ Radiation Treatment
- ☐ Sinus Problems
- ☐ Tuberculosis

Indicate which of the following you have had or have at present. By checking the box it will indicate a "Yes" response, leaving blank will indicate a "No" response.

- ☐ Taking a blood thinner or daily aspirin
- ☐ Subject to frequent headaches
- ☐ FEMALE: Taking birth control pills
- ☐ Presently being treated for any other illnesses
- ☐ Current tobacco user or former user
- ☐ FEMALE: Pregnant
- ☐ Taking dietary supplements
- ☐ Tested positive for the MTHFR mutation

If any condition or alerts selected above needs further clarification, please explain below:

_____

_____

List any other conditions, diseases, allergies, or health concerns not listed.

_____

_____

Do you take antibiotic premedication for your dental visits? If yes, please explain.

_____

_____

Name of physician and their phone number:

_____

_____

Most recent physician visit:

_____

_____

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment:

_____

_____

List all medications, supplements, and/or vitamins taken within the last two years:

_____

_____

☐ ***By checking this box, I acknowledge that the above information is correct and I understand it is my responsibility to inform the office of any changes in my health as soon as possible.**

Dental Information

How would you rate the condition of your mouth?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist name and how long you were a patient there:

_____

_____

Date of most recent dental exam: _____

Date of most recent dental x-rays: _____

I routinely see my dentist every:

☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

What is your immediate concern?

_____

_____

Personal History, Check all that apply:

☐ Had an unfavorable dental experience
☐ Had complications from past dental treatment
☐ Had trouble getting numb
☐ Had any reactions to local anesthetic
☐ Had/have braces, orthodontic treatment
☐ Had your bite adjusted
☐ Had any teeth removed
☐ Had/have problems or difficulty with your TMJ
☐ Had/have sleep apnea
☐ Drink multiple sodas, energy drinks, gatorade, tea or coffee with sugar, juices, or other drinks with sugar most days

If any of the checked boxes need further explanation, please describe:

_____

_____

_____

_____

Dentist Signature _____

Consent for Services and Financial Policy

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. 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 the time services are performed unless other arrangements are made. Patients with dental insurance understand that all dental services 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 patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. **However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company**. A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. I understand that any fee estimate for this dental care can only be extended for a period of 3 months from the date of the patient examination. In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and a 25% collection fee or reasonable attorney fees if suit be instituted hereunder. I grant my permission to Sunset Hills Dental, LLC or its assignee, to telephone me to discuss this statement or my treatment.

☐ ***By checking this box, I understand the above information and agree with its contents. The confirmation checkbox is required.**

PRINT NAME _____ SIGNATURE _____ DATE _____

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization. I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form. I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

☐ **By checking this box, I understand the above information and agree with its contents.**

PRINT NAME _____ SIGNATURE _____ DATE _____

Consent for Internet Communications

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

☐ ***I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site.**

PRINT NAME _____ SIGNATURE _____ DATE _____

CONSENT TO SHARE AND DISCUSS PRIVATE HEALTH INFORMATION

We are committed to respecting your healthcare privacy. Many patients elect to share their medical and dental information with a family member, friend, or representative. The purpose of this form is to enable our office to discuss the details of your case with a third party. Please complete the following form if you would like to grant this privilege to another individual. Upon written receipt, you may elect to cancel this authorization at any time.

□ I consent to sharing my medical and dental information with the following people:

Name: _____
Address: _____
_____
Telephone: _____

Name: _____
Address: _____
_____
Telephone: _____

□ Please stop sharing my medical and dental information with the following people:

Name: _____
Address: _____
_____
Telephone: _____

Name: _____
Address: _____
_____
Telephone: _____

I, the undersigned, hereby state that I have read the above, and/or it has been explained to me.

_____ _____
Patient Signature Date

_____ _____
Witness Date

Late and Missed Appointment Policy

At Sunset Hills Dental Group, we put our faith in you to keep your appointment. When we set up an appointment, a specific amount of time is reserved especially for you. Some offices double or even triple book appointments to prevent financial damage when one is missed. However, double booking an appointment does not allow us to give the care and attention needed to provide excellent quality dentistry and for this reason we choose to not do it.

If for any reason you must cancel or change your appointment, it is important that you give our office **at least 24 hour notice** to offer that spot to someone else.

- **Two missed appointments**: If two appointments are missed or canceled without 24 hour notice, a letter will be sent to your home reminding you of our policy.
- **Third missed appointment**: If a third appointment is missed without the required notification our office reserves the right to charge your account $62.00 for the missed appointment.
- **Three or more missed appointments:** If more than three appointments are missed without the proper notification, our office reserves the right to dismiss you as a patient and you will be asked to find another dental provider.

Late arrival: When we reserve time for you, we require all of that time to provide you with the best quality care possible. When you are late it decreases our ability to accomplish this.

I have read the above policy; I understand and agree to abide by the listed terms.

_____ _____

Signature of Financially Responsible Party Date