

# SUNSET HILLS DENTAL, L L C

www.mysunsethillsdental.com

11810 Gravois Rd | . • ST. LOUIS, MO 63127-1888

(314)842-5000

## Welcome to our Practice

Please let us know about your **child's medical** and dental history so we may serve you more effectively and in a manner that helps with the overall health and well-being of your child.

We realize that not all questions will pertain to your child. If you have questions, please ask and we will help to better explain the question.

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: \_\_\_\_\_ Prev. Visit: \_\_\_\_\_ Email Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Best time to call: \_\_\_\_\_  
Home Mobile Work Ext

Address: \_\_\_\_\_  
Address 1 Address 2  
City State Zip Code

Who does the child live with?

☐ Mother ☐ Father ☐ Guardian ☐ Grandparents

Siblings who are or who have been a patient in our office:

Is there anything that you would like to discuss with the Dentist in private, alone, or away from your child? ☐ Yes ☐ No

What is the reason for seeing the dentist today?

☐ First Visit ☐ Check-up ☐ Pain ☐ Other

Whom may we thank for referring you to our practice? Please mark the correct box and name them below.

☐ Another Dental Office ☐ Phonebook ☐ Friend ☐ Driving by ☐ Internet ☐ School  
☐ Work ☐ Other (name below): \_\_\_\_\_

### Guardian Information

Unless information is different, this form need only be completed for one child.

The following is for:

☐ The patients's parent/guardian    ☐ The person responsible for payment    ☐ Both    ☐ neither-not applicable

Last Name \_\_\_\_\_

First Name \_\_\_\_\_

MI \_\_\_\_\_

Preferred Name \_\_\_\_\_

Title: (Mr/Mrs/etc.) \_\_\_\_\_

Birth Date \_\_\_\_\_

Email Address \_\_\_\_\_

Phone: \_\_\_\_\_ Best time to call: \_\_\_\_\_  
Home Mobile Work Ext

Address: \_\_\_\_\_  
Address 1 Address 2  
City State Zip Code

Employer \_\_\_\_\_

### Other Guardian Information

Unless information is different, this form need only be completed for one child.

The following is for:

☐ The patients's parent/guardian    ☐ The person responsible for payment    ☐ Both    ☐ neither-not applicable

Last Name \_\_\_\_\_

First Name \_\_\_\_\_

MI \_\_\_\_\_

Preferred Name \_\_\_\_\_

Title: (Mr/Mrs,etc.) \_\_\_\_\_

Birth Date ☐ Yes ☐ No

Email Address \_\_\_\_\_

Phone: \_\_\_\_\_ Best time to call: \_\_\_\_\_  
Home Mobile Work Ext

Address: \_\_\_\_\_  
Address 1 Address 2  
City State Zip Code

## Dental Benefits Plan

### Primary

Name of Insured: \_\_\_\_\_  
Last First MI

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

Insurance Plan Name: \_\_\_\_\_

Plan phone number \_\_\_\_\_

### Secondary

Name of Insured: \_\_\_\_\_  
Last First MI

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

Insurance Plan Name: \_\_\_\_\_

Plan phone number \_\_\_\_\_

### Child's Medical & Dental History

Within the past year have there been any changes in your child's general health? ☐ Yes ☐ No

What is the approximate date of your child's last medical exam? \_\_\_\_\_

Your child's pediatrician name and phone number:

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Please indicate if your child has experienced any of the following.

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

Currently, or in the past, does/has your child:

- ☐ Take an antibiotic premedication for dental visits
- ☐ Take a blood thinner or daily aspirin
- ☐ Have Sensory issues
- ☐ Test positive for the MTHFR mutation(methylenetetrahydrofolate reductase gene mutation)
- ☐ Have complications with or after dental treatment
- ☐ Been the care of a physician due to a specific condition
- ☐ Been seen by a cardiologist
- ☐ Been admitted to a hospital in the last 5 years due to a surgery or illness
- ☐ Been vaccinated for HPV
- ☐ Take any prescription or non-prescription medications

If any of the previous questions are marked, please explain:

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

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Has your child been to a different dental office in the last 6 months? ☐ Yes ☐ No



What was done at your child's last dental visit, if at a different office?

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How frequently does your child brush their teeth?

☐ 3+ a day    ☐ Twice a day    ☐ Once a day    ☐ Weekly    ☐ Seldom    ☐ By parent    ☐ By child    ☐ Both

How often does your child floss?

☐ Once daily    ☐ Occasionally    ☐ Never    ☐ By parent    ☐ By child

Does your child drink multiple sodas, energy drinks, gatorade, tea with sugar, juices, or other drinks with sugar most days? ☐ Yes ☐ No

Does your child do any of the following?

☐ Lip sucking/biting    ☐ Pacifier    ☐ Nail biting    ☐ Finger/thumb sucking    ☐ Nursing/bottle    ☐ Grinds his teeth  
☐ Snores

#### Consent for Services

☐ \*To the best of my knowledge, all of the preceding information is true and correct. If there is any change in my child's health I will inform the office at my child's next dental appointment.

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my child's health.

I authorize the diagnosis of my child's dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnoses and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize my insurance carrier to submit payment directly to the dentist or dental practice, to be applied to my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance and I will be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on behalf of my children/dependents.

☐ \*I have read the above conditions of treatment and payment and agree to their content.

Relationship to Patient:

☐ Mother    ☐ Father    ☐ Guardian    ☐ Other

Parent/Guardian Signature \_\_\_\_\_

Dentist Signature \_\_\_\_\_

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Response Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

# 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 cost 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.

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Signature of Financially Responsible Party

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Date