Sage Dental Care & Advanced Denture and Implant Solutions

Patient

First Name: _____ Last Name: _____ Middle Initial:_____

Preferred Name: _____ Email: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Sex: ☐Male ☐Female Marital Status: ☐Married ☐Single ☐Separated ☐Divorced ☐Widowed

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

Patient is: ☐Policy Holder ☐Responsible Party

Emergency Contact Name: _____ Phone Number: _____

Relationship: _____

Primary Insurance Policy Holder

First Name: _____ Last Name: _____ Middle Initial:_____

Insurance Company: _____

Employer: _____

Birth Date: _____ Soc Sec: _____ Member ID: _____

Relationship to Insured: ☐Self ☐Spouse ☐Child ☐Other

Secondary Insurance Policy Holder

First Name: _____ Last Name: _____ Middle Initial:_____

Insurance Company: _____

Employer: _____

Birth Date: _____ Soc Sec: _____ Member ID: _____

Relationship to Insured: ☐Self ☐Spouse ☐Child ☐Other

How Did You Hear About US, Referred By: _____

Previous Dentist: _____

DENTAL HISTORY

Name _____ Nickname _____ Age _____
Referred by _____ How would you rate the condition of your mouth? ☐Excellent ☐Good ☐Fair ☐Poor
Previous Dentist _____ How long have you been a patient? _____ Months/Years
Date of most recent dental exam _____ /_____ /_____ Date of most recent x-rays _____ /_____ / _____
Date of most recent treatment (other than a cleaning) _____ / _____ / _____
I routinely see my dentist every: ☐3 mo. ☐4 mo. ☐6 mo. ☐12 mo. ☐Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:	**YES**	**NO**

PERSONAL HISTORY

1.	Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____] _____	☐	☐
2.	Have you had an unfavorable dental experience? _____	☐	☐
3.	Have you ever had complications from past dental treatment? _____	☐	☐
4.	Have you ever had trouble getting numb or had any reactions to local anesthetic? _____	☐	☐
5.	Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age? _____	☐	☐
6.	Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma? _____	☐	☐

GUM AND BONE

7.	Do your gums bleed or are they painful when brushing or flossing? _____	☐	☐
8.	Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____	☐	☐
9.	Have you ever noticed an unpleasant taste or odor in your mouth? _____	☐	☐
10.	Is there anyone with a history of periodontal disease in your family? _____	☐	☐
11.	Have you ever experienced gum recession? _____	☐	☐
12.	Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____	☐	☐
13.	Have you experienced a burning or painful sensation in your mouth not related to your teeth? _____	☐	☐

TOOTH STRUCTURE

14.	Have you had any cavities within the past 3 years? _____	☐	☐
15.	Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____	☐	☐
16.	Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____	☐	☐
17.	Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth? _____	☐	☐
18.	Do you have grooves or notches on your teeth near the gum line? _____	☐	☐
19.	Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____	☐	☐
20.	Do you frequently get food caught between any teeth? _____	☐	☐

BITE AND JAW JOINT

21.	Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____	☐	☐
22.	Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together? _____	☐	☐
23.	Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? _____	☐	☐
24.	In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed? _____	☐	☐
25.	Are your teeth becoming more crooked, crowded, or overlapped? _____	☐	☐
26.	Are your teeth developing spaces or becoming more loose? _____	☐	☐
27.	Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together? __	☐	☐
28.	Do you place your tongue between your teeth or close your teeth against your tongue? _____	☐	☐
29.	Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____	☐	☐
30.	Do you clench or grind your teeth together in the daytime or make them sore? _____	☐	☐
31.	Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth? ___	☐	☐
32.	Do you wear or have you ever worn a bite appliance? _____	☐	☐

SMILE CHARACTERISTICS

33.	Is there anything about the appearance of your teeth that you would like to change (shape, color, size)? _____	☐	☐
34.	Have you ever whitened (bleached) your teeth? _____	☐	☐
35.	Have you felt uncomfortable or self conscious about the appearance of your teeth? _____	☐	☐
36.	Have you been disappointed with the appearance of previous dental work? _____	☐	☐

Patient's Signature _____ Date _____
Doctor's Signature _____ Date _____

Medical History(Copy)(Copy)

Patient Name: Birth Date: Date Created:

Health problems and medications may have an important interrelationship with the dentistry you will receive. Please answer the following questions:

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other?	☐	If yes
Do you use controlled substances?	◯ Yes ◯ No	If yes

Do you have, or have you had, any of the following?

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

Have you ever had any serious illness not listed	◯ Yes ◯ No	If yes

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:

X

Date:_____

Sage Dental Care & Advanced Denture and Implant Solutions

General Informed Consent

_____ **Medical History Information**

Initial It is important that you inform us of any medical conditions and medication that you are taking each time that you come to an appointment as some medications can cause harmful reactions with dental anesthetics, analgesics, antibiotics or other medications. Please be sure to provide us with a list of any drug allergies you have.

_____ **Exam, X-ray's, and Photos**

Initial I understand I will be receiving an examination of my mouth and jaw and that in order to complete a thorough exam, radiographs are required. I understand the purpose of diagnostic x-rays are to provide the dentist with valuable information about my teeth and supporting bone that cannot be evaluated otherwise. Treatment will not be rendered without proper diagnostic radiographs. I understand that clinical photographs maybe taken. The purpose of these photos is to better communicate your case to parties involved and I give Sage Dental Care & Advanced Denture and Implant Solutions authorization to use these photos as necessary.

_____ **Changes in Treatment Plan**

Initial I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. For example, root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary after consultation. These charges may affect amount due for services rendered.

_____ **Local Anesthesia**

Initial I understand that although local anesthesia is extremely safe, some rare or more serious complications may occur secondary to the administration of local anesthesia. I understand that administering local anesthesia can lead to pain, infection, bleeding, or discomfort at the site of infection. Other complications include anaphylaxis (extreme allergic reaction), rapid or irregular heartbeat, jaw muscle pain, jaw joint pain, temporary numbness, and in rare circumstances, permanent numbness.

_____ **Narcotic Pain Medication**

Initial Due to recent changes with FDA and DEA regulations and the increase in prescription drug abuse, narcotic pain medications are reserved for pain management following invasive procedures only. No narcotic pain medication will be prescribed prior to invasive procedures or following procedures that do not justify pain management with narcotic pain medications. Refills may not be given following completion of prescribed amount, continued pain management will require management by pain management specialist.

_____ **Treatment Room**

Initial Due to safety and privacy issues associated with providing dental care, we only allow the patient to be in the room during exams, cleanings and all other dental procedures. Family members must remain in the waiting room and children must be supervised by an adult at all times.

Patient's Name: _____

Signature/Guardian: _____ Date:_____

OFFICE POLICY

Thank you for choosing Sage Dental Care & Advanced Denture and Implant Solutions as your provider for all of your dental care needs. We are committed to providing you with the highest quality dental care using the latest technology and the best materials available in dentistry today. We are also committed to providing you with up-to-date information and educational tools so that you may maintain healthy, beautiful smiles. These financial guidelines are intended to facilitate excellent service for yourself and all of our patients.

INSURANCE AND PAYMENT POLICIES:

For patients with dental insurance:

Please understand your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. Not all services are a covered benefit in all contracts and some insurance companies will arbitrarily select certain services they will not cover. Your insurance coverage does not always reflect the level of medical care you need. As a courtesy we will be submitting your information to your insurance company to assist you in filing your claim; however, any and all account balances are ultimately your responsibility. Your deductibles and your estimated portions are to be paid at the time services are rendered.

FEES FOR SERVICE ARE DUE AT THE TIME OF SERVICE. For treatment involving fees above $500.00 special financial arrangements may be discussed with our office administrator. Please note, for your convenience, we accept credit cards, debit cards, cash, money orders and Care Credit. At this time we **do not** accept personal checks.

We will be fair in making special financial arrangements with you, in return we ask you to be fair with your commitment to us. Any overdue balances may be charged a billing fee at a minimum of $25 on a monthly basis.

Please note, it is also your responsibility to update us on any changes in address, contact phone number and insurance carrier to better serve your needs.

CANCELLATION POLICY

Your appointment time is set aside especially for you. We ask that you honor your appointment time as a courtesy to the office staff and to other patients. If you must change or cannot make it to your appointment we require a 24 hour cancellation notice. We understand that emergency situations can arise that can lead to last minute cancellations, however, last minute rescheduling, cancellations or broken appointments may lead to a **$75 broken appointment fee**. If more than one family member is scheduled and fail to make their appointment, each individual family member will be responsible for the $75 broken appointment fee.

Appointment confirmation are done by text message, phone call and email. We ask that you respond as soon as possible to confirm your appointment. Failure to do so may result in your appointment needing to be rescheduled. Unconfirmed appointments are still your responsibility, broken appointment fees apply.

Signature: _____ Date: _____

USE OF PROTECTED HEALTH INFORMATION

Sage Dental Care
&
Advanced Denture and Implant Solutions

I understand that Sage Dental Care & Advanced Denture and Implant Solutions may use and/or disclose my protected health information for the following reasons:

1. For Medical/Dental Insurance Billing

2. Collaboration with Medical/Dental Specialist for my Direct Care.

Additionally, I give the authorization of Sage Dental Care & Advanced Denture and Implant Solutions to discuss my protected health information with the following:

☐ Any Family Member ☐ Other _____

Know Your Rights: I understand that, this Authorization permits Sage Dental Care & Advanced Denture and Implant Solutions to release, use or disclose my protected health information for the purpose of billing, treatment, or healthcare operations as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its corresponding regulations. I further understand that I may revoke this Authorization at any time by providing written notification. Revocation of this Authorization will be effective on the date notice is received and except to the extent that action has already been taken in reliance upon this Authorization.

When your protected health information is released as provided by this Authorization, please be aware that the named recipient (above) may not be legally obligated (under HIPAA) to obtain an authorization for subsequent re-disclosure of your protected health information.

I have read the contents of this Authorization and I am allowing Sage Dental Care & Advanced Denture and Implant Solutions to disclose my information as outlined above.

Patient Signature: _____ Date: _____

Representative Signature:_____ Date: _____

Declination:

I understand that I am declining release of medical/dental records form Sage Dental Care & Advanced Denture and Implant Solutions. I also understand that Sage Dental Care & Advanced Denture and Implant Solutions will not be able to discuss any aspect of my care with anyone regardless of the circumstance. I will be responsible for full payment of any service provided and any insurance billing will be done by myself. I will also be responsible for any transfer of information to specialist for my dental care.

Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

Sage Dental Care

I acknowledge that a copy of Sage Dental Care & Advanced Denture and Implant Solutions' HIPAA Notice of Privacy Practices is available to me by request at our office. I understand that the policy may change periodically and I am entitled to a copy by request. Refusal of acknowledgement does not alter the HIPAA policy followed. Any questions may be directed to us at:

1080 North Hills BLVD #150
Reno NV 89506
(775) 677-0790

7520 Longley Lane #150
Reno NV 89511
(775) 409-4282

Signature: _____ Date: _____

OFFICE USE ONLY

Sage Dental Care & Advanced Denture and Implant Solutions has made every effort to obtain acknowledgement of receipt of the HIPAA Notice of Privacy Practices; however, we were not able to obtain acknowledgement for the following reasons:

- ☐ Refusal to Sign
- ☐ Communication Barrier
- ☐ Emergency Situation

Signature: _____ Date: _____