

Dental History

What is the main reason(s) for your visit today? _____

Is there anything about your dental history that you would like us to know? If yes, please describe: _____

Have you ever had an upsetting dental experience? If yes, please explain _____

Date of last dental visit _____ Have you ever been seen by Dr. Sato at a different practice? Yes No

Have you ever been told that you need a pre-medication (generally an antibiotic) before dental treatment? Yes No

Previous Dentist's Name _____ Telephone Number _____

Address _____

How often do you brush your teeth? _____ How often do you floss? _____

Do You:

Clench or grind your teeth? Yes / No
Have tired jaws, especially in the morning? Yes / No
Have pain, popping or clicking in your jaw? Yes / No
Have sore muscles in your neck and shoulders? Yes / No

Have you ever:

Had a dentist recommend a mouth guard? Yes / No
Had Orthodontic treatment (braces, etc.)? Yes / No
Had oral surgery? Yes / No
Had periodontal (gum) treatment? Yes / No
Had a serious injury to the mouth or head? Yes / No

Do you have:

Sensitivity to hot or cold? Yes / No
Sensitivity to sweet foods? Yes / No
Pain when biting/chewing? Yes / No
Bad breath or bad tastes? Yes / No
Bleeding gums? Yes / No

Are you:

Overall happy with your smile? Yes / No
Pleased with the color of your teeth? Yes / No
Wanting to keep all of your teeth your whole life? Yes / No
Nervous about dental treatment? Yes / No

Billing Information

Person Financially Responsible for the Account: Patient Other (if "Other" please complete below)

Guarantor's Name: _____ Relation to patient: _____

Guarantor's Date of Birth: _____ Social Security # _____ - _____ - _____

Billing Address: _____

Guarantor's Phone Number: _____

Dental Insurance

Insurance Company: _____ Phone Number: _____

Insurance Company Address: _____

Group Number: _____ ID Number: _____

Who is the Subscriber of the policy: Patient Guarantor (listed above) Other (If "Other" please complete below)

Subscriber's Name: _____

Subscriber's Date of Birth: _____ Social Security # _____ - _____ - _____

Subscriber's Address: _____

Subscriber's Phone Number: _____ Subscriber's Employer: _____

Is there a secondary dental insurance? Yes No (If yes, please present the secondary card to our office staff)

Authorization and Release

The above information is accurate and complete to the best of my knowledge and is only for use in treatment, billing, and processing of insurance for benefits for which I am entitled. I authorize the dentist to release any information, including the diagnosis and the records of any treatment or examination rendered to me, or my child during the period of such dental care, to third party payers and/or other health practitioners. I authorize my insurance company to pay directly to the dental office the benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for my services. I agree to be responsible for payment of all services rendered, including services rendered on behalf of my dependents.

Signature of Patient (or Parent of Minor) _____ Date _____

Financial Agreement and Assignment of Benefits

I understand that services rendered to me by Steve A. Sato DDS, Inc. are my financial responsibility and that the Provider will bill my insurance company as a courtesy. I authorize my insurance company to pay my benefits directly to Steve A. Sato DDS, Inc. and I understand that I will be fully responsible for any outstanding balance on my account.

I also understand that should my insurance company send payment to me, I will forward the payment to Steve A. Sato DDS, Inc. within two business days. I agree that if I fail to send the payment to the Provider and they are forced to proceed with the collections process, I will be responsible for any cost incurred by the office to retrieve their monies.

Signature of Patient (or Patient/Guardian)

Acknowledgement of Receipt of Notice of Privacy Practices

(Note: You may refuse to sign this acknowledgement)

I hereby acknowledge that I have been offered a copy of the written "Notice of Privacy Practices" to read in the office that Steve A. Sato DDS, Inc. follows. I understand I am also entitled to a printed copy for my records if I so desire.

Signature of Patient (or Patient/Guardian)

For use by Steve A. Sato DDS, Inc. personnel if unable to obtain a written acknowledgement of receipt of the NOPP from the patient: I have made a good faith effort to obtain a written acknowledgement of receipt of the Notice of Privacy Practices from the named patient, but was unable to for the following reason:

- *Language Barrier*
- *Patient Cannot Read*
- *Unable to Sign*
- *Read Later and Return*
- *Patient Objects*
- *Other* _____

Employee Name

Date

Consent to Obtain Medication History

Our dental practice has adopted an electronic medical record system called “DoseSpot” in order to improve the quality of our services. This system also allows us to collect and review your “medication history.” A medication history is a list of prescription medicines that we or other doctors have recently prescribed for you in the **last 2 years**. This list is collected from a variety of sources, including your pharmacy and your health insurer.

****An accurate medication history is very important to helping us treat you properly and in avoiding potentially dangerous drug interactions.****

By signing this consent form you give us permission to collect and give your pharmacy and your health plan permission to disclose information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health conditions, such as depression. This information will become part of your medical record.

This medication history is a useful guide, but it may not be completely accurate. Some pharmacies do not make drug history available to us, and the drug history from your health plan might not include drugs that you purchased without using your health insurance. Your medication history might not include over the counter medicines, supplements or discuss everything you are taking, and for you to point out to us any errors in your medication history.

I give permission for STEVE A. SATO DDS, INC. to obtain my medication history from my pharmacy, my health plans and my other healthcare providers.

Signature of Patient (or Patient/Guardian)

I DO NOT consent to have my medication history obtained.

Overpayment / Credit Policy

Patients can use credits towards any service for themselves or credits can be transferred to anyone they choose in the practice. Refunds for credits will be issued upon request if a patient is not in active treatment and the responsible party does not have a balance on any other contractor services with our office.

Since we advocate lifetime retention, we will keep a credit on the books for a maximum of two years after treatment to be used towards any other treatment required. Credits remaining after two years from service date will be refunded by the end of the year. Credits present that are not the result of actual cash payment (vouchers, coupons, etc.) can only be used towards payment of services rendered and will not be refunded. There is no cash value for these as no actual money was actually received and there is no monetary value outside of the practice.

Signature of Patient (or Patient/Guardian)