SAWTOOTH DENTAL, PLLC

Eric Thomas, DDS ● Stephen Dixon, DDS ● Brent Sorenson, DDS

Welcome to our practice!

Thank you for giving us the opportunity to serve your dental needs.

PATIENT INFORMATION

Date ________________________ Home Phone (_____) ____________________ Cell Phone (_____) ______________________

May Sawtooth Dental, PLLC remind you of your appointment via TEXT MESSAGE and E-MAIL ? ☐ YES ☐ NO

Name ____ Preferred Name _________________________
LAST First Middle Initial

Address ____ Social Security Number _____________________

City ____ E-MAIL ____

State ______________________ Zip ______________________ ☐ Married ☐ Widowed ☐ Single ☐ Minor

Sex ☐ Male ☐ Female Age _________ Birth date: _______________ ☐ Separated ☐ Divorced

Patient Employer ____ Spouse Name ___________________________________

Patient Employer Phone _______________________________________ Spouse Employer _________________________________

Spouse Employer Phone (_____) ____________________

Whom may we thank for referring you? ____

Emergency Contact ____ Phone (_____) ______________________________________

RESPONSIBLE PARTY & PRIMARY INSURANCE

Person Responsible for the Account ____
LAST First Middle Initial

Relation to Patient _________________________ Birth date _______________________ Social Security # ____________________

Address (if different from patients) ____ Phone Number _____________________

City ______________________________ State _______________ Zip ______________Cell Number (_____) _________________

Policyholder Employed by ____ Business Phone Number (_____) _______________

Policyholder Name: _______________________________ Birth date _______________Social Security # ______________________

Insurance Company _____________________________________Group # ____________ Subscriber # _______________________

Names of other dependents covered under this plan ____

____

ADDITIONAL INSURANCE

Is Patient covered by additional insurance? ☐ Yes ☐ No

Policyholder Name ____ Birthdate _____________ Relation to Patient _______________

Address (if different from patients) ____ Phone # (___) ____________________

City ____ State __________________________ Zip __________________________

Policyholder Employed by ____ Business Phone Number (_____) _________________

Insurance Company ____

Social Security Number ________________________ Group # ______________________ Subscriber # _______________________

Names of other dependents covered under this plan ____

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MEDICAL HISTORY

Physician's Name ______________________ Date of Last Visit ______________

Are you under a physician's care now? ☐ Yes ☐ No ______________________

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No ______________________

Are you required by your Physician to have antibiotics prior to dental treatment ? ☐ Yes ☐ No

Have you ever had a serious head or neck injury? ☐ Yes ☐ No ______________________

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ Yes ☐ No

____

Are you taking any medications, pills or drugs? ☐ Yes ☐ No ______________________

____

____

Do you use Tobacco? ☐ Yes ☐ No Do you use controlled substances? ☐ Yes ☐ No

Are you Pregnant/Trying to get pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No Are you taking Oral Contraceptives? ☐ Yes ☐ No

Are you allergic to any of the following? ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex

☐ Other – please explain ______________________________________

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

Condition		Condition		Condition		Condition	
AIDS/HIV	☐ Yes ☐ No	Cortisone Medicine	☐ Yes ☐ No	Hemophelia	☐ 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	Tonsilitis	☐ 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

Are you interested in any cosmetic procedures? ☐ Whitening ☐ Veneers ☐ Clear Braces

Have you ever had any serious illness not listed? ☐ Yes ☐ No If yes: ______________________

Comments: ______________________________________

____

Date of last dental exam? ______________ Primary Purpose for Today's visit? ______________________

____

What dental aids do you use? ☐ Floss ☐ Water Pik ☐Mouth Rise ☐ Electric Toothbrush

SAWTOOTH DENTAL

AUTHORIZATION & RELEASE

I understand and acknowledge that all questions have been accurately answered and that providing incorrect information can be dangerous to my health.

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered, to my child or me during the period of such dental care and/or healthcare practitioners.

I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

I acknowledge that payment is due at the time of treatment unless other arrangements have been made. I understand that I will be assessed a 22% annual finance charge on any balance over 40 days.

I acknowledge that if I do not give 24 hours notice of a cancellation I will be charged a $25 no show fee.

I acknowledge that if I have a check returned for non-sufficient funds that I would be charged $25 for that returned check.

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SIGNATURE OF PATIENT, GUARDIAN OR PERSONAL REPRESENTATIVE DATE

PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement*

I, ____________________________________, have received a copy of this office's Notice of Privacy Practices.

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SIGNATURE OF PATIENT, GUARDIAN OR PERSONAL REPRESENTATIVE DATE

FINANCIAL AGREEMENT

We the undersigned, individually and as agent for the patient, understand and agree, jointly and severally, to the following:

1. That if this account is sent to collections, we agree that in addition to any amount left owing to Sawtooth Dental, PLLC we will be responsible for interest at a rate of 22% annually on any past due balance, calculated from the date of service, plus court costs and reasonable attorneys' fees, with or without suit, incurred in collecting any past due balance, and a collection fee if my account is assigned to a collection agency.
2. That we specifically authorize Sawtooth Dental, PLLC or any assignee thereof, to access our credit file should this account become delinquent. We recognize that insurance is a contract between the patient and insurance company, and agree to pay all charges under this agreement regardless of any insurance coverage. This agreement shall apply to any unpaid services owed to Sawtooth Dental, PLLC in writing that is to be revoked. We have either received or refused a copy of this agreement. We agree that no oral agreements have been made and that this agreement cannot be modified orally.
3. That we acknowledge that Sawtooth Dental, PLLC, including its attorneys and assigns, may have a legitimate business purpose in calling me to discuss this account and we expressly consent that we may be contacted at any telephone number, by a live caller, and that we will bear the cost of any charges associated with such a call. .
4. That we have read this agreement and understand its terms. A copy or fax of this document shall have the same legal effect as the original.

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SIGNATURE OF PATIENT, GUARDIAN OR PERSONAL REPRESENTATIVE DATE YOUR RELATIONSHIP TO PATIENT