SAPON & SWISHER
DENTAL

Patient Information

Name: _____ Preferred Name: _____

Title: Dr. Mr. Mrs. Ms.

Gender Identity: Male Female Other Preferred Pronouns: _____

Date of Birth: _____ Social Security Number: _____

Street Address: _____ Apt #: _____

City, State, Zip: _____

Relationship Status: Single Married Widowed Spouse's Name: _____

Employer: _____ Email: _____

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

Preferred Contact Method: Text Message Email Phone - (Cell Home Work)

Emergency Contact: _____ Contact Phone: _____

New Patients – Whom may we thank for referring you to our practice? _____

Dental Insurance Information

Employee/Subscriber Name: _____ Subscriber ID #: _____

Self Spouse Child Other: _____ Date of Birth: _____

Group/Employer Name: _____ Group Number: _____

Insurance Company Name: _____ Phone: _____

Claims Mailing Address: _____

Is patient covered by additional insurance? Yes No

I authorize release of any information concerning my/my child's healthcare recommendations and treatment for the purpose of evaluation and administering claims for insurance benefits.

I authorize payment of insurance directly to Sapon & Swisher Dental.

I understand my dental benefits may be less than the fees for dental services and insurance may not pay the fee charged in full.

I understand I am responsible for and agree to pay the total fees for my/my child's dental treatment.

I agree to pay applicable deductibles and estimated co-payments on the date the dental services are rendered. I understand not all dental treatment may be covered by my insurance plan and I agree to pay for any non-covered services on the date dental services are rendered.

I agree to pay the total cost of dental services rendered on the date of service if I/my child do not have dental insurance benefits.

I have read and understand all the information on this form.

Patient/Guardian Signature: _____ Date: _____

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Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering 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 (including vitamins or supplements)?

○ Yes ○ No If yes _____

_____

Have you ever taken Fosamax, Boniva, Prolia or any other medications containing bisphosponates?

○ Yes ○ No If yes _____

Are you on a special diet?

○ Yes ○ No If yes _____

Do you use tobacco? (Which type, how often?)

○ Yes ○ No If yes _____

Do you use controlled substances?

○ Yes ○ No If yes _____

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: _____

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Do you have, or have you had, any of the following? **If YES, please describe in COMMENTS below.**

Abnormal Bleeding ○ Yes ○ No	Congenital Heart Disorder ○ Yes ○ No	Hemophilia ○ Yes ○ No	Recent Weight Loss ○ Yes ○ No
Acid Reflux/GERD ○ Yes ○ No	Congestive Heart Failure ○ Yes ○ No	Hepatitis A ○ Yes ○ No	Renal Dialysis ○ Yes ○ No
AIDS/HIV Positive ○ Yes ○ No	Cortisone Medicine ○ Yes ○ No	Hepatitis B ○ Yes ○ No	Rheumatic or Scarlet Fever ○ Yes ○ No
Alzheimer's Disease ○ Yes ○ No	Dementia ○ Yes ○ No	Hepatitis C ○ Yes ○ No	Rheumatism ○ Yes ○ No
Anaphylaxis ○ Yes ○ No	Diabetes ○ Yes ○ No	Herpes ○ Yes ○ No	Seasonal Allergies ○ Yes ○ No
Anemia ○ Yes ○ No	Drug Addiction ○ Yes ○ No	High Blood Pressure ○ Yes ○ No	Shingles ○ Yes ○ No
Angina/Chest Pain ○ Yes ○ No	Dry Mouth ○ Yes ○ No	High Cholesterol ○ Yes ○ No	Sinus Trouble ○ Yes ○ No
Arthritis ○ Yes ○ No	Eating Disorder ○ Yes ○ No	Hives or Rash ○ Yes ○ No	Sleep Apnea ○ Yes ○ No
Artificial Heart Valve ○ Yes ○ No	Emphysema ○ Yes ○ No	Hypoglycemia ○ Yes ○ No	Stroke ○ Yes ○ No
Artificial Joint ○ Yes ○ No	Epilepsy/Seizures ○ Yes ○ No	Kidney Problems ○ Yes ○ No	Thyroid Disease ○ Yes ○ No
Asthma ○ Yes ○ No	Fainting Spells/Dizziness ○ Yes ○ No	Liver Disease ○ Yes ○ No	Tonsilitis ○ Yes ○ No
Autoimmune Disease ○ Yes ○ No	Frequent Headaches ○ Yes ○ No	Low Blood Pressure ○ Yes ○ No	Tuberculosis ○ Yes ○ No
Blood Disease ○ Yes ○ No	Glaucoma ○ Yes ○ No	Mental Health Condition ○ Yes ○ No	Tumors/Growths ○ Yes ○ No
Blood Transfusion ○ Yes ○ No	Hearing Impaired ○ Yes ○ No	Mitral Valve Prolapse ○ Yes ○ No	Ulcers ○ Yes ○ No
Bruise Easily ○ Yes ○ No	Heart Attack/Failure ○ Yes ○ No	Osteoporosis ○ Yes ○ No	Sexually Transmitted Disease ○ Yes ○ No
Cancer ○ Yes ○ No	Heart Murmur ○ Yes ○ No	Pain in Jaw Joints ○ Yes ○ No	Yellow Jaundice ○ Yes ○ No
Chemotherapy ○ Yes ○ No	Heart Pacemaker ○ Yes ○ No	Psychiatric Care ○ Yes ○ No	
Cold Sores ○ Yes ○ No	Heart Trouble/Disease ○ Yes ○ No	Radiation Treatments ○ Yes ○ No	

Have you ever had a serious illness not listed above?

○ 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 that dental office of any changes in medical status.

_____ _____ _____

Patient Name Signature of Patient, Parent or Guardian Date

SAPON & SWISHER
DENTAL

80 Whitewood Rd.
Charlottesville, VA 22901

HIPAA Consent Form

Patient Name: _____

HIPAA – Notice of Privacy Practice

HIPAA is a federal law developed to provide a standard for the protection of your health information. The purpose of the Notice of Privacy Practice is to explain how Sapon & Swisher Dental may use or disclose your health care information. The Notice also explains the rights that you are guaranteed under HIPAA regulations.

Though Sapon & Swisher Dental has always taken great care to protect the integrity and confidentiality of your health care information, we are now required by the HIPAA Privacy Rule to distribute this notice to you and obtain acknowledgement that you have received the Notice.

Signing below indicates that you have received the Notice of Privacy Practice. If you have any questions, please contact our HIPAA Compliance Officer listed:

Mary Yowell, Compliance Officer
434-973-1222
80 Whitewood Rd.
Charlottesville, VA 22901

I hereby acknowledge that I have received a copy of Sapon & Swisher Dental Notice of Privacy Practices.

_____
Initials of Patient/Guardian

Permission to Share Medical Information

My medical information may be obtained and exchanged verbally to: _____

_____
Initials of Patient/Guardian

Permission to Bill Insurance

All professional services rendered are charged to the patient. Necessary forms will be completed by the office of Sapon & Swisher Dental to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage.
I understand my signature authorizes releasing of the information of the insurer or agency given to Sapon & Swisher Dental for participating health insurance plans.

Signature: _____ Date: _____

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Financial Policy Acknowledgment

The following information is to inform you of our financial policy. If, at any time, you have questions regarding this policy, please do not hesitate to ask any member of our business team.

We are committed to providing you with the highest quality of care. Our fees are a reflection of the quality of care we provide. We continue our commitment by accepting a variety of financial options to enable you to receive the dental care you need. We accept cash, check, VISA, MasterCard, and Discover. We have also partnered with a third-party company to offer the flexibility of deferred interest and extended payment options. **Check policy**: if your check is returned for any reason, a $25 fee will be charged.

We will communicate all recommended treatment options and associated fees prior to the start of treatment. Payment is expected at the time of treatment. A delinquent account impedes our ability to provide you with the quality dental care that you deserve. It is our policy that the parent or guardian who accompanies a child to our office for treatment is responsible for payment of all services rendered.

We are committed to respecting your time and ask that you make every effort to keep the appointment time reserved exclusively for you. We understand there may be times when you are unable to keep your scheduled appointment time. However, any appointment missed may be subject to a missed appointment fee of $35. Should you find it necessary to reschedule an appointment, please provide us with a notice of at least 24 hours to avoid being charged the fee.

As a courtesy to our patients with dental insurance benefits, we will submit your claim and provide any necessary information to assist you in receiving your dental benefits.

We require that any applicable deductibles and estimated patient portion be paid at the time treatment is rendered. We do accept assignment of insurance benefits as a form of payment to help reduce your immediate out-of-pocket expense.

Providing us with your insurance provider's information prior to your visit will expedite the processing of claims. If you have a direct reimbursement policy, payment in full is expected on the day of service and your dental plan will reimburse you.

Important Facts about your Dental Insurance

- Dental insurance is a contract between the patient and the insurance company. It is a benefit to assist you with the cost of dental care. At no time should insurance benefits compromise your doctor's diagnosis, treatment recommendations, or affect your choice of treatment.
- It is your responsibility to understand the type of dental insurance you have and the benefits selected by you and/or your employer.
- You, not the insurance company, are responsible for the fees of services rendered.

Patient/Guardian Signature: _____ Date: _____