

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: _____

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 bisphosphonates?

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: _____



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

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

S A P O N & S W I S H E R
D E N T A L

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: _____



DENTAL OFFICE FINANCIAL AGREEMENT
(PLEASE READ CAREFULLY)

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require that you read and sign prior to any treatment.

GENERAL:

We will communicate all recommended treatment options and associated fees prior to the start of your treatment.

INSURANCE:

Dental insurance is a contract between the patient and the insurance company. At no time should insurance benefits compromise your doctor's diagnosis, treatment recommendations or affect your choice of treatment. **Sapon & Swisher Dental is not responsible for knowing the specifics of your dental coverage.** Real time benefits are subject to your eligibility, plan limitations, deductibles, and annual maximums at the time the claim is processed. Extensive and/or ongoing treatment rendered at our office OR provided by another office during your current plan year can affect your available maximum of benefits. You could be responsible up to the provider fee if your treatment is not covered by your insurance. Should you receive a bill from us regarding your visit here, we ask that you contact your insurance company for more details as they would know your policies specific guidelines and limitations.

MISSED APPOINTMENTS:

Unless we receive notice of cancellation 24 hours in advance, you will be charged \$30.00. Please help us service you better by keeping scheduled appointments.

PAYMENT:

Full Payment is due at the time of service.

If insurance benefits apply, estimated patient co-payments and deductibles are due at the time of service. We accept all forms of payment – Apple pay, Cash, check, VISA, MasterCard, Discover, and Care Credit. Check policy: If your check is returned for any reason, a \$25 fee will be charged

DELINQUENT ACCOUNTS:

If your balance is 90 days past due, your account will be turned over to Collections. You will not be reappointed and/or any future appointments scheduled will be cancelled until the balance has been resolved through the Collection Agency.

I have read, understand, and agree to the terms and conditions of this Financial Agreement.

Patient/Guardian Signature:

Date: