SunWest dental

Smile and Oral Health Evaluation

Thank you in advance for taking the time to allow your new dental team the opportunity to get to know you better. Where applicable please rate your responses from 1-10 with 1 being a little and 10 being a lot.

Patient Name _____

1. What did you like about your previous dental experiences?
   Explain: _____
2. What did you not like about your previous dental experience or experiences?
   Explain: _____
3. Is there anything we can do to make your visit more comfortable? ☐Yes ☐No
   Explain: _____
4. Rate how anxious you are about dental treatment. 1 2 3 4 5 6 7 8 9 10
   Tell us more: _____
5. Rate your overall oral health. 1 2 3 4 5 6 7 8 9 10
   Tell us more: _____
6. Would you like optimal oral health care? ☐Yes ☐No
   Tell us more: _____
7. Rate the appearance of your smile. 1 2 3 4 5 6 7 8 9 10
   Tell us more: _____
8. Rate the color of your teeth? 1 2 3 4 5 6 7 8 9 10
   Tell us more: _____
9. Rate your concern with mercury fillings. 1 2 3 4 5 6 7 8 9 10
   Tell us more: _____
10. Rate the straightness of your teeth. 1 2 3 4 5 6 7 8 9 10
    Tell us more: _____
11. Are you concerned with losing or missing teeth? ☐Yes ☐No
    Tell us more: _____
12. Is there anything we can do to enhance your smile and optimize your oral health? ☐Yes ☐No
    Tell us more: _____

PATIENT / GUARDIAN SIGNATURE **PRINTED NAME** **DATE**

DR.'S SIGNATURE DATE

SunWest dental

Patient Information

Patient Name:_____ Preferred Name:_____

Address:_____ City:_____ State:_____ Zip:_____

Cell Phone:_____ Home Phone:_____

Email:_____ ☐Married ☐Single ☐Child

Gender:_____ Age:_____ Date of Birth:_____ Social Security #:_____

Employer:_____ Occupation:_____

Work Address:_____ Work Phone:_____

Emergency Contact:_____ Phone:_____

Parent / Guardian Information (If under the age of 18)

Parent/Guardian Name:_____ Relationship to child:_____

Address:_____ City:_____ State:_____ Zip:_____

Cell Phone:_____ Home Phone:_____

Gender:_____ Age:_____ Date of Birth:_____ Social Security #:_____

Employer:_____ Occupation:_____

Work Address:_____ Work Phone:_____

Insurance Information

Primary Insured (Subscriber):_____ Relationship to Patient:_____

Date of Birth:_____ Subscriber ID#:_____

Subscriber Employer or Plan Sponsor:_____ Group#:_____

Insurance Company:_____

Additional Insurance

Primary Insured (Subscriber):_____ Relationship to Patient:_____

Date of Birth:_____ Subscriber ID#:_____

Subscriber Employer or Plan Sponsor:_____ Group#:_____

Insurance Company:_____

Authorization and Release

I authorize my insurance company to pay Sunwest Dental all insurance benefits otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges not paid by insurance.** Sunwest Dental may use my health care information and may disclose such information to my insurance company (ies) and their agents for the purpose of obtaining payment for the services and determining insurance benefits payable for related services, as pertaining to the HIPAA guidelines.

_____

Patient/Parent or Guardian Signature **Printed Name** **Date**

Dental History

Reason for today's visit: _____

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

Approx date of last dental visit: _____

Please mark all that apply:

- ☐ TOOTHACHE
- ☐ LOOSE, CHIPPED, CRACKED OR BROKEN FILLINGS
- ☐ LOOSE, CHIPPED, CRACKED OR BROKEN TEETH
- ☐ FOOD CATCHES
- ☐ FLOSSING BREAKS OR HURTS
- ☐ PAIN, CLICKING OR POPPING OF JAW
- ☐ GRINDING OF TEETH
- ☐ CLENCHING OF JAW
- ☐ HEAD ACHES
- ☐ SNORING / SLEEP APNEA
- ☐ SENSITIVITY
  - ☐ COLD
  - ☐ HOT
  - ☐ SWEET
  - ☐ CHEWING
  - ☐ TOUCH
- ☐ SINUS PROBLEM
- ☐ GAGGING
- ☐ DRY MOUTH
- ☐ DARK OR WHITE SPOTS ON TEETH
- ☐ GUMS
  - ☐ BLEEDING
  - ☐ TENDER OR SORE
- ☐ LOOSE TEETH
- ☐ TEETH HAVE SHIFTED
- ☐ BAD BREATH
- ☐ BAD TASTE IN MOUTH
- ☐ SORES OR GROWTHS IN MOUTH
- ☐ OTHER _____

Medical History

Please mark all that apply:

Have you been: ☐ Hospitalized? ☐ Are You Taking Medication? ☐ Do You Have Allergies?

Please describe: _____

_____

YES	NO		YES	NO		YES	NO	
☐	☐	*PRE-MED - AMOX	☐	☐	BLOOD TRANSFUSION	☐	☐	MENTAL DISORDERS
☐	☐	*PRE-MED-CLIND	☐	☐	CANCER_____	☐	☐	MITRAL VALVE PROLAP
☐	☐	*PRE-MED-OTHER_____	☐	☐	CHEMICAL / DRUG DEPENDENCIES	☐	☐	NERVOUS DISORDERS
☐	☐	ALLERGY - ASPIRIN	☐	☐	CHEMO THERAPY	☐	☐	NURSING
☐	☐	ALLERGY - CODEINE	☐	☐	CIRCULATORY PROBLEMS	☐	☐	PACEMAKER
☐	☐	ALLERGY - ERYTHRO	☐	☐	CORTISONE TREATMENT	☐	☐	PERSISTENT COUGH
☐	☐	ALLERGY - HAY FEVER	☐	☐	DIABETES	☐	☐	PREGNANT
☐	☐	ALLERGY - LATEX	☐	☐	DIZZINESS	☐	☐	RADIATION TREATMENT
☐	☐	ALLERGY - PENICILLIN	☐	☐	EPILEPSY	☐	☐	RESPIRATORY PROBLEMS
☐	☐	ALLERGY - SULFA	☐	☐	FAINTING	☐	☐	RHEUMATIC FEVER
☐	☐	ALLERGY - OTHER_____	☐	☐	GLAUCOMA	☐	☐	SCARLET FEVER
☐	☐	ANEMIA	☐	☐	HEAD INJURIES	☐	☐	SHORTNESS OF BREATH
☐	☐	ARTHRITIS	☐	☐	HEART DISEASE	☐	☐	STROKE
☐	☐	ARTIFICIAL HEART VALVE	☐	☐	HEART MURMUR	☐	☐	SWELLING FEET / ANKLE
☐	☐	ARTIFICIAL JOINTS	☐	☐	HEART PROBLEMS	☐	☐	TAKING BIRTH CONTROL
☐	☐	ASTHMA	☐	☐	HEMOPHILIA	☐	☐	THYROID CONDITION
☐	☐	BACK PROBLEMS	☐	☐	HEPATITIS	☐	☐	TOBACCO USAGE
☐	☐	BIPHOSPHATE MEDS (FosaMax, Acetol, Atelviz, Didronel, Boniva)	☐	☐	HIGH BLOOD PRESSURE	☐	☐	TONSILLITIS
			☐	☐	JAUNDICE	☐	☐	TUBERCULOSIS
☐	☐	BLEEDING DISORDERS	☐	☐	KIDNEY DISEASE	☐	☐	ULCERS
☐	☐	BLOOD THINNERS	☐	☐	LIVER DISEASE	☐	☐	VENEREAL DISEASE
☐	☐	BLOOD DISEASE	☐	☐	MARIJUANA USAGE	☐	☐	OTHER_____

Physicians Name: _____ Phone: _____

Pharmacy Name: _____ Phone: _____

In Office Use

HEAD & NECK EXAM	WNL or : _____
SOFT TISSUE	WNL or : _____
TMJ EXAM	WNL or : _____
OCCLUSION	CLASS I II II
ORTHO	☐ YES ☐ NO

In Office Notes

To the best of my knowledge the above information is accurate and complete. I will not hold the doctor or any members of their staff responsible for any errors or omissions I may have made in the completion of this form.

PATIENT / GUARDIAN SIGNATURE **PRINTED NAME** **DATE**

DR.'S SIGNATURE DATE

SunWest dental

Sunwest Dental *is committed to providing you with the best dental care available. We have found that a clear understanding of our office financial guidelines relieve some of the anxiety associated with going to the dentist. We want to be certain that our guidelines are clear and that all of your questions are answered to your satisfaction. For your convenience we honor several different payment plans.*

Payment Options:

When you do not have dental insurance, we ask that you pay for your dental services in full at the end of each appointment. We gladly accept Cash, MasterCard, Visa, Discover and American Express. We also offer Healthy Smiles Dental plan for those without insurance as an added value to you.

Dental Insurance:

As a courtesy we will file your insurance claim for you. We will make a good faith estimate for planned treatment and request that you pay your estimated portion at the time of service. When payment has been received from your insurance carrier, we will settle the outstanding balance of your account with you (there may be a difference between the estimated portion and actual payment). As a service to you, we will complete and file the appropriate claim forms with your insurance carrier(s). We are happy to provide any x-rays or additional information they might require.

If your insurer denies coverage or delays payment beyond 60 days from the claim filing date, the entire amount will become due and payable by you. Although we make every effort to help you obtain your full benefit, there are many variables we cannot anticipate nor control. Please be aware that your insurance benefits are a contract between you, your employer (if applicable) and insurance company.

Financial Services:

We offer CareCredit service that allows you to pay over time with convenient monthly payments.
For more information please inquire with the front office staff.

Cancelling Treatment:

We understand that sometimes a patient may find it necessary to cancel treatment that has not started or is not yet complete. If that treatment was paid in advance then you may be entitled to refund up to the full amount. In cases where treatment is in progress your prepayment will be reduced by the amount of work completed. If you only partially prepaid for this treatment, you could still have a balance due.

Refund Policy:

As part of our fraud and abuse controls our office staff do not have the ability to directly issue a refund. They will submit a refund request to our Accounts Payable department on your behalf. In the event of HSA Accounts or third party payors, like CareCredit, refunds must be processed directly back to the originator and you will receive a credit on your account as opposed to a check in the mail. Our process, including internal controls, takes about two weeks to complete.

We Would Also Like You to Know:

- Our office requires a minimum of 2 business days notice (longer if possible) if you are unable to keep your reserved appointment time.
- YOUR APPOINTMENT IS SPECIFICALLY RESERVED FOR YOU. A fee of $50 per hour of missed appointment time will be charged to the patient for any appointment that is canceled without at least two business days' notice.
- There will be a $25.00 charge for unpaid returned checks.

I authorize payment to be made directly to Sunwest Dental by my insurance company and I accept financial responsibility for all services not covered by my insurance. I authorize release of any medical information requested by my insurance carrier. I agree to pay interest of 1.5% (18% annually) on any balance over 30 days. I hereby agree that in the event of default of any amount due, and if this account is placed with a collection agency or attorney for collection or legal action, to pay an additional charge equal to the cost of collection including any attorney fees and court costs incurred and permitted by laws governing these transactions.

SIGNATURE OF PATIENT / GUARDIAN

Patient/Parent or Guardian Signature	Printed Name	Date

SunWest dental

NOTICE OF PRIVACY PRACTICES

PROTECTING YOUR CONFIDENTIAL HEALTH INFORMATION IS IMPORTANT TO US!

NOTICE OF PRIVACY PRACTICES
This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

OUR PROMISE!

Dear Patient:
This is not meant to alarm you! Quite the opposite! It is our desire to communicate to you that we are taking the new Federal (HIPAA – Health Insurance Portability and Accountability Act) laws written to protect the confidentiality of your health information seriously. We do not ever want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside of our office

SO WHAT HAS CHANGED?
WHY A PRIVACY POLICY NOW?
VERY GOOD QUESTIONS!

The most significant variable that has motivated the Federal government to legally enforce the importance of the privacy of health information is the rapid evolution of computer technology and its use in healthcare.

The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the Internet, phone, faxes, copy machines, and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we use to ensure the protection of your health information everywhere it is used.

We want you to know about these policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures and your rights as our valuable patient.

We will use and communicate your **HEALTH INFORMATION** only for the purposes of providing your treatment, obtaining payment and conducting health care operations. Your health information will not be used for other purposes unless we have asked for and been voluntarily given your written permission.

HOW YOUR HEALTH INFORMATION MAY BE USED

TO PROVIDE TREATMENT
We will use your HEALTH INFORMATION within our office to provide you with the best dental care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between hygienist, dental assistant, dentist, and business office staff. In addition, we may share your health information with physicians, referring dentists, clinical and dental laboratories, pharmacies or other health care personnel providing you services and/or treatment.

TO OBTAIN PAYMENT
We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

TO CONDUCT HEALTH CARE OPERATIONS
Your health information may be used during performance evaluation of our staff. Some of our best teaching opportunities use clinical situation experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine process and certification, licensing or credentialing activities.

IN PATIENT REMINDERS
Because we believe regular care is very important to your oral and general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family.

These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best preventive and restorative care modern dentistry can provide. They may include postcards, letters, telephone reminders or electronic reminders such as email (unless you tell us that you do not want to receive these reminders).

ABUSE OR NEGLECT
We will notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law or with the patient's agreement.

SunWest dental

PUBLIC HEALTH AND NATIONAL SECURITY
We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

FOR LAW ENFORCEMENT
As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

FAMILY, FRIENDS AND CAREGIVERS
We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medication, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want we will use our very best judgment when sharing your health information only when it will be important to those participating in providing your care.

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION
Other than is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

PATIENT ACKNOWLEDGMENT

PATIENT NAME: _____

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not, we would appreciate very much your acknowledging your receipt of our policy by your signature. We look forward to guiding you with your dental care.

PATIENT RIGHTS
This new law is careful to describe that you have the following rights related to your health information.

RESTRICTIONS
You have the right to request restrictions on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable restriction preferences from our clients.

CONFIDENTIAL COMMUNICATIONS
You have the right to request that we communicate with you in a certain way. You may request that we only communicate your health information privately with no other family members present or through mailed communications that are sealed. We will make every effort to honor your reasonable requests for confidential communications.

INSPECT AND COPY YOUR HEALTH INFORMATION
You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe your reason for the change.

AMEND YOUR HEALTH INFORMATION
You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe your reason for the change.

Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete.

DOCUMENTATION OF HEALTH INFORMATION
You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health operations. Our documentation procedures will enable us to provide information on health information usage from April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We may need to charge you a reasonable fee for your request.

REQUEST A PAPER COPY OF THE NOTICE
You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you.

We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all of our patients receive a copy of the revised Notice.

You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. Please let us know of your concerns or complaints in writing.

ADDITIONAL PEOPLE WE CAN RELEASE INFORMATION TO:

_____

_____

_____

Patient/Parent or Guardian Signature **Printed Name** **Date**