

# SORGEN

DENTISTRY

## 1 PATIENT INFORMATION:

DATE \_\_\_\_\_

EMAIL \_\_\_\_\_

PATIENT'S NAME \_\_\_\_\_

BIRTH DATE \_\_\_\_\_

ADDRESS \_\_\_\_\_

AGE \_\_\_\_\_

CITY & ZIP \_\_\_\_\_

GENDER: MALE  FEMALE

HOME PHONE \_\_\_\_\_

EMERGENCY CONTACT NAME \_\_\_\_\_

CELL PHONE \_\_\_\_\_

EMERGENCY CONTACT NUMBER \_\_\_\_\_

## 2 WHO MAY WE THANK FOR REFERRING YOU TO OUR PRACTICE?

FAMILY / FRIEND NAME \_\_\_\_\_

GOOGLE

OTHER: \_\_\_\_\_

OFFICE STAFF NAME \_\_\_\_\_

FACEBOOK

SPECIALIST NAME \_\_\_\_\_

WEBSITE

## 3 RESPONSIBLE PARTY INFORMATION:

SELF OR PARENT/GUARDIAN IF UNDER 18 (FIRST, MIDDLE INITIAL, LAST) \_\_\_\_\_

EMPLOYER \_\_\_\_\_

ADDRESS (STREET, CITY, STATE, ZIP CODE) \_\_\_\_\_

INSURANCE COMPANY \_\_\_\_\_

HOME PHONE \_\_\_\_\_

INSURANCE COMPANY ADDRESS \_\_\_\_\_

CELL PHONE \_\_\_\_\_

INSURANCE POLICY/GROUP NUMBER \_\_\_\_\_

WORK PHONE \_\_\_\_\_

INSURANCE ID NUMBER \_\_\_\_\_

EMAIL ADDRESS \_\_\_\_\_

SECONDARY INSURANCE COMPANY \_\_\_\_\_

BIRTH DATE \_\_\_\_\_

SECONDARY INSURANCE COMPANY ADDRESS \_\_\_\_\_

RELATIONSHIP TO PATIENT \_\_\_\_\_

SECONDARY INSURANCE POLICY/GROUP NUMBER \_\_\_\_\_

SOCIAL SECURITY NUMBER \_\_\_\_\_

SECONDARY INSURANCE ID NUMBER \_\_\_\_\_

I, THE UNDERSIGNED, HEREBY VERIFY THAT THE ABOVE INFORMATION IS CORRECT. I UNDERSTAND THAT IN ORDER FOR DR. BRYAN E. SORGEN, DDS TO EVALUATE THE CONDITION OF MY DENTAL HEALTH, I MUST CONSENT TO PROCEDURES NECESSARY FOR DIAGNOSIS, TO BE PERFORMED BY DR. BRYAN E. SORGEN AND/OR HIS STAFF. THESE PROCEDURES MAY INCLUDE BUT ARE NOT LIMITED TO ORAL EXAMS AND X-RAYS. I FURTHER UNDERSTAND THAT SORGEN DENTISTRY PROVIDES ONLY AN ESTIMATE OF THE AMOUNT THAT MY INSURANCE COMPANY MAY PAY, AND I WILL BE RESPONSIBLE FOR THE PORTION OF THE FEE THAT INSURANCE DOES NOT COVER.

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

PARENT / GUARDIAN SIGNATURE IF MINOR \_\_\_\_\_ DATE \_\_\_\_\_

## 4 MEDICAL HISTORY:

ARE YOU UNDER A PHYSICIAN'S CARE NOW?  YES  NO

IF SO, WHAT CONDITION? \_\_\_\_\_ NAME OF PHYSICIAN \_\_\_\_\_

### MEDICATIONS

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING OR HAVE TAKEN IN THE LAST SIX MONTHS INCLUDING VITAMINS, PRESCRIPTIONS FOR HEART OR BLOOD PRESSURE, CORTIZONE, ANTIBIOTICS, ANTIFUNGAL, ANTICANCER, AND/OR OSTEOPOROSIS/BONE LOSS TREATMENT

### PREVIOUS SURGERIES AND/OR HOSPITALIZATIONS

PLEASE INCLUDE DATES

DO YOU USE TOBACCO?  YES  NO

DO YOU DRINK ALCOHOL?  YES  NO

DO YOU USE CONTROLLED SUBSTANCES?  YES  NO

DO YOU SNORE?  YES  NO

### FEMALE PATIENTS ONLY:

TAKING ORAL CONTRACEPTIVES?  YES  NO

ARE YOU PREGNANT?  YES  NO

ARE YOU NURSING?  YES  NO

HAVE YOU EVER BEEN DIAGNOSED WITH SLEEP APNEA?  YES  NO

HAVE YOU EVER TAKEN BISPSPHONATES (FOSAMAX, ACTONEL)?  YES  NO

HAVE YOU HAD AN ORTHOPEDIC TOTAL JOINT REPLACEMENT?  YES  NO

### ARE YOU ALLERGIC OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING?

ASPIRIN, ACETEMINOPHEN OR IBUPROFEN

PENICILLIN OR OTHER ANTIBIOTICS

CODEINE OR OTHER NARCOTICS

SULFA DRUGS

LOCAL ANESTHETICS

ACRYLIC OR METAL

LATEX

OTHER \_\_\_\_\_

### HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING DISEASES OR PROBLEMS?

ABNORMAL BLEEDING

AIDS/HIV INFECTION

ANEMIA

ANGINA (CHEST PAIN)

ARTERIOSCLEROSIS

ARTIFICIAL HEART VALVE

ASTHMA

AUTOIMMUNE DISEASE

BLOOD TRANSFUSION

CANCER/CHEMO/RADIATION

CARDIOVASCULAR DISEASE

CHRONIC BRONCHITIS

CHRONIC PAIN

DIABETES

EATING DISORDER

EMPHYSEMA

EPILEPSY

FAINTING SPELLS

GERD/REFLUX

GLAUCOMA

HEART ATTACK(S)

HEART MURMUR

HEMOPHILIA

HEPATITIS

HIGH BLOOD PRESSURE

KIDNEY PROBLEMS

LUPUS

MENTAL HEALTH DISORDER

MIGRAINE HEADACHES

MITRAL VALVE PROLAPSE

NEUROLOGICAL DISORDER

OSTEOPOROSIS

PACEMAKER

RHEUMATIC FEVER

RHEUMATOID ARTHRITIS

SHORTNESS OF BREATH

STROKE(S)

THYROID DISEASES

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 HEALTH. IT IS MY RESPONSIBILITY TO INFORM SORGEN DENTISTRY OF ANY CHANGES IN MEDICAL STATUS.

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

PARENT / GUARDIAN SIGNATURE IF MINOR \_\_\_\_\_ DATE \_\_\_\_\_

## 5 DENTAL HISTORY:

WHAT IS THE REASON FOR YOUR DENTAL VISIT TODAY? \_\_\_\_\_

DATE OF YOUR LAST DENTAL EXAM? \_\_\_\_\_

DATE OF LAST DENTAL X-RAYS? \_\_\_\_\_

HOW OFTEN DO YOU BRUSH? \_\_\_\_\_

HOW OFTEN DO YOU FLOSS? \_\_\_\_\_

PREVIOUS DEEP CLEANINGS?  YES  NO

DO YOU WEAR A NIGHTGUARD?  YES  NO

DO YOU GRIND YOUR TEETH?  YES  NO

PREVIOUS ORTHODONTIC TREATMENT?  YES  NO

DO YOU HAVE ANY OF THE FOLLOWING?

BAD BREATH

DRY MOUTH

PARTIALS

BLEEDING GUMS

DIFFICULTY CHEWING

SENSITIVITY TO COLD

BLISTERS ON MOUTH

EAR PAIN

SENSITIVITY TO HOT

BROKEN FILLINGS

JAW PAIN

SENSITIVITY TO SWEETS

CLICKING JAW

LOOSE TEETH

SENSITIVITY TO PRESSURE

DENTURES

MOUTH PAIN

SWOLLEN GUMS

DIFFICULTY OPENING/CLOSING

MOUTH SORES

TMJ PROBLEMS

UNPLEASANT PAST DENTAL EXPERIENCES?  YES  NO

DO YOU HAVE ANXIETY ABOUT DENTAL VISITS?  YES  NO

HAVE YOU HAD PROBLEMS WITH THE EFFECTIVENESS OF DENTAL ANESTHETICS IN THE PAST?  YES  NO

WHEN DENTAL TREATMENT IS NECESSARY, WHICH WOULD YOU PREFER?

SHORTER APPOINTMENTS, MULTIPLE VISITS

LONGER APPOINTMENTS, TO GET AS MUCH DONE AS POSSIBLE

NITROUS OXIDE

## 6 SMILE ASSESSMENT:

ARE YOU COMFORTABLE SHOWING YOUR TEETH WHEN YOU SMILE?  YES  NO

ARE YOU HAPPY WITH THE APPEARANCE OF YOUR TEETH?  YES  NO

DO YOU HAVE UNSIGHTLY CROWNS OR FILLINGS?  YES  NO

ARE YOUR GUMS RECEDING?  YES  NO

ARE YOUR TEETH OR GUMS SENSITIVE?  YES  NO

DO YOU FEEL YOUR TEETH ARE TOO LONG OR TOO SHORT?  YES  NO

ARE YOU HAPPY WITH THE ALIGNMENT OF YOUR TEETH?  YES  NO

DO YOU LIKE THE COLOR OF YOUR TEETH?  YES  NO

ARE YOU MISSING TEETH?  YES  NO

WOULD YOU LIKE TO DISCUSS HOW TO IMPROVE THE COLOR OF YOUR TEETH?  YES  NO

WOULD YOU LIKE TO DISCUSS WAYS TO IMPROVE THE LOOK OF YOUR TEETH?  YES  NO

## 7 FINANCIAL POLICY:

Thank you for choosing Sorgen Dentistry, the office of Dr. Bryan E. Sorgen, DDS. In efforts to better serve you, we would like to take the time to explain the financial policy at our office.

First and foremost, please understand that our primary goal is to provide you with expert recommendations in line with our conservative clinical philosophy. We will be sensitive to your financial circumstances and do everything possible to help you achieve the highest standard of oral care. In our office, we strive to maximize your insurance benefits and make any remaining balance affordable. Our fees are based on the quality of materials we use and the time, effort and skill required in performing the treatment you need.

Once you provide the office with your dental policy information, as a customer service to you we are happy to file your dental insurance on your behalf. Please understand it is your responsibility to keep our office up-to-date on your current insurance coverage. Based on the limited details we receive from your insurance company, we do our best to provide an accurate estimation of coverage. Should there be any difference between the estimate and actual benefits covered, the remaining account balance will be your responsibility.

We accept the following forms of payment: Cash, Check, Visa, MasterCard, Discover, and AmericanExpress. In addition, we also offer CareCredit – a patient payment program offering NO INTEREST and extended payment plans.

Payment for services is due at the time services are rendered unless prior arrangements have been made. Checks that are returned to our office from your financial institution are subject to a \$25 fee. Past due accounts having a balance due for more than 60 days will be charged 1.5% interest per month until the account is reconciled. Delinquent accounts having a balance due for more than 90 days will be transferred to a collection agency.

## 8 SCHEDULING POLICY:

Our practice is dedicated to quality care and exceptional service. As such, Dr. Bryan E. Sorgen and his dental team spend extensive amounts of time preparing for your visit. Missed appointments create scheduling problems for our team and prevent other patients in urgent need of dental treatment from being seen. If you find that you must change your appointment, kindly give our office 48 hours' notice so that we may make every effort to accommodate other patients in need of care.

***If you miss or cancel your appointment without providing 48 hours' notice, it will result in \$75 fee.***

*I HAVE READ AND UNDERSTAND THE ABOVE OUTLINED FINANCIAL AND SCHEDULING POLICIES.*

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

PARENT / GUARDIAN SIGNATURE IF MINOR \_\_\_\_\_ DATE \_\_\_\_\_

## 9 NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT:

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up with multiple healthcare providers who may be involved in my treatment both directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that Dr. Bryan E. Sorgen, DDS has the right to change the Notice of Privacy Practices from time to time and that I may contact the office at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree than you are bound to abide by such restrictions.

*I HAVE READ AND UNDERSTAND THE ABOVE OUTLINED HIPAA PRACTICES.*

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

PARENT / GUARDIAN SIGNATURE IF MINOR \_\_\_\_\_ DATE \_\_\_\_\_

## 10 AUTHORIZATION FOR USE OF PATIENT PHOTOGRAPHIC AND/OR VIDEO IMAGES:

I authorize the use and disclosure of my name, photographic/video images, and/or testimonial for marketing purposes by Sorgen Dentistry. The photographic/video images and/or testimonial will be used for Social Media and/or Advertising. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPAA privacy regulations.

I understand that I may revoke this authorization at any time, but such revocation must be in writing and received by the practice via registered mail. Revocation affects disclosure moving forward and is not retroactive. This authorization expires 99 years from the date signed.

*I HAVE READ AND UNDERSTAND THE ABOVE OUTLINED DISCLOSURE.*

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

PARENT / GUARDIAN SIGNATURE IF MINOR \_\_\_\_\_ DATE \_\_\_\_\_