SORGEN DENTISTRY

1 PATIENT INFORMATION:

DATE ______________________________

PATIENT'S NAME ______________________________

ADDRESS ______________________________

CITY & ZIP ______________________________

HOME PHONE ______________________________

CELL PHONE ______________________________

EMAIL ______________________________

BIRTH DATE ______________________________

AGE ______________________________

GENDER: MALE ◯ FEMALE ◯

EMERGENCY CONTACT NAME ______________________________

EMERGENCY CONTACT NUMBER ______________________________

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

FAMILY / FRIEND NAME ______________________________

OFFICE STAFF NAME ______________________________

SPECIALIST NAME ______________________________

◯ GOOGLE

◯ FACEBOOK

◯ WEBSITE

◯ OTHER: ______________________________

3 RESPONSIBLE PARTY INFORMATION:

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

____
ADDRESS (STREET, CITY, STATE, ZIP CODE)

____
HOME PHONE

____
CELL PHONE

____
WORK PHONE

____
EMAIL ADDRESS

____
BIRTH DATE

____
RELATIONSHIP TO PATIENT

____
SOCIAL SECURITY NUMBER

____
EMPLOYER

____
INSURANCE COMPANY

____
INSURANCE COMPANY ADDRESS

____
INSURANCE POLICY/GROUP NUMBER

____
INSURANCE ID NUMBER

____
SECONDARY INSURANCE COMPANY

____
SECONDARY INSURANCE COMPANY ADDRESS

____
SECONDARY INSURANCE POLICY/GROUP 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 BISPHOSPHONATES (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
- ◯ BLEEDING GUMS
- ◯ BLISTERS ON MOUTH
- ◯ BROKEN FILLINGS
- ◯ CLICKING JAW
- ◯ DENTURES
- ◯ DIFFICULTY OPENING/CLOSING
- ◯ DRY MOUTH
- ◯ DIFFICULTY CHEWING
- ◯ EAR PAIN
- ◯ JAW PAIN
- ◯ LOOSE TEETH
- ◯ MOUTH PAIN
- ◯ MOUTH SORES
- ◯ PARTIALS
- ◯ SENSITIVITY TO COLD
- ◯ SENSITIVITY TO HOT
- ◯ SENSITIVITY TO SWEETS
- ◯ SENSITIVITY TO PRESSURE
- ◯ SWOLLEN GUMS
- ◯ 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

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

ARE YOU MISSING 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 24 hours' notice, it will result in a $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 ______________________