WELCOME TO SANDIA DENTAL CARE

Welcome and thank you for selecting Sandia Dental Care and our dental health care team. We strive to provide our patients the best possible dental care. If you have any questions or need assistance, please ask us. We will be happy to help.

I was referred by: □Mailer □Bill board □Web site □Google □Radio □Other/Name_____

Patient Information

Name: _____ Date:_____

Gender: □Male □Female Status: □Minor □Single □Married □Separated □Divorced □Widowed

Birth Date: _____/_____/_____ Soc. Sec. #: _____

Address: _____

City: _____State: _____Zip:_____

E-mail address: _____ □Yes I want to receive future news and updates from Sandia Dental

Home Ph: _____ Mobile Ph: _____ Work Phone: _____

Employer: _____ Occupation: _____

Responsible Party Information

(Skip if this portion does not apply to you)

Name: _____Relationship to Patient: _____
DOB: _____Driver's Lic. #: _____Soc. Sec. #: _____
Address: _____
City: _____State: _____ Zip: _____
Employer: _____Occupation: _____
Home Phone: _____Work Phone: _____ Ext. _____
Cell Phone: _____ Prefer Calls at: □ Home □ Work □ Cell

In Case of Emergency:

Contact Name: _____Relationship: _____

Home Phone: _____Work Phone: _____Ext. _____

Dental Insurance Information

Policy Holder Name: _____

DOB: _____/_____/_____ Soc. Sec. # _____

Insurance Plan: _____

Employer: _____

Insurance Address: _____

_____

Insurance Ph#: _____

Group #: _____ Payor ID: _____

Policy Holder Name:_____

DOB: _____/_____/_____ Soc. Sec. # _____

Insurance Plan: _____

Employer: _____

Insurance Address: _____

_____

Insurance Ph#: _____

Group #: _____ Payor ID: _____

□ I authorize the dentist to release any information, including the diagnosis and any record of treatment or examination, rendered to me or my child during the period of such dental care to third-party payers and/or other health practitioners.

□ I authorize and request my insurance company to pay directly to the dentist any insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all the services rendered on my behalf or my dependents.

□ I request and authorize the dental staff to perform necessary dental services for my child or dependent, including but not limited to, X-rays and administration of anesthetics that are deemed advisable by the doctor, whether or not I am present at the actual appointment when treatment is rendered.

_____ _____ _____

Signature of Patient or Parent/Guardian of Minor | Signature of Co-Responsible Party | Date

Medical History

Although dentistry treats primarily the area in and around your mouth, your mouth is a part of your entire body. We believe in the importance of treating the patient holistically. Therefore, other health problems or medications that you may be taking could be relevant to your dental care. Thank you for answering the following questions.

Are you under a physician's care now? □Yes □No If Yes, please explain:_____

Physicians name, address, and phone_____

Have you ever been hospitalized or had a major operation? □Yes □No If Yes, please explain: _____

Have you ever had a serious head/neck injury? □Yes □No If yes, please explain: _____

Are you taking any medications, vitamins, pills or drugs? □Yes □No Please list or provide copy:_____

_____

Do you have acid reflux? □Yes □No

Have you taken Phen-Fen or Redux? □Yes □No

Snoring? □Yes □No

Sleep apnea? □Yes □No

Do you use tobacco? □Yes □No

Do you use controlled substances? □Yes □No

Women

Are you pregnant or trying to get pregnant? □Yes □No Taking oral contraceptives? □Yes □No Nursing? □Yes □No

Are you allergic to any of the following?

□Aspirin □Penicillin □Codeine □ Acrylic □Metal □Latex □Tetracycline □Erythromycin □Sedatives □Local anesthetics

□ Other please explain:_____

Do you have, or have you had, any of the following? Please check all that apply and circle the appropriate diagnosis.

- □ AIDS/HIV positive
- □ Alzheimer's disease
- □ Anaphylaxis
- □ Anemia
- □ Angina
- □ Arthritis/gout
- □ Artificial heart valve
- □ Artificial joint
- □ Asthma
- □ Blood disease
- □ Blood transfusion
- □ Breathing problems
- □ Bruise easily
- □ Cancer
- □ Chemotherapy
- □ Chest pains
- □ Cold sores
- □ Congenital heart disorder
- □ Convulsions
- □ Diabetes
- □ Drug addiction
- □ Easily winded
- □ Emphysema
- □ Epilepsy or seizures
- □ Excessive bleeding
- □ Excessive thirst
- □ Frequent cough
- □ Frequent diarrhea
- □ Frequent headaches
- □ Genital herpes
- □ Glaucoma
- □ Hay fever
- □ Heart attack/failure
- □ Heart murmur
- □ Heart pace maker
- □ Hemophilia
- □ Hepatitis A
- □ Hepatitis B or C
- □ Herpes
- □ High blood pressure
- □ Hives or rash
- □ Hypoglycemia
- □ Irregular heartbeat
- □ Kidney problems
- □ Leukemia
- □ Liver disease
- □ Low blood pressure
- □ Lung Disease
- □ Mitral valve prolapse
- □ Pain in jaw joints
- □ Parathyroid disease
- □ Psychiatric care
- □ Radiation treatments
- □ Recent weight loss
- □ Heart trouble/disease
- □ Renal disease
- □ Rheumatic fever
- □ Scarlet fever
- □ Rheumatism
- □ Shingles
- □ Sickle cell disease
- □ Sinus trouble
- □ Spinal bifida
- □ Stomach/intestinal disease
- □ Stroke
- □ Swelling of limbs
- □ Thyroid disease
- □ Tonsillitis
- □ Tuberculosis
- □ Ulcers
- □ Venereal disease
- □ Yellow jaundice
- □ Fainting spells

Have you ever had a serious illness NOT listed above? **□Yes** **□No**

If yes please explain:_____

To the best of my knowledge, I have answered the questions on this form accurately. I understand that it is my responsibility to inform the dental office promptly of any changes in overall health or medical status.

_____ _____

Signature of Patient, Parent, or Guardian Date

Dental History

Reason for visit today? _____

Date of Last Dental Visit _____ Previous Dentist's Name: _____

How often do you have dental examinations? _____How often do you brush your teeth? _____

How often do you floss? _____What dental aids do you use?(Proxybrush, rinses, picks etc.) _____

Are any of your teeth sensitive to:

Hot or cold? □ Yes □ No

Sweets? □ Yes □ No

Biting or chewing? □ Yes □ No

Do you notice any mouth odor or bad taste? □ Yes □ No

Do you frequently get cold sores, blisters or any other oral lesions? □ Yes □ No

Do your gums bleed or hurt? □ Yes □ No

Have your parents experienced gum disease or tooth loss? □ Yes □ No

Have you noticed any loose teeth or change in your bite? □ Yes □ No

Does food tend to become caught in your teeth? □ Yes □ No

If yes, where _____

Do you:

Clench or grind your teeth while awake? □ Yes □ No

Clench or grind your teeth while you sleep? □ Yes □ No

Bite your lips or cheeks regularly? □ Yes □ No

Hold foreign objects with your teeth? □ Yes □ No

(pencils, pipe, pins, nails, fingernails)

Mouth breathe while awake or asleep? □ Yes □ No

Have tired jaws, especially in the morning? □ Yes □ No

Have you ever had:

Orthodontic treatment? □ Yes □ No

Traditional Braces? □ Yes □ No

Do you wear retainers? □ Yes □ No

Are you interested in straightening your teeth? □ Yes □ No

Would you like more information on Invisalign?

Oral surgery? □ Yes □ No

Periodontal treatment? □ Yes □ No

Your teeth ground or the bite adjusted? □ Yes □ No

A bite plate or mouth guard? □ Yes □ No

If yes, describe_____

A serious injury to the mouth? □ Yes □ No

If yes, describe_____

Have you ever experienced:

Clicking or popping of the jaw? □ Yes □ No

Joint, ear or side of face pain? □ Yes □ No

Difficulty in closing mouth? □ Yes □ No

Are you satisfied with your Teeth's appearance? □ Yes □ No

Do you feel nervous about having dental treatment? □ Yes □ No

If so, what is your biggest concern?_____

Is there anything else about having dental treatment that you would like us to know?

_____

_____

_____

Office Policies

Thank you for choosing Sandia Dental Care for your dental care needs. We believe it's important to share our policies with our patients in advance. As always, we are pleased to answer any questions you may have or explain the treatment process in greater detail. Please read thoroughly and sign below indicating that you understand these policies and agree to comply with them. We welcome your questions and comments and are committed to providing excellent dental care services to all our patients. We appreciate the confidence you place in us.

Insurance

We may accept assignment of insurance benefits from your primary carrier after your second visit. Your coinsurance portion, including any deductible, is due at the time of service. Your co-insurance or co-payment is calculated on the information provided by your carrier at the time of estimate. Please note that your insurance policy is a contract between you and your insurance company. We accept assignment of benefits as a courtesy to our patients. Any claim not paid by your insurance carrier within 60 days will be billed to the patient.

Missed Appointments:

Please help us serve you and our other patients better by keeping your scheduled appointments. Our answering machine does not accept cancellations. We prefer to speak with you in person and require 24-hour advanced notice to reschedule or cancel appointments. If you DO NOT give **a 24-hour notice** to reschedule or cancel your appointment there WILL BE **a $60.00** fee charged to your account.

Delinquent Accounts:

In the event payments are not received by agreed upon dates, a 1.75% late charge (21% APR) may be added to the delinquent account. Attorney's fees and collection fees incurred to settle any outstanding balance are the responsibility of the patient. There will be a $25.00 fee for any returned check.

Methods of Payment

Payment for services is expected at the time of treatment unless prior arrangements have been made. For your convenience we accept:

Cash, Check, Credit Card, Care Credit (MasterCard, Visa, Discover, and American Express).

☐ Check here if you'd like to learn more about Care Credit® (Deferred interest financing program)

_____	_____	_____
Signature of Patient or Parent/Guardian of Minor	Signature of Co-Responsible Party	Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement*

I, _____
(*Please Print Name***)**,
have received a copy of this office's Notice of Privacy Practices.

_____ _____
Signature **Date**

Office purposes only:
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, *but acknowledgement could not be obtained because:*

___ Individual refused to sign

___ Communication barriers prohibited obtaining the acknowledgement

___ An emergency situation prevented us from obtaining acknowledgement

___ Other (Please Specify)

_____

_____

Sandia Dental Care
6800 Montgomery Blvd. N.E. Suite C
Albuquerque, New Mexico 87109

Phone (505) 884-8000

DENTAL TREATMENT CONSENT FORM

For your convenience, we make available this generalized dental consent form for you to review and sign. Please do not hesitate to ask our dental staff any questions you may have.

DRUGS AND MEDICATIONS
I understand that local anesthetics, antibiotics, and pain medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and or anaphylactic shock (severe allergic reaction).

PERIODONTAL LOSS (TISSUE & BONE)
I understand that serious gum problems can lead to bone infection or bone loss and that it can lead to the loss of my teeth. Alternative treatments include gum surgery, replacement and or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition.

ENDODONTIC TREATMENT (ROOT CANAL)
I realized there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extend through the root, which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy).

CROWNS, BRIDGES AND CAPS
I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or cap including shape, fit, size, and color will be before cementation.

REMOVAL OF TEETH
If the teeth are savable or restorable, the alternatives to removal of teeth are root canal therapy, crowns and periodontal surgery. I understand removing teeth does not always remove all the infection, if present and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection dry socket, loss of feeling in my teeth lips, tongue and surrounding tissue (paresthesia) that can last for an indefinite period of time (days or months) ,or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.

DENTURE, COMPLETE OR PARTIAL
I realize that full or partial dentures are artificial, constructed of plastic, metal, and or porcelain. The problems of wearing these appliances include looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new dentures (including shape, fit, size, placement, and color) will be the "teeth in wax" try-in visits. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee.

CHANGE IN TREATMENT PLAN
I understand that during or following treatment it may be necessary to change or add procedure because of conditions found on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedure.

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made to me by anyone regarding the dental treatment that I have requested and authorized for my minor child or myself. I have had full opportunity to discuss and ask questions regarding the dental treatment, and all questions have been answered to my satisfaction.

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent/ Guardian/Representative Date