Sunshine Dental LLC
Let's Brighten your Smile

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

Patient Information

Patient Name:_____ **Date of Birth:** _____ **Sex:**_____

Home address:_____ **City:**_____ **State:**_____ **Zip:**_____

Billing address (if different):_____ City:_____ State:_____ Zip:_____

Home Phone:_____ **Cell:**_____ **E-mail**_____ Driver's license#:_____

Social Security#_____ Employer/Occupation:_____ Work phone#_____

Parent/Spouse name and phone#_____

Emergency contact (other than Spouse)_____

Insurance Information

Primary Dental insurance:_____ **Id/policy#**_____

Subscriber's name and date of birth:_____ **Subscriber SS#**_____

Secondary Dental Insurance:_____ Id/policy#_____

Subscriber's name and date of birth:_____ Subscriber SS#_____

Name of your medical doctor:_____ Date of last visit to medical doctor:_____

Name of previous dentist:_____ Date of last visit to dentist:_____

Referred to us by: Search engine (Google) Flyer in the mail Facebook Driving by
(Please circle one)

Existing patient:_____ Other:_____
(Existing patient name)

Dental Health History

Are you apprehensive about dental treatment? _____Y N
Have you had problems with previous dental treatment?_____Y N
Do you gag easily?_____Y N
Do you wear dentures?_____Y N
Does food catch between your teeth?_____Y N
Do you have difficulty in chewing your food? _____Y N
Do you chew on only one side of your mouth? _____Y N
Do you avoid brushing any part of your mouth because of pain? _____Y N
Do your gums bleed easily?_____Y N
Do your gums bleed when you floss?_____Y N
Do your gums feel swollen or tender? _____Y N
Have you ever noticed slow- healing sores in or around your mouth?_____Y N
Are your teeth sensitive? _____Y N
Do you take fluoride supplements?_____Y N
Do you feel twinges of pain when your teeth come in contact with:
- Hot foods or liquids____
- Cold foods or liquids____
- Sours?____
- Sweets?_____

Are you dissatisfied with the appearance of your teeth?_____Y N
How often do you brush? _____
How often do you floss? _____
Does your jaw make noise so that it bothers you or others?___Y N
Do you clench or grind your jaws frequently? _____Y N
Does your jaw get stuck so that you can't open freely? _____ Y N
Does it hurt when you chew or open wide to take a bite?_ ____Y N
Do you have earaches or pain in front of the ears? _____Y N
Do you have any jaw symptoms or headaches upon awaking in the morning? _____Y N
Does your jaw pain or discomfort affect your appetite, sleep, daily routine, or other activities? _____Y N
Do you take medications or pills for pain or discomfort (pain relievers, muscle relaxants, antidepressants)? _____Y N
Do you have a temporomandibular (TMD) disorder?_____Y N
Do you have pain in the face, cheeks, jaw, joints, throat, or temples?_____Y N
Are you unable to open your mouth as far as you want?_____Y N
Are you aware of an uncomfortable bite?_____Y N
Have you had a blow to the jaw (trauma)?_____Y N
Are you a habitual gum chewer or pipe smoker?_____Y N

Sunshine Dental LLC
Let's Brighten your Smile

Patient Name:			Date of birth: Date:		
	Yes	No		Yes	No
Heart Problems			Hepatitis, jaundice, or liver trouble		
Chest Pain			Herpes or other STD		
Shortness of breath			HIV-positive/AIDS		
Blood pressure problem			Glaucoma		
Heart murmur			Do you wear contact lenses?		
Heart valve problem			History of head injury?		
Taking Heart Medication			Epilepsy or other neurological disease?		
Rheumatic Fever			History of alcohol or drug abuse?		
Pacemaker			previously that you feel we should know about?		
Artificial heart valve			If so, please describe:		
Blood Problems			**During the past 12 months, have you taken any of the following?**		
Easy Bruising			Antibiotics or sulfa drugs		
Frequent nosebleeds			Anticoagulants (e.g. Coumadin)		
Abnormal bleeding			High blood pressure medicine		
Blood disease (anemia)			Tranquilizers		
Ever require a blood transfusion?			Insulin, Orinase, or similar drug		
Allergy Problems			Aspirin		
Hay fever			Digitalis or drugs for heart trouble		
Sinus problems			Nitroglycerin		
Skin rashes			Cortisone (steroids)		
Taking allergy medication			Natural remedies		
Asthma			Nonprescription drug/supplements		
Intestinal Problems			Other		
Ulcers			**Women**		
Weight gain or loss			Are you taking contraceptives or other hormones?		
Special diet			Are you pregnant?		
Constipation/Diarrhea			If so, expected delivery date		
Kidney or bladder problems			Are you nursing?		
Bone or joint problems			Have you reached menopause?		
Arthritis			If so, do you have any symptoms?		
Back or neck pain			**Are you allergic, or have you reacted adversely, to any of the following**		
Joint replacement (total, pins,implants)			Local anesthetics ("Novocaine")		
Fainting spells, seizures, or epilepsy			Penicillin or other antibiotics		
Stroke(s)			Sulfa drugs		
Frequent or severe headaches			Barbiturates, sedatives, or sleeping pills		
Thyroid problems			Aspirin, Acetaminophen, or Ibuprofen		
Persistent cough or swollen glands			Codeine, Demerol, or other narcotics		
Premedications required by physician			Reaction to metals		
Cancer/tumor			Latex or rubber dam		
Diabetes					
Urinate more than 6 times a day			Other		
Thirsty or mouth is dry much of the time			Notes:		
Family history of diabetes					
Tuberculosis or other respiratory disease					
Do you drink alcohol?					
If so, how much			***Patient/Parent Signature:***		
Do you smoke?					
If so, how much			Dentist signature:		

OFFICE GUIDELINES

Sunshine Dental LLC is committed to providing all patients with exceptional service quality care. Please review our office guidelines and sign/date below. Thank you.

Cancellation Guide

We respect the importance of your time and work to schedule appointments that accommodate the scheduling needs of all our patients. Broken and missed appointments create an inconvenience for other patients as well as our practice. As a result, we follow the model commonly used by many other dental practices in the area. If you find that you are unable to make your reserved appointment, we **REQUIRE** a **24-hour notice**. You may leave a message at any time on our answering machine within 24 hours, by calling 413-372-5565. There will be a **$25 fee** assessed for every **half hour** missed of your appointment reservation without 24-hour notification.

If you break your appointment with less than 24 hours notice more than 2 (two) times we will no longer book you an appointment. You will have to come in as a walk-in basis only. If you continue to come in as a walk-in we may re-instate your ability to make a scheduled appointment. However, if you continue to break or no show your appointments you will be dismissed as a patient and will no longer be able to be seen in our office.

We understand emergencies do occur and we do not wish to penalize patients for unavoidable situations; in such situations, we waive the first offense. We record all appointments, cancellation and no-show appointments and discourage repeat abuse of our scheduling guidelines.

Scheduled Appointments

In order to best accommodate all of our patients and keep our schedule as accurate as possible, we require a confirmation call or text (reply back to auto text) to keep your appointment on the schedule. If we do not receive a call or text back **confirming your appointment within 24 hours**, you will be still be seen however you will be considered a walk-in and may have to wait. We will still attend to you, however after we have seen our confirmed appointments. **If you arrive more than 15 minutes after your scheduled appointment you may have to be rescheduled**. If you know you are going to arrive late, please call our office and we can advise whether or not we need to reschedule. Rescheduling is based on the remaining days schedule. Your time and all of our patients' time is important to us, please help us adhere to our standards.

Financial Obligations/ Payment Guidelines

Patients **with** dental benefits: As a courtesy to our patients who have dental benefits, we are happy to file your claims electronically from our office. Please understand that it is your responsibility to know your specific plan/ policy coverage. Your dental benefits may cover more or less than we estimate. Therefore, after we receive payments/adjustments from your insurance, we will send you a statement with any remaining balance. Patients **without dental benefits** are required to pay in full at the time of services rendered. Patients with a **Quality dental plan** (QPD) membership, offered in office, are required to pay in full at the time of the services rendered.

Payment Plan Options

Sunshine Dental LLC offers payments plan options through Care Credit. Care Credit offers interest free payment options along with extended payment plans. Log on to www.carecredit.com for more information. Brochures available upon request. If you have any questions, don't hesitate to ask. Thank you for your cooperation and understanding as we institute these policies. These policies will enable us to better serve the needs of all patients.

I have read and understand all the policies. Sign below and please date.

X_____ Date_____

Sunshine Dental LLC
Let's Brighten your Smile

HIPAA Patient Consent Form

Our notice of privacy practices provides information about how we may use and disclose protected health information about you (the patient). The notice contains a Patient Right section describing your rights under the law (this law may be requested at the front desk). You have the right to review our full notice before signing consent. The terms of our notice may change. If we change our notice you may obtain a revised coy by contacting our office. You have the right to request that we restrict protected health information that is used or disclosed for treatment, payment or healthcare operations. By signing this form, you consent to our use and disclosure of protected health information about your treatment, payment and healthcare operations. You have the right to revoke this consent, in writing, signed by you. However, such revocation shall not affect any disclosures we have already made in reliance on your prior consent. The practice provides this form to comply with health insurance Portability and Accountability Act of 1996 (HIPPA)

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or healthcare operations.
- The practice has a Notice of Privacy Practices and the patient has the opportunity to review this notice.
- The practice reserves the right to change the Notice of Privacy Policy.
- The patient has the right to restrict the use of their information.
- The patient may revoke this consent in writing at any time for all future disclosures will then cease.
- The practice may condition treatment upon execution of the consent. No insurance can be billed on the patient's behalf without this signed HIPPA consent form, therefore payment in full is required at the time of services rendered.

INFORMATION SHARING Please list any individuals we can share personal information with, other than health care providers

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____ _____

PATIENT SIGNATURE TODAYS DATE

(RELATIONSHIP TO PATIENT) _____