Chart #:
FOR OFFICE USE ONLY

PATIENT REGISTRATION

PATIENT INFORMATION

Patient's Name: _____, _____ _____ Date: _____
Last, First MI (Preferred Name)

Address: _____
Street Apartment #

_____
City State Zip Code

Email: _____ **Gender:** ☐ Male ☐ Female **Family Status**: ☐ Single ☐ Married ☐ Child

Social Security #: _____ **Medicaid ID**: _____ **Birth Date**: _ _____

Drivers License # _____ **Office Use only: Copy in file? ☐ Yes ☐ No*

****HIPAA**:** *Do we have permission to leave appointment, billing or dental information on your answering machine, voicemail or e-mail at the following numbers? Please check "Yes" or "No" for each contact number.*

DO YOU NEED COMMUNICATION ASSISTANCE ☐ Yes Please explain _____

☐ NCAN (No communication Assistance needed)

Home Phone: _____	☐ Yes ☐ No	Best time to call: _____
Work Phone: _____ Ext: _____	☐ Yes ☐ No	Best time to call: _____
Cell Phone: _____	☐ Yes ☐ No	Best time to call: _____
Cell Text Message: _____	☐ Yes ☐ No	
E-mail: _____	☐ Yes ☐ No	
Fax: _____	☐ Yes ☐ No	

RESPONSIBLE PARTY/GUARANTOR INFORMATION

Only if the person responsible for this account is NOT the patient, complete the following information for the Guarantor:

Guarantor Name:
Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other _____
Gender: ☐ Male ☐ Female **Family Status**: ☐ Married ☐ Single ☐ Divorced ☐ Child ☐ Other _____

Address: _____
Street City State Zip Code

Social Security #: _____ **Birth Date:** _____
Drivers License # _____ **Office Use only: Copy in file? ☐ Yes ☐ No*

Phone Numbers: Home: _____ Work: _____ Ext: _____
Cell: _____ Fax: _____ E-mail: _____
Employer Name: _____ **Occupation:** _____

Employers Address: _____
Street City State Zip Code Phone

REFERRAL INFORMATION

How did you learn about, or who referred you to, our dental office? ☐ Patient/friend ☐ Our Staff, ☐ Another Dental Office, ☐ Yellow Pages, ☐ Insurance Plan, ☐ Newspaper, ☐ TV, ☐ Website, ☐ Newsletter, ☐ School, ☐ Your employer ☐ Direct Mail Postcard ☐ Other _____

Name of person or dental or medical office who referred you: _____
Please indicate your preferred dentist or hygienist in our office: _____

INSURANCE INFORMATION

Primary Insurance

Name of Primary Subscriber/Insured: _____ Is the insured a patient? ☐ Yes ☐ No
(Last, First, MI)

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insured's Social Security # _____ Birth Date: _____ Date Employed _____

Insured's Address: _____
(Street, City, State, Zip Code)

Insured's Employer Name: _____ Work Phone: _____ Ext _____

Address: _____
(Street, City, State, Zip Code)

Insurance Carrier/Plan Name: _____ Insurance Group #: _____ Insurance ID#: _____

Insurance Company Address: _____
(Street, City, State, Zip Code, Phone)

Medical Insurance

Name of Primary Subscriber/Insured: _____ Is the insured a patient? ☐ Yes ☐ No
(Last, First, MI)

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Legal Guardian ☐ Other _____

Insured's Social Security # _____ Birth Date: _____ Date Employed _____

Insured's Address: _____
(Street, City, State, Zip Code)

Insured's Employer Name: _____ Work Phone: _____ Ext _____

Address: _____
(Street, City, State, Zip Code)

Insurance Carrier/Plan Name: _____ Insurance Group #: _____ Insurance ID#: _____

Insurance Company Address: _____
(Street, City, State, Zip Code, Phone)

Reviewed by: _____ Date: _____
Dentist's Signature

TERMS AND CONDITIONS OF SERVICE

In consideration of all services provided by Sage Dental Group of Florida, PLLC, and its affiliated dental practices doing business as Sage Dental and their employees and contractors, or by Sage Dental Group of Georgia, LLC, and its affiliated dental practices and their employees and contractors (individually and collectively, the "Dental Group"), the undersigned hereby acknowledges and agrees on behalf of himself or herself, and on behalf of his or her children, dependents, and other persons for whom he or she serves as guarantor (collectively, "Dependents"), with the following terms and conditions of service:

Medical Information. The undersigned hereby certifies that all information provided to the Dental Group is true, correct and complete and agrees to promptly inform the Dental Group of any changes in any information (including regarding any Dependent). The Dental Group is authorized to use and disclose to any insurance, billing, management or processing company, agency or organization any health care information and medical records relating to the undersigned or any Dependent to obtain payment for services, determine insurance benefits, or otherwise as required by law. The Dental Group is authorized to contact the undersigned at any telephone number provided above (unless otherwise revoked in writing) to discuss this form and any billing, treatment, or other matter related to any dental treatment (including for any Dependent).

Treatment; Informed Consent. The undersigned authorizes the Dental Group and any treating dentist, hygienist, and staff member to perform all treatment described in any treatment plan (and including all other services determined by such dentist to be necessary or appropriate in connection with such treatment plan) accepted by undersigned for himself or herself or any Dependent. Dentistry is a biological procedure and not an exact science; therefore, despite the highest standard of care, no guarantee is or can be given by the Dental Group or any dentist or any other person employed or contracted by the Dental Group regarding any treatment or the results that may be obtained. The patient must comply with all specified appointments, procedures, and continuing care, and failure to do so will adversely affect the patient's treatment often necessitating additional required treatment (or retreatment) with additional fees. Failure to show within 15 minutes of the scheduled time for, or provide at least 48 hours advance notice of cancellation of, any appointment for any reason will result in a broken appointment fee. The Dental Group does not exercise control over the professional services of any of its treating dentists; therefore, the undersigned shall solely hold the treating dentist responsible for any treatment performed (including, without limitation, treatment provided under the treating dentist's supervision) and agrees to hold harmless the Dental Group and its interest holders, members, managers, officers, directors, owners, affiliates, employees, agents, contractors, and all other persons and entities under common control or ownership with the Dental Group. **Fees in treatment plans for non-insurance/discount plan patients are only valid for 30 days; all insurance/discount plan fees are subject to change at any time based upon changes in plan fee schedules or to correct errors.**

Financial Responsibility; Insurance. **THE UNDERSIGNED PATIENT AND GUARANTOR ASSUME FULL RESPONSIBILITY FOR PAYMENT OF ALL FEES AND CHARGES FOR ALL SERVICES OF THE DENTAL GROUP, WHETHER OR NOT COVERED BY INSURANCE. THE PATIENT'S PORTION OF ALL FEES (INCLUDING ALL DEDUCTIBLES AND CO-PAYS) IS DUE AND PAYABLE IN FULL AT THE TIME SERVICES ARE PERFORMED.** For treatment involving multiple appointments, such as a crown, root canal, denture, or implant, the entire patient portion is normally due when treatment is started. Any special financial arrangements must be made before treatment is started. All insurance, discount plans and discount coupons must be presented before treatment is started. The Dental Group submits insurance claims solely to primary dental insurance for patients' convenience and does not assume responsibility for the processing of such insurance or failure of insurance to pay for any reason. Dental insurance rarely covers all fees; estimated or preauthorized insurance benefits are not guaranteed. The undersigned agrees to pay promptly on demand any balance not paid by insurance within 60 days after the date of service. A service charge of 1½% per month (18% per annum) is charged on all balances more than 30 days past due. Insurance balances are considered past due if not paid within 60 days of the date of service. The undersigned shall pay all costs incurred by the Dental Group relating to collection of any unpaid or delinquent balance (including, without limitation, attorneys and collection agency fees, court costs, paralegals) whether or not suit is filed. The Dental Group reserves the right to terminate or deny any treatment if the patient's account is delinquent.

Assignment of Benefits; Authorization and Release. The undersigned hereby certifies that all insurance coverage described above is current and valid and assigns directly to the Dental Group all insurance benefits covering the undersigned or any Dependent for all services rendered. The undersigned hereby agrees that his or her signature below will be maintained "on file"; the Dental Group is authorized to use such signature on all applicable insurance claims and submissions. If any insurance payment is made to the undersigned, he or she shall immediately remit such payment to the Dental Group.

Notice of Privacy Practices. The undersigned has reviewed a copy of the Dental Group's Notice of Privacy Practices effective April 14, 2003, as amended.

I have read the above terms and conditions of service by the Dental Group and understand and accept such terms:

_____ Date signed: _____
Signature of Patient, Parent, Legal Guardian,
Health Care Proxy or Surrogate, or Power of Attorney

_____ Relationship to Patient: _____ Date signed: _____
Printed name of Patient, Parent, Legal Guardian,
Health Care Proxy or Surrogate, or Power of Attorney

_____ Date signed: _____
Signature of Witness

_____
Printed name of Witness

HIPAA COMPLIANCE

Patient Consent to Receive Mail and/or Telephone Messages

Patient's Name: (*Please print*)

_____
LAST NAME FIRST NAME MIDDLE

1. Do we have your permission to send recall/treatment appointment reminders to your home? Yes____ No ____

2. Do we have your permission to leave the following information on your home answering machine or voice mail?

Appointment Information	Yes ____	No ____
Billing Information	Yes ____	No ____
Dental/Medical Information	Yes ____	No ____

3. Do we have your permission to leave the following information on your work answering machine or voice mail?

Appointment Information	Yes ____	No ____
Billing Information	Yes ____	No ____
Dental/Medical Information	Yes ____	No ____

4. Do we have your permission to send the following information to your e-mail address provided to us on your patient registration form?

Appointment Information	Yes ____	No ____
Billing Information	Yes ____	No ____
Dental/Medical Information	Yes ____	No ____

5. Do we have your permission to send the following information to your cell phone number (including text messages) provided to us on your patient registration form?

Appointment Information	Yes ____	No ____
Billing Information	Yes ____	No ____
Dental/Medical Information	Yes ____	No ____

6. Do we have your permission to send the following information to your fax machine at the number provided to us on your patient registration form?

Appointment Information	Yes ____	No ____
Billing Information	Yes ____	No ____
Dental/Medical Information	Yes ____	No ____

7. I hereby give permission to share any information concerning me with the person(s) named below:

Name: _____ Name: _____

DATE: _____

SIGNED: _____ **WITNESS:** _____

Print Name: _____ Print Name: _____

Relationship to Patient: Self ____ Spouse _____ Parent _____ Child ____ Legal Guardian ____ Other: _____

Health History Form

ADA American Dental Association®
America's leading advocate for oral health

Email: Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: *Last* *First* *Middle*
Home Phone: *Include area code* ( )
Business/Cell Phone: *Include area code* ( )
Address: *Mailing address*
City: State: Zip:
Occupation: Height: Weight: Date of Birth: Sex: M F
SS# or Patient ID: Emergency Contact: Relationship: Home Phone: *Include area code* ( ) Cell Phone: *Include area code* ( )
If you are completing this form for another person, what is your relationship to that person?
Your Name *Relationship*

Do you have any of the following diseases or problems: *(Check DK if you Don't Know the answer to the the question)*	**Yes**	**No**	**DK**
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information

For the following questions, please mark (X) your responses to the following questions.

	Yes	**No**	**DK**
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐

If yes, how often? *Circle one:* DAILY / WEEKLY / OCCASIONALLY

Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	**No**	**DK**
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam:
What was done at that time?
Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

Medical Information

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	**No**	**DK**
Are you now under the care of a physician?	☐	☐	☐

Physician Name: Phone: *Include area code* ( )
Address/City/State/Zip:

Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

If yes, what condition is being treated?
Date of last physical exam:

	Yes	**No**	**DK**
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what was the illness or problem?

Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐

If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:

Medical Information

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

(Check DK if you Don't Know the answer to the question)

	Yes	No	DK
Do you wear contact lenses?	☐	☐	☐
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐	☐
Date: _____ If yes, have you had any complications? _____			
Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease?	☐	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia®, Zometa®, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	☐	☐	☐
Date Treatment began:			

	Yes	No	DK
Do you use controlled substances (drugs)?	☐	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)?	☐	☐	☐
If so, how interested are you in stopping? *Circle one:* VERY / SOMEWHAT / NOT INTERESTED			
Do you drink alcoholic beverages?	☐	☐	☐
If yes, how much alcohol did you drink in the last 24 hours? _____			
If yes, how much do you typically drink in a week? _____			
WOMEN ONLY Are you:			
Pregnant?	☐	☐	☐
Number of weeks: _____			
Taking birth control pills or hormonal replacement?	☐	☐	☐
Nursing?	☐	☐	☐

Allergies. Are you allergic to or have you had a reaction to:
To all **yes** responses, specify type of reaction.

	Yes	No	DK
Local anesthetics _____	☐	☐	☐
Aspirin _____	☐	☐	☐
Penicillin or other antibiotics _____	☐	☐	☐
Barbiturates, sedatives, or sleeping pills _____	☐	☐	☐
Sulfa drugs _____	☐	☐	☐
Codeine or other narcotics _____	☐	☐	☐
Metals _____	☐	☐	☐
Latex (rubber) _____	☐	☐	☐
Iodine _____	☐	☐	☐
Hay fever/seasonal _____	☐	☐	☐
Animals _____	☐	☐	☐
Food _____	☐	☐	☐
Other _____	☐	☐	☐

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital heart disease (CHD)			
. Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
. Repaired CHD with residual defects	☐	☐	☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

	Yes	No	DK
Cardiovascular disease	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Other congenital heart defects	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion If yes, date: _____	☐	☐	☐
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐

	Yes	No	DK
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐

	Yes	No	DK
Glaucoma	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders If yes, specify: _____	☐	☐	☐
Sleep disorder	☐	☐	☐
Do you snore?	☐	☐	☐
Mental health disorders Specify: _____	☐	☐	☐
Recurrent Infections Type of infection: _____	☐	☐	☐
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/ migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☐	☐	☐
Name of physician or dentist making recommendation:	Phone: *Include area code* ( )		
Do you have any disease, condition, or problem not listed above that you think I should know about? Please explain:	☐	☐	☐

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: Date:

Signature of Dentist: Date:

Comments:

FOR COMPLETION BY DENTIST