SACHS FAMILY DENTAL

We would like to welcome you to the office! Please take a few minutes to fill out this form. If you have any questions we will be glad to help.

PATIENT INFORMATION

First Name:_____ Last Name:_____ Middle Initial:_____
Preferred Name:_____ Birth Date:_____ Sex: ☐ M ☐ F
Soc. Sec.#_____ ☐ Child ☐ Single ☐ Married ☐ Widowed ☐ Other
Address:_____
City:_____ State:_____ Zip:_____ Home Phone:_____
Cell Phone:_____ Email: _____
Drivers License #_____
Whom may we thank for referring you? _____

EMERGENCY CONTACT

First Name: _____ Last Name: _____
Relation to Patient: _____ Phone Number:_____

PRIMARY INSURANCE

Name of Policy Holder:_____ Date of Birth:_____ Relation to Patient:_____
Soc. Sec. #:_____ Subscriber ID:_____
Insurance Company:_____ Phone:_____
Address:_____ City:_____ State:_____ Zip:_____
Employer:_____ Group #:_____

SECONDARY INSURANCE

Name of Policy Holder:_____ Date of Birth:_____ Relation to Patient:_____
Soc. Sec. #:_____ Subscriber ID:_____
Insurance Company:_____ Phone:_____
Address:_____ City:_____ State:_____ Zip:_____
Employer:_____ Group #:_____

DENTAL MEDICAL HISTORY FORM

GENERAL INFORMATION

Patient Name: _____

Reason for today's visit? _____ Are you in dental discomfort today? _____

Former Dentist: _____ Date of last dental care: _____

DENTAL HISTORY

Check if you have had problems with any of the following:

____ Bad Breath ____ Food Collection between teeth ____ Periodontal Treatment ____ Clicking/popping jaw

____ Bleeding gums ____ Grinding/clenching teeth ____ Sore/growth in mouth ____ Loose teeth/ broken fillings

____ Sensitivity to hot ____ Sensitivity to cold ____ Sensitivity to sweets ____ Sensitivity when biting

How often do you brush? _____ How often do you floss? _____

How do you feel about the appearance of your teeth? _____

MEDICAL HISTORY

Are you under a physician's care now? □ Y □ N If yes, please explain: _____

Have you ever been hospitalized or had a major operation? □ Y □ N If yes, please explain: _____

Have you ever had a serious head or neck injury? □ Y □ N If yes, please explain: _____

Are you taking any medications, pills, or drugs? □ Y □ N If yes, please explain: _____

Have you ever taken Phen-fen or Redux? □ Y □ N

Do you use tobacco? □ Y □ N If yes, how often? _____

Are you allergic to any of the following?

□Aspirin	□Penicillin/Amoxicillin	□Codeine	□Local Anesthetics	□Acrylic	□Metal
□Latex	□Sulfa Drugs	□Other If yes, please explain _____			

For Women: Are you taking birth control? □ Y □ N Are you pregnant? □ Y □ N Due Date_____ Nursing? □ Y □ N

Health Conditions: (Please indicate if you have had any of the following)

□ Y □ N AIDS/HIV POSITIVE	□ Y □ N DRUG ADDICTION	□ Y □ N LOW BLOOD PRESSURE
□ Y □ N ALZHEIMER'S DISEASE	□ Y □ N EASILY WINDED	□ Y □ N MITRAL VALVE PROLAPSE
□ Y □ N ANAPHYLAXIS	□ Y □ N EMPHYSEMA	□ Y □ N NERVOUS PROBLEMS
□ Y □ N ANEMIA	□ Y □ N EPILEPSY OR SEISURES	□ Y □ N PACEMAKER/HEART SURGERY
□ Y □ N ANGINA	□ Y □ N EXCESSIVE BLEEDING	□ Y □ N PSYCHIATRIC CARE
□ Y □ N ARTHRITIS/GOUT	□ Y □ N EXCESSIVE THIRST	□ Y □ N RADIATION TREATMENT
□ Y □ N ARTIFICIAL HEART VALVE	□ Y □ N FAINTING	□ Y □ N RECENT WEIGHT LOSS
□ Y □ N ARTIFICIAL JOINTS	□ Y □ N FREQUENT COUGH	□ Y □ N RENAL DIALYSIS
□ Y □ N ASTHMA	□ Y □ N FREQUENT HEADACHES	□ Y □ N RHEUMATIC FEVER
□ Y □ N BLOOD DISEASE	□ Y □ N GLAUCOMA	□ Y □ N SHINGLES
□ Y □ N BLOOD TRANSFUSION	□ Y □ N HEART MURMUR	□ Y □ N SICKLE CELL DISEASE
□ Y □ N BREATHING PROBLEM	□ Y □ N HEART PROBLEMS	□ Y □ N SINUS TROUBLE
□ Y □ N BRUISE EASILY	□ Y □ N HEMOPHILIA	□ Y □ N SPINA BIFIDA
□ Y □ N CANCER	□ Y □ N HEPATITIS A	□ Y □ N STROKE
□ Y □ N CHEMICAL DEPENDANCY	□ Y □ N HEPATITIS B OR C	□ Y □ N SURGICAL IMPLANT
□ Y □ N CHEMOTHERAPY	□ Y □ N HERPES	□ Y □ N SWELLING OF LIMBS
□ Y □ N CHEST PAINS	□ Y □ N HIGH BLOOD PRESSURE	□ Y □ N THYROID DISEASE
□ Y □ N CIRCULATORY PROBLEMS	□ Y □ N HIVES OR RASH	□ Y □ N TONSILLITIS
□ Y □ N CORTISONE MEDICINE	□ Y □ N HYPOGLYCEMIA	□ Y □ N TUBERCULOSIS
□ Y □ N COLD SORES	□ Y □ N IRREGULAR HEARTBEAT	□ Y □ N TUMORS OR GROWTHS
□ Y □ N CONGENIAL HEART	□ Y □ N JAW PAIN	□ Y □ N ULCERS
□ Y □ N CONVULSIONS	□ Y □ N KIDNEY PROBLEMS	□ Y □ N VENEREAL DISEASE
□ Y □ N DIABETES	□ Y □ N LIVER DISEASE	□ Y □ N YELLOW JAUNDICE

Have you ever had any serious illness not listed above? □ Y □ N

If yes, please explain: _____

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

Signature: _____ Date: _____

1442 E. 820 N● OREM, UT 84097● PH: (801)225-470 ● FAX (801)225-4840 ●EMAIL: SACHSFAMILYDENTAL@OUTLOOK.COM

FINANCIAL POLICY

We are committed to providing you with the best possible dental care. Our fees reflect our professional commitment and excellence. If you have dental insurance, we are happy to help you obtain you maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy. For the convenience of our patients, we offer the following methods of payment or fees:

- Payment in full is expected at the time of service. We gladly accept cash, check, credit card or debit card for each appointment as services are rendered.
- Visa, MasterCard, Discover and American Express are accepted.
- For insurance patients, we gladly accept insurance assignments, but require that the deductible and non-covered fees be paid at each visit.
- Care Credit accounts are gladly accepted. Credit approval is required.
- There will be a $38 service fee for any returned checks.
- If payment is not paid in full within 90 days, a monthly charge of 1.5% and a $10 rebilling fee will be added to your account each month.

Please be aware, any parent bringing a child to our office is legally responsible for payment of all services rendered.

CARE CREDIT:
Please understand that Care Credit is a credit card and must be treated as such. Your payment agreement with Care Credit is a contract between you and Care Credit and we are not a party to that agreement. Please read all contract agreements carefully and thoroughly.

REGARDING INSURANCE:

- Your insurance policy is a contract between you and your insurance company. We are not a part of that contract. This office files your insurance as a courtesy to you.
- Our fees generally, but not necessarily, fall within the usual and customary fee structure as determined by your insurance carrier.
- Not all dental services are a covered benefit in all contracts.
- You (not the insurance company) are responsible to us for all our fees for services rendered to you.
- For patients who have insurance, an ESTIMATE of benefits that the insurance company is expected to pay is given to you. All co-payments and deductible payments are expected at the time services are rendered. *Please keep us informed of any insurance changes.

MISSED APPOINTMENTS:
Please understand a specific and valuable amount of time has been set aside for the appointment with Dr. Sachs and his staff. A 24-hour business day notification of a cancelled appointment is required. If the appointment is missed or not canceled within a 24-hour business day, $25 will be charged to the account per hour scheduled. Please help us serve you better by keeping scheduled appointments. If you arrive for your appointment more than 15 minutes late you may be asked to reschedule as a courtesy to our other patients who have scheduled appointment times.

I agree to pay interest at the rate of 18% annually on all past due balances from the original due date, plus court costs and reasonable attorneys' fees, with or without suit, incurred in collecting any past due balance, and a collection fee if my account is assigned to a collection agency.

I have read and fully understand Sachs Family Dental's Financial Policy.

_____	_____	_____
(Print Name)	Signature	Date

1442 E. 820 N• OREM, UT 84097• PH: (801)225-4701• FAX (801)225-4840 •EMAIL: SACHSFAMILYDENTAL@OUTLOOK.COM

RESPONSIBLE PARTY (Whomever is signing the forms)

☐ **SAME AS PATIENT**

Full Name: _____ Sex: ☐ M ☐ F Age: _____ Birthdate: _____

Address: _____ City: _____ State: _____ Zip: _____

Social Security : _____ Home #: _____ Cell #: _____

Email Address: _____

HIPPA PRIVACY POLICY

I _____ (Person signing form) authorize Sachs Family Dental to disclose my/my children(s) account information, balance, and treatments needed to the following persons:

Name: _____ Relationship: _____ DOB: _____

Name: _____ Relationship: _____ DOB: _____

Name: _____ Relationship: _____ DOB: _____

Name: _____ Relationship: _____ DOB: _____

I understand that by signing this form, the person(s) listed above may have access to my information.

NOTICE OF PRIVACY PRACTICES:

I acknowledge that the notice of privacy practices has been made available to me. **Please initial here** ☐

Print Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____

SACHS FAMILY
DENTAL

DR. STEVEN P. SACHS DDS

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you, examining your teeth, prescribing medications and faxing them to be filled, referring you to another doctor or clinic for other health care or services, or getting copies of your health information from another professional that you m ay have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment, preparing and sending bills or claims, and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits, internal quality assurance, personnel decisions, participation in managed care plans, defense of legal matters, business planning, and outside storage of our records.

We routinely use our health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we will ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- When a state or federal law mandates that certain health information be reported for a specific purpose;
- For public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical violence;
- Uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- Disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- Disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;

- Disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- Uses and disclosures to prevent a serious threat to health or safety;
- Uses or disclosures for specialized government officials, for lawful national intelligence activities, for military purposes, or for the evaluation and health of members of the foreign service;
- Disclosures of de-identified information;
- Disclosures relating to worker's compensation programs;
- Incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- Disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

APPOINTMENT REMINDERS

We may call, text or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at your office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form". The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's our idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours. If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the address or fax shown at the bottom of the first page.

YOUR RIGHTS REGUARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- Ask us to restrict our uses and disclosures for purposes or treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address or fax shown at the bottom of the first page.
- Ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E-mail to your personal E-mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address or fax shown at the bottom of the first page.
- Ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance if we deny your request; we will send you a written explanation, and instructions about how to get an impartial review of your denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address or fax shown at the bottom of the first page.