SWEET LIFE dental

NEW PATIENT REGISTRATION

First Name: Last Name: Preferred Name:

Gender:
F / M /prefer not to answer

Date of Birth (mm/dd/yyyy):

Social Security #:

Cell phone: Email address:

Home Address: City: Zip Code:

How did you hear about us?

- ☐ Friend/Relative (name)
- ☐ Drive-by
- ☐ Facebook
- ☐ Insurance Company
- ☐ Google

Emergency Contact (name): Relationship: Phone:

Medical History

Last Name: _____ First Name: _____ Birthdate: _____

List all medications that you are now taking:

_____ _____

_____ _____

_____ _____

Pharmacy: _____ **Pharmacy location/ phone:** _____

Are you allergic, or have you reacted adversely, to any of the following?

☐ Local anesthetic ☐ Penicillin ☐ Sulfa ☐ Latex ☐ Metal ☐ Aspirin, acetaminophen, or ibuprofen
☐ Codeine and narcotics ☐ Barbiturates and sedatives ☐ Other _____

Have you ever taken Fosamax, Boniva, Actonel, or other bisphosphonates? ☐ Y ☐ N

Tobacco use? If so, what kind and how much? _____

Do you have any of the following medical conditions?

Y	N		Y	N	
☐	☐	Asthma	☐	☐	Osteoporosis
☐	☐	Pulmonary disease: _____	☐	☐	Joint replacement
☐	☐	Anemia or bleeding problems	☐	☐	Kidney disease or dialysis
☐	☐	Allergies or sinus problems	☐	☐	Liver disease or hepatitis A/B/C *circle one*
☐	☐	Artificial heart valve	☐	☐	Stomach/intestinal disease or GERD or ulcers
☐	☐	Heart pacemaker	☐	☐	Psychiatric treatment, depression, anxiety
☐	☐	Congenital heart defects	☐	☐	Seizures, epilepsy
☐	☐	Heart Trouble: _____	☐	☐	Glaucoma
☐	☐	Heart attack	☐	☐	Tuberculosis
☐	☐	High Blood Pressure	☐	☐	Stroke
☐	☐	Thyroid: hyper/hypo *circle one*	☐	☐	Alcohol/drug abuse
☐	☐	Cancer: _____	☐	☐	Radiation therapy to head and neck: past or current
☐	☐	Diabetes: type 1/type 2 *circle one*	☐	☐	AIDS/HIV+ or other STDs: _____
☐	☐	Autoimmune disease: _____	☐	☐	Other medical conditions: _____

Females only: Check all that apply.

☐ Pregnant, expected delivery date: _____ ☐ Nursing ☐ Taking oral contraceptives

Reason for today's visit _____ Are you in pain? _____

Name of former dentist _____ City/State _____

Date of last cleaning and exam: _____ Do your gums bleed? ☐ Y ☐ N

List any problems with previous dental treatment _____

Do you grind or clench your teeth? ☐ Y ☐ N Do you have any jaw symptoms? ☐ Y ☐ N

Do you have dry mouth? ☐ Y ☐ N Are you satisfied with your smile? ☐ Y ☐ N

I have answered all of the above to the best of my knowledge and will notify the dentist or staff of any changes in medical history.

Signature X _____ Date: _____

Financial Agreement

* All fees or copays are due at the time of service.
* Checks that are returned due to insufficient funds are subject to a $25 service.
* For my convenience, this office may release my information to my insurance company, if applicable, and receive payment directly from them. I authorize my insurance company to pay benefits directly to Sweet Life Dental or Dr. Tzeng.
* **Every effort will be made to help me with my insurance, and the office strives to provide accurate information regarding my insurance eligibility and payment. However, I understand that the office can only give estimates at best, and if my insurance does not pay as expected, I will be responsible for any fees not paid.**
* On any outstanding balance 30 days past due, I agree to pay finance charges of 1.5% per month (18% APR).
* If there is an outstanding balance 60 days past due, my account will be sent to collections, and I agree to pay all related fees and attorney/court costs.
* Appointments broken without 24 hours notice are subject to a **$50 fee per hour blocked for 30 minute appointment.** Exceptions for extenuating circumstances may be considered.
* Treatment plans may change, and if so, I will be responsible for the work actually done.
* There is a $25 fee for any release of x-rays and/or records. Please allow ten (10) business days.

Privacy Act Agreement

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA or the Healthcare Privacy Act). I understand that by signing this consent, I authorize Sweet Life Dental to use and/or disclose my protected information to carry out the following:

- Treatment which includes direct and/or indirect treatment by other healthcare providers involved in my treatment.
- Obtaining payment from parents/spouses/family members and third party payers, ie my dental insurance company.
- The day to day healthcare operations of the dental practice.

If I wish to review and secure a detailed copy of Sweet Life Dental's HIPAA Notice of Privacy Practices, I have informed the practice. I understand that you reserve the right to change the terms of this notice from time to time and that I may request the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and healthcare operations. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent will not be affected.

I understand the office's financial policy and consent to the office's privacy act agreement and have been given the opportunity to ask any questions.

Signature: _____ Date: _____

Name (print): _____