

Welcome Form

Patient Information

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Date Alternate Phone Last Name

Middle Initial First Name Home Phone

Social Security Number/HIC/Patient ID #/Medicaid # (If you are uninsured, type NA to proceed) Street Address City

State

☐ Alabama	☐ Alaska	☐ Arizona
☐ Arkansas	☐ California	☐ Colorado
☐ Connecticut	☐ Delaware	☐ Florida
☐ Georgia	☐ Hawaii	☐ Idaho
☐ Illinois	☐ Indiana	☐ Iowa
☐ Kansas	☐ Kentucky	☐ Louisiana
☐ Maine	☐ Maryland	☐ Massachusetts
☐ Michigan	☐ Minnesota	☐ Mississippi
☐ Missouri	☐ Montana	☐ Nebraska
☐ Nevada	☐ New Hampshire	☐ New Jersey
☐ New Mexico	☐ New York	☐ North Carolina
☐ North Dakota	☐ Ohio	☐ Oklahoma
☐ Oregon	☐ Pennsylvania	☐ Rhode Island
☐ South Carolina	☐ South Dakota	☐ Tennessee
☐ Texas	☐ Utah	☐ Vermont
☐ Virginia	☐ Washington	☐ West Virginia
☐ Wisconsin	☐ Wyoming	☐ Puerto Rico
☐ District of Columbia	☐ US Virgin Islands	

ZIP Code Email

Sex

☐ Male	☐ Female	☐ Other
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Birthdate

Marital Status

☐ Single	☐ Married	☐ Divorced
☐ Separated	☐ Widowed	☐ Minor
☐ Partnered		

Patient Employer/School (Answer only if you receive insurance through your School or Employer)	Occupation	Whom may we thank for referring you?
In case of emergency who should be notified?		

Primary Insurance

First Name of Person Responsible for Account	Middle Initial of Person Responsible for Account	Last Name of Person Responsible for Account
Relation to Patient	Birthdate (if different from patient)	Social Security Number (if different from patient)
Address (if different from patient's)	City	State
ZIP Code	Phone (if different from patient)	Employer or Group Name (Type SELF if you are uninsured)
Insurance Company (Type SELF if you are uninsured)	Contact #	Group # (Type SELF if you are uninsured)
Subscriber # (Type SELF if you are uninsured)	Name of other dependents covered under this plan (Optional)	

Additional Insurance

Is patient covered by additional insurance? (If no, Select no and skip to the next section)		
☐ Yes	☐ No	
Subscriber Name	Birthdate	Relation to Patient
Address (if different from patient's)	City	State
ZIP Code	Phone	Subscriber Employed by
Insurance Company	Social Security Number	Contract #
Group #	Subscriber #	Name of other dependents covered under this plan

Dental History

Reason for Today's Visit

Former Dentist

Date of last dental care (if unsure use your best guess)

Date of last dental x-rays (if unsure use your best guess)

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

☐ Bad breath

☐ Bleeding gums

☐ Clicking or popping jaw

☐ Food collection between teeth

☐ Grinding teeth

☐ Loose teeth or broken fillings

☐ Periodontal treatment

☐ Sensitivity to cold

☐ Sensitivity to hot

☐ Sensitivity to sweets

☐ Sensitivity when biting

☐ Sores or growths in your mouth

☐ None of the above

How often do you floss?

How often do you brush?

Medical History

Physician's Name

Date of Last Visit (if unsure use your best guess)

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva.

☐ Yes

☐ No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of loimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine).

☐ Yes

☐ No

Have you had any serious illnesses or operations?

☐ Yes

☐ No

If yes, describe

Have you ever had a blood transfusion?

☐ Yes

☐ No

If yes, give approximate dates:

Are you pregnant?

☐ Yes

☐ No

Are you nursing?

☐ Yes

☐ No

Are you taking birth control pills?

☐ Yes

☐ No

Check if you have or have had any of the following:

☐ Anemia

☐ Arthritis/Rheumatism

☐ Artificial Heart Valves

- | | | |
|--|---|---|
| ☐ Artificial Joints | ☐ Asthma | ☐ Back Problems |
| ☐ Blood Disease | ☐ Cancer | ☐ Chemical Dependency |
| ☐ Chemotherapy | ☐ Circulatory Problems | ☐ Cortisone Treatments |
| ☐ Cough, Persistent | ☐ Cough up blood | ☐ Diabetes |
| ☐ Epilepsy | ☐ Fainting | ☐ Glaucoma |
| ☐ Headaches | ☐ Heart Murmur | ☐ Heart Problems |
| ☐ Hemophilia | ☐ Hepatitis | ☐ High Blood Pressure |
| ☐ HIV/AIDS | ☐ Jaw Pain | ☐ Kidney Disease |
| ☐ Liver Disease | ☐ Mitral Valve Prolapse | ☐ Pacemaker |
| ☐ Radiation Treatment | ☐ Respiratory Disease | ☐ Rheumatic Fever |
| ☐ Scarlet Fever | ☐ Shortness of Breath | ☐ Skin Rash |
| ☐ Stroke | ☐ Swelling of Feet or Ankles | ☐ Thyroid Problems |
| ☐ Tobacco Habit | ☐ Tonsillitis | ☐ Tuberculosis |
| ☐ Ulcers | ☐ Venereal Disease | ☐ I have no known medical conditions |

MEDICATIONS (List medications you are currently taking or type NONE if you do not take any medications):

ALLERGIES (List any allergies or type NONE if you do not have any known allergies)

Authorization

I certify that I, and/or my dependent(s), have insurance coverage with _____ (Type names of Insurance Company Below or Type SELF if you are a private or uninsured patient) and assign directly to Sunflower Dental Group and all insurance benefits, if any, otherwise payable to me for services rendered. I understand that if I am uninsured, I am responsible for all charges based on Sunflower Dental Groups most recent fee schedule.

I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Sunflower Dental Group dentists may use my health care information and may disclose such information to the above-name Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

I understand that it is my responsibility to update the practice if my insurance information is changed and provide accurate and timely information to Sunflower Dental Group so that this information can be used to submit claims to my insurance provider and that if I do not provide this information prior to my visit, I will be responsible for any unpaid claims.

I have reviewed all practice policies including those about cancellation and rescheduling and I will do my best to comply with them. I understand that patients who fail to follow these policies could be subject to cancellation fees or be dismissed from the practice.

Signature of Patient, Parent, Guardian
or Personal Representative

Date

Name of Patient, Parent, Guardian or
Personal Representative

Relationship to Patient

Payment is due in full at time of treatment unless prior arrangements have been approved.

Privacy Policy Acknowledgement

Dear Valued Patient,

Thank you for choosing Sunflower Dental Group! This year marks the beginning of many exciting changes in our office in an effort to improve service and quality of care for you so that you can regain and maintain your health as quickly, efficiently, and inexpensively as possible. Sunflower Dental Group is excited to have you and we will try to make your experience at our dental office the best it can be. Our goal is to keep all patients as happy as possible and to make any accommodations our patients may need to make this the best experience for them as it is for us. At our office, all patients are treated with respect and are very important to us. Your health is always our number one priority. Therefore, please read and follow the below policies to give us and you the best possible experience:

- ☐ 1. Lateness and No Shows Policy: Please try at the best of your ability to arrive on time for your appointment. This time frame has been scheduled exclusively for you. As long as a patient arrives on time, we will do our best to get you out on time. Unless in the rare occurrence of a delay prior to your appointment due to a patient emergency that required our immediate attention. If you are more than 15 minutes late to your scheduled appointment, you may be required to reschedule. As goes for keeping a scheduled appointment. Please notify us at least 24 hours in advance if you are unable to keep your appointment. There is a \$75 fee for all no-show or late cancellation patients.
- ☐ 2. Zero Balance Policy: Our office is becoming a zero balance practice. We ask all patients to pay all charges, co pays, and fees required of them at the time of service. Patients must maintain a zero balance with us at all times unless they have qualified for payment plans. If account balances are not current, we reserve the right to refuse service.
- ☐ 3. Cleanliness and Infection Control: These are of the utmost importance to us. We have the latest sterilization technology and disinfect each room after each and every patient. We ask to you cooperate with your care team if we ask you to wear a mask or take your temperature at times depending on our discretion and current health codes.
- ☐ 4. Insurance Coverage: Treatment recommendations are based on your health, not on your insurance or lack thereof. If you have insurance it is your responsibility to be aware of what your benefits are. Ultimately, you are the one fully responsible for any treatment performed . Your benefits are a contract between you and your insurance company. We cannot be responsible for what your insurance will or will not cover. Please notify us of any changes or loss of insurance coverage to assist us in helping you in any way possible.
- ☐ 5. Emergencies: It is our goal to eliminate all of the potential dental emergencies you may have by providing care for you before it becomes a problem. In the rare instance of an emergency, you have our assurances that we will take care of you in a timely manner. In order to do this, we would like to define for you what a true emergency is. Swelling , bleeding, severe pain that has kept you up at night or requires medication, or a restoration in a visible area that falls out are all considered emergencies. If you have any of these symptoms, we ask that you call us right away. We will provide you with the next available emergency appointment. We do set aside time each day for emergency visits.

6. Referring Others to Our Practice: Our policy is to make your experience in our office an exceptional one. The biggest compliment that we can receive is you telling your friends and family about our office. This is greatly appreciated .

I have read , signed and understand the above policies to the best of my ability. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges not covered by insurance. I authorize the use of this signature on all insurance submissions. In case of default of payment, I promise to pay any legal interest on the balance due at 1 ½% per month together with any collection cost of 35% .and reasonable attorney fees incurred to effect collection on this account.

Signature of patient or parent of minor Date

HIPAA Form

PATIENT HIPAA AWARENESS

With my permission, Sunflower Dental Group may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Sunflower Dental Group Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Sunflower Dental Group reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer.

With my permission, the office of Sunflower Dental Group may call my home or other designated locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my permission, the office of Sunflower Dental Group may mail to my home or other designated locations any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. This also includes texting appointment reminders.

With my permission, the office of Sunflower Dental Group may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Sunflower Dental Group restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this, I am allowing Sunflower Dental Group to use and disclosure my PHI for TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

Signature of Patient or Legal Guardian	Print Name of Patient or Legal Guardian	Date