Sonoma Smiles

Thank you for selecting our dental team. We will always offer you the most current dental care available. To help us to better serve you, please fill out these forms for us. Thank you for your cooperation.

The Sonoma Smiles Team

Today's Date_____

Personal Information

Name_____
Social Security #_____
Preferred first name_____Date of Birth_____
Circle: Minor Single Married
Address_____City, State, Zip_____
Your employer_____Occupation_____
Spouse's name_____
Spouse's employer_____Spouse's occupation_____
How did you find out about our office?_____

How May We Contact You?

Home phone_____Work phone_____
Cellular phone_____Email_____
Where do you prefer to receive calls (circle)? Home work cell

Responsible Party, If Minor

Name_____Relation to patient_____
Date of Birth_____Social Security #_____DL#_____

Insurance Information

Do you have a dental benefit plan? Y/N

Carrier_____Insurance phone #_____
Name of insured_____
Social Security #_____
Do you have an additional dental plan? Y/N
Carrier_____Insurance phone #_____

How Can We Make Your Appointment More Comfortable?

Would you like?

- **Fresh coffee when you arrive?**
- **An iPod to listen to during treatment?**
- **A blanket to help keep you warm?**
- **A paraffin wax treatment for your hands?**
- **Sunglasses to wear during your appointment?**
- **A pillow to help support your neck?**
- **To use a chair massage pad?**
- **Anything else we haven't thought of? _____**

What Did You Not Like About Your Past Dental Appointments?

Was the treatment uncomfortable? Y/N
Was the staff unfriendly? Y/N
Were the fees not explained before your appointments? Y/N
Anything we have not thought of?_____

What Is The First Thing You Would Like Us to Help You With?

List in order of importance:_____
_____
_____

Photographic Release

Dr. Sutton and his team often take digital photos in order to properly document the condition of your teeth and gums. Additionally, these photos will help us to make more accurate diagnoses and may be used to better explain your existing dental health. Dr. Sutton may publish articles and make presentation to other dentists where these photos are invaluable in explaining the latest techniques and the results that can be achieved when done precisely. My signature acknowledges that photographs of me may be used for educational purposes as stated above.

Signature of patient_____Date_____

Medical Health

General Health: (circle) Excellent Good Fair Poor
Date of Last Physical:_____
Name and Address of Physician:_____
List of all medications presently taking:_____
_____
Have you been hospitalized or under a doctor's care during the past 3 years? Y/N
Has a doctor told you that you need antibiotics to pre-medicate for dental work? Y/N

Please circle all of the following you have had or now have:

AIDS/HIV	Diabetes	HPV
Anemia	Drug/Alcohol Abuse	Kidney Disease
Arthritis	Emphysema	Liver Disease
Artificial Joints	Epilepsy/Seizure	Lupus
Asthma	Fainting	Mental Disorders
Blood Diseases	Fibromyalgia	Osteoporosis
Blood Transfusion	Fosomax	Pacemaker
Cancer	GERD	Radiation Treatment
Chemotherapy	Heart Disease	Rheumatoid Arthritis
Cold Sores	Heart Murmur	Stroke
Congenital Heart	Hepatitis-A B C	Ulcer
Defect	H/L Blood Pressure	Venereal Disease

Do you have any disease, condition or problem not listed? _____
Are you allergic to: Penicillin Codeine Local Anesthetic
Other_____?

Are you subject to prolonged bleeding? Y/N

WOMEN: Are you pregnant? Y/N Are you taking birth control medication? Y/N

Dental History

1. **Are your teeth sensitive to:**
   Heat? Cold? Sweets? Pressure?
   If yes,where?_____

2. **Are you dissatisfied with the way your teeth look?**
   Color? Shape? Spaces?
   If yes, what would you like to change?
   _____
3. **Are you missing any teeth? Y/N**
4. **Do your gums bleed when brushing? Y/N**
5. **Do your gums bleed when flossing? Y/N**

6. **Do you smoke? Y/N If yes, how long and how much? _____**
7. **Do you drink soda? Y/N If yes, how much per day? _____**
8. **How often do you brush? _____**
9. **How often do you floss? _____**
10. **Has the fear of dental work kept you from regular dental visits? Y/N**
11. **Are you interested in sedation dentistry? Y/N**
12. **When your last dental appointment was and what did you have done?**
    _____
13. **How long since your last thorough examination with full mouth x-rays?**
    _____
14. **Who was your previous dentist? _____**
15. **What prompted you to seek dental care at this time?**
    _____
16. **Is there anything else we should know?_____**
    _____

Sleep Questionnaire

1. **Do you experience frequent, heavy snoring? Y/N**
2. **Do you notice significant day time drowsiness? Y/N**
3. **Have you been told you stop breathing while sleeping? Y/N**
4. **Are you aware of any teeth grinding at night? Y/N**
5. **Do you have morning headaches? Y/N**
6. **Do you wear a CPAP? Y/N If so, for how long? _____Who prescribed it? _____**
7. **Do any other members of your family wear a CPAP? Y/N**

Please take the following "Epworth Sleepiness Test" A score of ten or above indicatives you may be having a problem with daytime sleepiness.

How likely are you to fall asleep in the following situations?
0=would never doze
1=slight chance of dozing
2=moderate chance of dozing
3=high chance of dozing

Activity

Sitting and reading _____
Watching television _____
Sitting, inactive in a public place (theater, meeting) ____
As a passenger in a car for an hour with no break ____
Lying down to rest in the afternoon, if circumstance permit _____
Sitting taking to someone ____
Sitting quietly after lunch without alcohol _____
In a car while stopped for a few minutes in traffic ____

Total Score: ____

Authorization, Release and Agreement to Pay for Services Rendered

I authorize the dentist to release any information, including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care, to third party payers and/or health practitioners. I authorize and hereby request my insurance company to pay directly to the dentist (or the dental group) insurance benefits otherwise payable to me. I understand that my dental insurance may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

I, _____verify all information provided on these forms is completely accurate to the best of my knowledge.

Signature of patient (or parent, if minor) _____Date_____

Our Financial Alliance

Our goal in discussing financial arrangements with you is straightforward: to create an understanding and partnership in the settlement of your account

It is important to us that the quality of our business services matches the quality of our dentistry. We want the handling of your account, from the start through the final payments to be perceived as an extension of the dental care we provide you and your family.

Patient's Role

As with any partnership, both parties have a role to play. Our role is to provide you with quality service. In turn, your role is to pay for your treatment in a timely manner. Our team will work with you to determine financial arrangements that make sense for both of us. With an agreement made, our joint follow-through will result in a win for everyone.

In developing a financial arrangement it is important to remember your dental future. Our experience has shown that when an account lingers, patients are likely to defer their appointments. It is discouraging to add new charges to an account when trying to pay off old charges. With this in mind, we will concentrate our efforts on clearing your account in as short a time as is comfortable for both of us.

All patients must complete our Financial Compliance Form before seeing the doctor.

Payment options:

1. **Full payment is due at the time of service with cash, check, Visa, MasterCard, Discover, American Express, or Care Credit.**
2. **We offer access to extended payment plans with credit approval.**
3. **If you have dental insurance, will estimate what your insurance company will pay. We require payment of your uninsured portion upon receipt of services.**

Regarding Insurance

Each insurance company is different. Please note that your initial payment at our office for the above noted procedures is only an estimate. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. However, as part of the financial arrangement process, we will bill your insurance company for your procedures and help you to maximize your reimbursement. Any unpaid balance after insurance pays is due with 30 days. In the event that your insurance company has not paid on your claim within 45 days, the full balance will automatically be transferred to you.

Missed Appointments

We reserve the right to charge for missed appointments at the rate of a normal office visit. Please help us serve you and our other patients better by keeping scheduled appointments. Appointments that are missed or changed at the last minute are then unavailable to patients who need appointments. Please consider your schedule carefully when making appointments.

I understand that payment is due at the time of service. I understand that if my account reaches collections status (90 days), my account may be turned over to a collection agency. I will pay ALL costs of collection, including court costs and attorney's fees incurred for collection.

I have read the Financial Alliance. I understand and agree to abide by the policies therein.

Patient Signature (parent, if minor):_____Date:_____