Mendota Dental Associates

Dr. Stephen Sawyer, DDS

REGISTRATION

Today's Date: _____

PATIENT NAME: _____ **DATE OF BIRTH:** _____

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

Cell Phone #:_____ Home Phone #:_____

Email:_____ Social Security #: _____
(Needed for insurance purposes)

Sex: ❑ Female ❑ Male **Marital Status:** ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Employer Name:_____ Occupation: _____

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT: ❑ **SELF** ***(If self, no need to complete this section)***

❑ **OTHER** (Name):_____ Date of Birth: _____

Relationship to you:_____ Their Social Security #: _____

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

Cell Phone #:_____ Home Phone #:_____

HOW DID YOU HEAR ABOUT US? ❑ Flyer ❑ Internet ❑ Insurance ❑ Live Nearby

❑ Family member/friend:_____ ❑ Other: _____

EMERGENCY CONTACT: _____ Relationship to you:_____

Their Cell Phone #:_____ Their Home Phone #: _____

PRIMARY DENTAL INSURANCE CARRIER: _____

Group #:_____ ID #: _____

Insurance Address: _____

Subscriber: ❑ Self ❑ **Other** (Name):_____ Relationship to you: _____

[*Other's*] Date of Birth:_____ **[*Other's*]** Social Security #: _____
(Needed for insurance purposes)

DO YOU HAVE SECONDARY DENTAL INSURANCE? ❑ Yes ❑ No

Secondary Insurance Carrier: _____

Group #:_____ ID #: _____

Insurance Address: _____

Subscriber: ❑ Self ❑ **Other** (Name):_____ Relationship to you: _____

[*Other's*] Date of Birth:_____ **[*Other's*]** Social Security #: _____
(Needed for insurance purposes)

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MEDICAL HISTORY

1. Patient Name:_____ Date of Birth: _____
2. Medical Physician's Name/Clinic: _____

   Phone Number:_____ Location: _____
3. Have you had any need for medical care *other than routine visits* within the past two years? ❑ Yes ❑ No

   If yes, please explain: _____
4. Have you been hospitalized within the past five years? ❑ Yes ❑ No

   If yes, please explain: _____
5. List all medications (and dosage), including over-the-counter, herbal remedies, and regular doses of aspirin:

   _____ _____ _____

   _____ _____ _____

   _____ _____ _____
6. Are you required to take a pre-med (antibiotic) before your dental visits (due to knee/hip replacement or heart condition?

   ❑ Yes ❑ No If yes, reason and year it was done: _____
7. Have you ever taken bone loss prevention medication such as Fosamax, Actonel, Boniva, or other Bisphosphonates?

   ❑ Yes ❑ No If yes, please list the name and dosage: _____
8. Have you had any allergic reaction (or adverse) reaction to any substance or medication? ❑ Yes ❑ No

   If yes, please explain: _____
9. **WOMEN ONLY:** Are you pregnant or think you *could* be? ❑ Yes ❑ No If yes, _____ months pregnant

   Are you nursing? ❑ Yes ❑ No Do you use a birth control prescription? ❑ Yes ❑ No
10. **INDICATE WHICH OF THE FOLLOWING YOU'VE HAD OR CURRENTLY HAVE:** ***(Check ALL that apply)***

- ❑ Heart (Surgery, Disease, Attack)
- ❑ Artificial Heart Valve/Pacemaker
- ❑ Chest Pain
- ❑ Congenital Heart Disease
- ❑ Heart Murmur
- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Mitral Valve Prolapse
- ❑ Stroke
- ❑ Rheumatic Fever
- ❑ Cortisone Medication
- ❑ Swollen Ankles
- ❑ Special and/or Restricted Diet
- ❑ High Cholesterol
- ❑ Kidney Problems
- ❑ Ulcers
- ❑ Diabetes
- ❑ Artificial Joint (Hip, Knee, etc.)
- ❑ Thyroid Problems
- ❑ Glaucoma
- ❑ Emphysema
- ❑ Chronic Cough
- ❑ Tuberculosis
- ❑ Asthma
- ❑ Allergies/Hay Fever/Hives
- ❑ Sinus Problems
- ❑ Radiation Therapy
- ❑ Chemotherapy
- ❑ Tumors
- ❑ Hepatitis *(circle one)* A B C
- ❑ Venereal Disease
- ❑ AIDS/HIV Positive
- ❑ Cold Sores/Fever Blisters
- ❑ Blood Transfusions
- ❑ Hemophilia
- ❑ Sickle Cell Disease
- ❑ Liver Disease/Yellow Jaundice
- ❑ Neurological Disorders
- ❑ Bruise Easily
- ❑ Latex Sensitivity
- ❑ Epilepsy or Seizures
- ❑ Fainting or Dizzy Spells
- ❑ Nervousness/Anxiety
- ❑ Alzheimer's Disease
- ❑ Psychiatric/Psychological Care
- ❑ ADHD
- ❑ Autism
- ❑ Dementia
- ❑ Hearing Impaired
- ❑ Vision Impaired
- ❑ Cancer (Type) _____
- ❑ Any other condition, disease, or problem not listed here?

  Please explain: _____

  _____

  _____

I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider to release such information to you.

√**Patient Signature:**_____ Date: _____

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DENTAL HISTORY

1. Patient Name:_____ Date of Birth: _____

2. Previous Dentist's Name/Clinic: _____

Phone Number:_____ Location: _____

3. What is the main reason for your visit today? _____

4. When was last date you had the following dental procedures done:

Dental Exam:_____ Dental Cleaning: _____ Full Mouth X-Rays: _____

5. Was anything other than routine dental care done at your last dental visit? ❑ Yes ❑ No

If yes, please explain: _____

6. How often do you have dental exams?_____ Brush your teeth?_____ Floss? _____

7. Have you ever used or are currently using topical fluoride? ❑ Yes ❑ No

8. Do you use any other dental aids (waterpik, proxy brushes, toothpicks, etc.)?_____

9. **INDICATE WHICH OF THE FOLLOWING APPLIES TO YOU:** ***(Check ALL that apply)***

- ❑ Sensitivity to hot or cold
- ❑ Sensitivity to sweets
- ❑ Biting or chewing problems
- ❑ Mouth odors or bad tastes
- ❑ Frequent cold sores, blisters or other oral lesions
- ❑ Bleeding and/or sore gums
- ❑ Parent's history of gum disease or tooth loss
- ❑ Loose teeth or change in bite
- ❑ Clenching/grinding teeth while awake or asleep
- ❑ Biting your lips or cheeks
- ❑ Food gets caught in between teeth?
- ❑ Hold foreign objects with your teeth (pencil, pipe, etc.)
- ❑ Mouth breathing while awake or asleep
- ❑ Snoring or other sleeping disorders
- ❑ Smoke or chew tobacco or other tobacco products
- ❑ Tired jaws, especially in the morning
- ❑ Clicking or popping of the jaw
- ❑ Pain in your joint, ear, or side of face
- ❑ Difficulty in opening or closing your mouth
- ❑ Difficulty in chewing on either side of your mouth
- ❑ Headaches, neck aches or shoulder aches
- ❑ Sore muscles in your neck or shoulders
- ❑ Nervousness/anxiety about dental treatments

CHECK ALL THAT YOU HAVE HAD:

- ❑ Orthodontic treatment
- ❑ Oral Surgery
- ❑ Periodontal treatment
- ❑ My teeth ground down or bite adjusted
- ❑ A bite plate or mouth guard
- ❑ A serious injury to my mouth or head

Please explain:_____

_____

_____

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10. Are you satisfied with the appearance of your teeth? ❑ Yes ❑ No

If not, tell us what you'd like to change: _____

11. Anything else you'd like us to know regarding your dental care? _____

_____

_____

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CONSENTS

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION (HIPAA)

_____ INITIALS

1. **PURPOSE OF CONSENT:** By signing this form, you consent to our use of your protected health information to carry out treatment, payment activities and healthcare operations.
2. **NOTICE OF PRIVACY PRACTICES:** You have the right to read the Notice of Privacy Practices before you decide whether to sign this consent. Our Notice of Privacy Practices provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your health information, and of other important matters about your protected health information. We encourage you to read it carefully and completely before signing this consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change them, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.
3. You may obtain a copy of our Notice of Privacy Practices, including any revisions at any time by contacting our business manager at Mendota Dental Associates, 720 Main Street, Suite 213, Mendota Heights, MN 55118; Phone 651-209-9219; Fax 651-454-1405.
4. **RIGHT TO REVOKE:** You have the right to revoke this consent at any time by giving us written notice of your revocation submitted to our business manager. Please understand that revocation of this consent will not affect any action we took before we received your revocation, and that we may decline to treat you or continue treating you if you revoke this consent.

COMMITMENT TO FINANCIAL AGREEMENT

_____ INITIALS

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

1. **PAYMENT IN FULL BY CASH, CHECK, OR CREDIT CARD.** Services paid on the day of treatment may be eligible for a savings if no insurance benefits are involved.
2. **PAYMENT BY YOUR DENTAL INSURANCE BENEFITS.** We will file your benefit claims and accept payment directly from your insurance company, provided that deductibles and any estimated non-covered fees are paid at time of appointment. Please note that your benefits are a contract between you, your employer, and your insurance company; We are not a party to that contract; We cannot guarantee your benefits or speak for your insurance company; We can only estimate your benefits. Please note that you are responsible to pay all fees for services provided to you, regardless of the outcome of any insurance benefit claim that we file on your behalf.
3. **THIRD PARTY FINANCING WITH CARECREDIT.** You may apply for a line of credit and make monthly payments to CareCredit. You may visit www.CareCredit.com for more information and to apply.

YOUR AMOUNT DUE FOR TREATMENT MUST BE PAID ON THE DATE YOU RECEIVE TREATMENT.

An interest charge of 1.5% per month will be charged to any balance after 60 days. We cannot bill another party on your behalf. By signing below, you agree to pay all costs of collections that may occur, including but not limited to interest, attorney or collection agency fees.

CANCELLATION POLICY WITH MENDOTA DENTAL

_____ INITIALS

1. The appointments you make with Dr. Sawyer and his dental team are reservations and are considered a commitment to your dental health and our business relationship with you. Failed appointments are a disappointment to everyone involved, including you, our doctors, dental team, and other patients in need of dental treatment.
2. When patients do not show for their scheduled appointments, or do not give us adequate cancellation notice, we are not given the opportunity to reschedule that time with other patients who do have a true dental need. **WE ASK FOR A 48-HOUR NOTICE FOR CANCELLATIONS.**
3. Any patient that fails to show up for their scheduled appointments without any notice three (3) or more times, or continues without 48-hour notice, may have a cancellation fee of $25 for every 30 minutes of scheduled appointment time that was reserved for you, or may be dismissed from our office. It's very important to us to be able to maintain available times for all patients.

CONSENT FOR TREATMENT

_____ INITIALS

1. I am here of my free will and hereby authorize Dr. Sawyer and his designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed necessary by Dr. Sawyer to make a thorough diagnosis of my dental needs.
2. Upon such diagnosis, I authorize Dr. Sawyer to perform all recommended treatment that has been discussed and mutually agreed upon by me, and to employ such assistance as required to provide the proper care.
3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I give consent to Dr. Sawyer or any of his designated staff's use and disclosure of any oral, written, or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed.
5. I agree that this Consent for Treatment Agreement will remain active for any and all future treatment, until I have asked to end this agreement.

By signing below, I acknowledge that I have read and understand the above content and have had the opportunity to ask questions.

√ Patient Signature:_____ Date:_____