PATIENT MEDICAL HISTORY

Patient's Name:

For Office Use Only
ID:

Address:	Today's Date:	Date of Last Visit:	Date of Med. History:

City State Zip:	Email:

Home Phone:	Work Phone:	Cell Phone:	Birth Date:	Social Security No.:	Marital Status:

Primary Dental Guarantor:	Home Phone:	Work Phone:	Cell Phone:

Secondary Dental Guarantor:	Home Phone:	Work Phone:	Cell Phone:

Physician Name:	Physician Phone:

Pharmacy:	Pharmacy Phone:

For Office Use Only

Medical Alerts:

Sex:

If female please answer the following:

Y N
- ☐ ☐ Are you taking Birth Control Pills?
- ☐ ☐ Are you pregnant? If Yes, # of weeks
- ☐ ☐ Are you nursing?

Please answer the following:

Y N
- ☐ ☐ Do you smoke or use tobacco?

For Office Use Only
BP Heart Rate:

Height:

Weight:

Y	N	Conditions
☐	☐	Blood Disorder/Anemia
☐	☐	Unexplained Bleeding Or Bruising
☐	☐	Taking Blood Thinner
☐	☐	Angina Pectoris
☐	☐	Heart Attack
☐	☐	Heart Murmur
☐	☐	Heart Surgery/ Stents
☐	☐	Pace Maker
☐	☐	High Blood Pressure
☐	☐	Low Blood Pressure
☐	☐	High Cholesterol
☐	☐	Arthritis
☐	☐	Artificial Bones/Joints
☐	☐	Bisphosphonate Use
☐	☐	Need Premed?
☐	☐	Stroke
☐	☐	Breathing/Lung Issues
☐	☐	Asthma
☐	☐	Sinus Problems
☐	☐	Seasonal Allergies
☐	☐	GI Issues
☐	☐	GERD/Reflux

Y	N	Conditions
☐	☐	Alcohol/Drug Use
☐	☐	Cancer/Chemotherapy
☐	☐	Radiation Therapy
☐	☐	Depression Or Anxiety
☐	☐	ADD/ADHD
☐	☐	Diabetes
☐	☐	Glaucoma
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	HIV+ AIDS
☐	☐	Hepatitis B/C
☐	☐	Special Needs
☐	☐	Sleep Disorder/CPAP Use
☐	☐	Seizure Disorder
☐	☐	Thyroid Problems
☐	☐	Frequent Headaches
☐	☐	Persistant Cough
☐	☐	Cold Or Flu Symptoms
☐	☐	Recent Diarrhea
☐	☐	Recent Surgery Or Hospitalization
☐	☐	Taking Supplements/Vitamins
☐	☐	Pain In Jaw Joints

Y	N	Conditions
☐	☐	Bleeding/Sore Gums
☐	☐	Dental Anxiety
☐	☐	Loose Teeth
☐	☐	Sensitive Teeth
☐	☐	Orthodontic Treatment (Braces)
☐	☐	Pain In Teeth Or Gums

Y	N	Allergies
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline

Other

_____

_____

_____

Medications:

Y N

☐ ☐ **Is there any disease, condition, or problem that you think this office should know about that is not covered above? If yes, please describe below...**

Notes:

Signature: _____ **Date:** _____

(If Under 18, Parent or Guardian Signature Required)

Acknowledgment and receipt of Notice of Privacy Practices

You may refuse to sign this acknowledgment.

As required by the Privacy Regulations, this practice may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.

I have received a copy of Sparta Dental, SC's Notice of Privacy Practices (available upon request or on our website at www.spartadental.com). I understand that this office may change the terms of its notice, and make the new notice provisions effective for all protected health information that it maintains.

I authorize Sparta Dental Center, SC and any of its employees to disclose and discuss my patient health care records (including the diagnosis, records, examination, and treatment rendered), billing, and insurance claim information to the following persons, including those involved in my care or payment for that care:

Name: _____ Relationship to Patient:_____

Name: _____ Relationship to Patient:_____

Name: _____ Relationship to Patient:_____

I understand that this consent is effective until revoked by me. I understand that I may revoke this consent at any time by giving written notice of revocation to Sparta Dental Center, SC. Revocation of this consent will not affect any action that was taken in reliance on this authorization before written notice of revocation was received.

I understand that I have the right to receive a copy of this authorization.

I, (please print name) _____Date of Birth_____
am confirming my written permission for the disclosure of my protected health information, as described in this form and in the Privacy Practices of Sparta Dental, SC.

By refusing to sign this acknowledgment we are unable to submit your dental claims to your insurance.

Signature: _____ Date: _____

Relationship to Patient :_____
(self, parent, legal guardian)

For office use only

We could not obtain written acknowledgment because:

__ Individual refused to sign.
__ Communication barriers prevented us from obtaining a signature.
__An emergency situation prevented us from obtaining a signature..

Sparta Dental Center
Office Policy Statement

Our practice believes in the theories of modern dental care. Through proper preventive care and regular checkups, we believe that it is highly likely that most of our patients can expect to keep all of their teeth for all of their lives.

We realize that every person's financial situation is different. For this reason, we have worked hard to provide a variety of payment options to help you receive the dental care needed in order to enjoy a healthy and confident smile. Patient account portions are due at the time of service. At this time, we are not accepting medical assistance or Title 19. All patients, without insurance, including medical assistance patients, have the following payment options:

1. Cash/Check
2. Credit Cards: We have arrangements to accept payment by Mastercard, Visa, Discover, and Debit cards.
3. Care Credit: For your convenience, we have made arrangements with a finance company for patients who desire to make monthly payments. Brochures are available from our front staff and your application can be processed for approval online or over the phone.
4. Uninsured patients will receive a 5% discount for all treatment paid in full with cash or check. Patients 65-74yrs old will receive an additional 5% discount. Patients 75-84yrs old will receive an additional 10%. Patients 85yrs and older will receive an additional 15% off.

Dental Insurance
Our doctors choose their patient's course of treatment by determining the most effective method to treat a condition, and not by what is dictated by an insurance company. Most PPO plans cover the least expensive course of treatment when more than one treatment exists (they call it "alternate benefits" in most policies). Our doctors will do their best to advise you of your treatment options, but they are not familiar with each individual insurance policy. It is the patient's responsibility to pay any charges for these treatments not covered by the insurance company's fee allowance.

As a courtesy, we will file primary and secondary dental insurances for services provided to you. The patient is responsible for any remaining balance after secondary insurance has paid. Patient is also responsible for filing any claims above and beyond secondary insurance. The patient is responsible for providing complete and accurate insurance information to our office in a timely manner. At the time of your appointment, we can estimate what your insurance may cover. Your estimated portion is due on the date of service. We encourage all patients to contact their insurance company to verify policy coverage information, as the patient is ultimately responsible for understanding his/her own policy. If there are any questions about coverage, we encourage patients to request a pre-determination of coverage. We can also file this as a courtesy.
I understand that payment is my obligation regardless of insurance or any other third-party involvement.

Treatment
By scheduling an appointment, I am consenting to the treatment that will be provided during the appointment, including anesthetic as needed. I have had the opportunity to discuss benefits and risks, and am making an informed decision.

I understand that treatment recommendations are based on information collected by the dentist and staff during the course of an examination that may include periodontal charting (gum measurements) and radiographs (x-rays). In order for proper diagnosis, periodontal charting and radiographs are required periodically per my doctor's recommendation and if I choose to deny them, I understand that I will be asked to sign a records transfer and seek care at another clinic.

Dental amalgams (silver fillings) are used in this office as well as resin (tooth colored fillings). I have my choice of materials, however if there is a best option, my dentist will inform me and make the recommendation as to which material should be used. My insurance company may not cover the resins at the same rate that they cover amalgams.

Emergencies
I consent to any procedure deemed necessary for my well being should an emergency arise during the course of the appointment.

Broken Appointments
Due to the need to help all patients as efficiently as possible, we need 48 hours notice if you must cancel or reschedule your appointment. This allows us sufficient time to schedule another appointment in your allotted time. We know that emergencies do happen, so we allow 2 broken (failed, short notice cancellation) appointments. After your second broken appointment, you will be on an on-call only basis for future appointments. On the 3rd broken appointment, you may request your records to be transferred to a dental practice of your choice that can better accommodate your scheduling needs.

Transfer of Records
A records release form must be signed and returned one week prior to the date that records are needed.

Returned check policy
There is a $25.00 fee per check for a check that is returned to us. All checks returned NSF will be sent to Tri-State Adjustments for collection.

Collection Policy
We will attempt to collect any remaining account balances up to 3 times via phone and mail. If no response is received account will be forwarded to Tri-State Adjustments for collections thus terminating patient/ doctor relationship.

Doctor/Patient Relationship
We will consider that any patient not having contact with our office for 18 months is voluntarily terminating their patient/doctor relationship with Sparta Dental Center.

Disclosure Regarding Electronic Signatures

1. In providing your electronic signature, you verify that the information you have provided is correct as of corresponding appointment date. The signature applies only to the medical history record corresponding appointment date. The software prevents this electronic signature from being associated with a modified medical history record.
2. You have the right to a printed copy of today's medical history record upon request.
3. You may contact your dentist's office at any time to update your medical history information. A new digital signature will be required.

I have read and agree to the Office Policies of Sparta Dental Center, SC. I understand that failure to comply with these policies may result in termination of my patient relationship from Sparta Dental Center, SC.

Signature: _____ Date:_____

Relationship to Patient:_____

PATIENT: _____ DATE _____

It is the policy of **Sparta Dental Center** to inform parents of all recommended procedures for your child. At each examination appointment, we will identify any dental treatment needed and describe this to you and your child. Each regular examination visit consists of oral hygiene instructions, cleaning of the teeth, topical application of fluoride, radiographs (x-rays) if needed, and examination of the teeth, hard and soft tissues of the mouth and the bite. Any other treatment needed such as fillings, extractions, etc., will be performed at a separate appointment after obtaining your permission.

- **1**. I hereby authorize Dr. Knoll and staff to perform the following dental treatments or oral surgery procedures, including the use of any necessary or advisable local anesthesia, radiographs (x-rays) or diagnostic aids.

- **2**. In general terms the dental procedures or operation may include

_____Initial A. Cleaning of the teeth and exam

_____Initial B. Topical application of fluoride

_____Initial C. Application of sealants to the grooves of the teeth.

_____Initial D. Treatment of the decayed or injured teeth with a dental restoration

_____Initial E. I elect resin/amalgam (**circle one**) for posterior teeth. Resin will be done on all Anterior teeth

_____Initial F. Use of local anesthesia, by injection, to numb the teeth worked on. Numbness Usually lasts 1- 3 hours. **Please do not tell your child they are going to get a "shot we have special ways of informing them to ease anxiety.**

_____Initial G. Use of nitrous oxide may be used to help children relax and feel the injection less.

_____Initial H. **I further understand that parents and family members will be asked to remain in the reception area so Dr. Knoll and staff can focus entirely on your child.**

_____ Initial I. Restraints will not be used! If patient is uncooperative he/she will be Dismissed for the day (a referral to a pediatric dentist or a mild sedative maybe prescribed)

_____ Initial J. I understand that insurance may not cover any or all of the above procedures, and I am responsible for any amount not covered by insurance on the day of service.

_____ _____

SIGNATURE OF PARENT OR GUARDIAN RELATIONSHIP TO PATIENT

This authorization will remain in effect until changes are made by the parent/guardian as signed above or until patient becomes 18 years old.

In my absence, I hereby give authorization for the person listed below to bring my child to Sparta Dental Center and to consent for any and all recommended dental services.

Legal guardian must bring child to first dental appointment.

_____Relationship to child: _____