We would like to welcome you to our office. Sparta Dental Center is up to date with modern dental technology that focuses on comprehensive and preventative care. Our professional staff has set high standards to provide optimal care. We believe that the best investment anyone can make is to prevent the pain and discomfort associated with oral disease. In order to accomplish this, we require an initial visit to our office for a complete oral evaluation for every new patient.

In order to establish a doctor/patient relationship, several services will be provided at your first visit to our office. Specific radiographs (X-rays) will be taken, your oral condition is documented, including any previous dental work, and gums will be evaluated for periodontitis (advancing gum disease). Dr. Knoll will then review the information and do an exam.

Following the exam, the dentist and hygienist will present a recommended treatment plan to you. The treatment plan will detail the type of cleaning needed and will list recommended extractions, restorations (fillings, crowns/caps, etc), or other work. It will also list our fees, and you will have an opportunity to discuss payment options with our administrative staff.

After your initial visit, you will be able to schedule a cleaning (please note that a cleaning is typically NOT done at your initial visit) and the treatment that you have chosen. Therefore, if you have any questions or are unhappy about any treatment (proposed or performed), fees, or insurance, please discuss it with us. Also, please take this opportunity to review our OFFICE POLICY STATEMENT to ensure that our expectations of you are in accordance with what you are looking for in a dental healthcare provider.

At your first appointment we would like you to arrive 15 minutes early

Again, we welcome you and look forward to seeing you soon

Christina, Krista, Marcia and Megan
Administration Team
Sparta Dental Center

PATIENT INFORMATION FORM

For Office Use Only
ID:

Patient's Name:

Gender (Please check off next to appropriate answer)

MALE _____	FEMALE _____

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:

Emergency Contact:	Phone:

Physician Name:	Clinic Name:	Physician Phone:

Pharmacy:	Pharmacy Phone:

INSURANCE INFORMATION

This section must be completed if we will be billing for you.

Primary Insurance:	Person Covered:

Patient's Relationship to Insured: (Please check off next to appropriate answer)

SELF _____	SPOUSE _____	CHILD _____

Insured's DOB:	Identification No.:

Employer Name:	Employer Address:

Secondary Coverage:	Person Covered:

Patient's Relationship to Insured: (Please check off next to appropriate answer)

SELF _____	SPOUSE _____	CHILD _____

Insured's DOB:	Identification No.:

Employer Name:	Employer Address:

Signature: ____ Date:_________________

(If Under 18, Parent or Guardian Signature Required)

PATIENT MEDICAL INFORMATION FORM

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	Allergies
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline

Other

____

____

____

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
☐	☐	Persistent Cough
☐	☐	Cold or Flu Symptoms
☐	☐	Recent Surgery or Hospitalization

Please answer the following:

Y	N	
☐	☐	Do you smoke or use tobacco?
☐	☐	Do you vape or use an e cig?

Weight: ☐

Height: ☐

If female, please answer the following:

Y	N	
☐	☐	Are you pregnant?

If Yes, # of weeks ☐

☐	☐	Are you nursing?

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.

Please list any vitamins, supplements, homeopathic therapies, or medications that you are currently using below.

I certify this information is complete and accurate.

Signature: ______________________________

Date: ______________________

For Office Use Only

BP: / Heart Rate:

PATIENT DENTAL INFORMATION FORM

Y/N Dental Questions

Y N

☐ ☐ Do you have current pain in teeth or gums?

☐ ☐ Do you have bleeding/sore gums?

☐ ☐ Do you have bad breath?

☐ ☐ Do you have loose/shifted teeth?

☐ ☐ Do you have broken/chipped teeth?

☐ ☐ Do you have missing permanent teeth?

☐ ☐ Do you have sensitive teeth?

☐ ☐ Do you experience dry mouth?

☐ ☐ Do you have trouble getting numb?

☐ ☐ Do you consume soda/energy drinks frequently?

☐ ☐ Do you have pain in your jaw joint(s)?

☐ ☐ Do you have clicking/noise in your jaw joint(s)?

☐ ☐ Do you clench or grind your teeth?

☐ ☐ Do you snore?

☐ ☐ Do you have a history of orthodontic treatment (braces)?

☐ ☐ Do you wear retainers?

☐ ☐ Do you have dental implants?

☐ ☐ Do you have a history of jaw or face surgery?

☐ ☐ Do you have a history of gum treatments or surgery?

☐ ☐ Do you wear dentures or partials?

☐ ☐ Are you happy with the appearance of your teeth?

☐ ☐ Would you like straighter teeth?

☐ ☐ Would you like whiter teeth?

☐ ☐ Do you have dental anxiety that prevents you from seeking regular dental care?

How long ago was your last dental visit?

____

How often do you brush your teeth?

____

How often do you floss your teeth?

____

Please explain any **yes** answers from the Dental Questions section in the space provided below.

I certify that this information is complete and accurate.

Patient/Guardian Signature: ______________________________

Date: ________________________

Medical Record Release Request

Primary Care Physician: ____________________

Phone Number: ____________________

Facility (Gundersen/Mayo): ____________________

Location (Sparta/Onalaska/Lacrosse/Tomah) ____________________

I hereby authorize you to release my medical diagnosis and medication list to Dr. Jennifer Knoll at

Sparta Dental Center, SC
3000 Riley Road
Sparta, WI 54656

Alternatively, an email with the information can be sent to sdcfrontoffice@gmail.com

Patient name: ____________________

Patient date of birth: ____________________

Patient address: ____________________

Patient phone number: ____________________

Patient/Parent/Gaurdian Signature: ____________________

Date: __________

A signature is required from all patients over the age of 18 (parent or legal guardian if the patient is a minor).

Relationship to Patient: ____________________

SPARTA DENTAL CENTER

Dental Record Release Request

I, ______________________________, hereby authorize

____

____

to disclose and provide copies of any and all clinical treatment records and information concerning my care to **Sparta Dental Center, SC**, at the address below or email to sdcfrontoffice@gmail.com.

These records may include, but are not limited to: personal patient information, medical and dental histories, examination records, radiographs, clinical photographs, treatment plans and records, referral and consultation recommendations and reports, diagnostic models, and other related materials.

Patient(s) names: ______________________________

Patient(s) date of birth: ______________________________

Patient(s) address: ______________________________

Patient(s) phone number: ______________________________

Patient Signature: ______________________________ Date: __________

A signature is required from all patients over the age of 18 (parent or legal guardian if the patient is a minor).

Additional family member's signatures (if needed): ______________________________

____

____

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:____