Thank you for choosing our office. Because we care, we want to find out as much information as possible so we can render accurate treatment. Please fill out this confidential form completely. Thank You.

Patient Info:

Today's date: _____

☐Male
☐Female Birth date _____ Age_____ E-mail _____

Name: Last_____First_____MI_____Nickname_____

Address: Street_____City_____State_____Zip_____

Home Phone_____ Work Phone _____Cell Phone_____

Social Security_____Employer_____Occuptaion_____

☐Single ☐Divorced
☐Married Spouse Name_____ ☐Widowed

Responsible Party: ***(For decision making if the patient is underage & also for payment)***

(If different than patient listed above) Relationship to patient_____

Name: Last_____First_____Middle_____Suffix_____

Birth date_____ Social Security_____ E-mail _____

Address: Street_____City_____State_____Zip_____

Home Phone_____ Work Phone_____ Cell Phone_____

Employer_____ Occupation_____

☐Married Spouse Name_____
☐Divorced *(Only need info below if patient is a Dependent)*
Other Responsible Party Name_____

Address_____Phone_____

***Dental Insurance*:**

☐**No Dental Insurance**

☐**Primary Insurance**	☐**Secondary Insurance**
Ins. Co._____	Ins. Co._____
Ins. Phone_____	Ins. Phone_____
Name of Insured_____	Name of Insured_____
Relationship to patient_____	Relationship to patient_____
SS#_____ DOB_____	SS#_____ DOB_____
ID #_____Group #_____	ID #_____Group #_____
Employer_____	Employer_____
Employer Phone_____	Employer Phone_____

Getting to know you:

How did you hear about us?

☐I am an existing patient ☐Sign ☐Insurance
☐Phone Book ☐Newspaper ☐Website
- ❑ AT & T-Yellow Pages
- ❑ Yellow Book-Yellow Pages
- ❑ Impact-Small Local Book

Did someone refer you to our office? ☐No ☐Yes Who can we thank? _____
Do we treat a family member? ☐No ☐Yes Who? _____

~Please continue on reverse side~

Dental History:

Your last dental visit was_____ Last complete exam was_____ Was treatment completed? ☐No ☐Yes

Previous Dentist_____ Where? _____

My last x-rays were taken_____ May we contact them for your dental records? ☐No ☐Yes

Your Mouth:

What is the major reason you seek care at this time? _____

☐Exam/Cleaning ☐Pain ☐Cosmetic ☐Missing Teeth ☐Infection
☐Broken Teeth ☐Dentures ☐Color ☐Bad Taste/Odor ☐Orthodontics

Would you like to improve your smile? ☐No ☐Yes How?_____
How are your gums? ☐Seem healthy ☐Bleed occasionally ☐Bleed Often ☐Swollen
How is your ability to chew? ☐Fine ☐Limited ☐Needs help
How are your teeth? ☐Seldom hurt ☐Sensitivity to hot/cold ☐Pain to sweets ☐Pain to chew
How is your jaw? ☐Pops/clicks when moving ☐Has locked open/shut ☐Causes pain

******I understand that patient names will be posted in our appointment books, on charts, and on schedules posted in treatment areas of the office and that patient privacy will be maintained as much as possible. I also understand that the staff of Sattler Family & Cosmetic Dentistry may take photos of treatment that may be used in educational settings and professional teaching.***

Signed _____ ***Date*** _____

Medical History:

Females only

- ☐ I am pregnant, may be, or am attempting to become so. Today's date: _____
  How many weeks pregnant are you? _____ Physician_____
  **NOTE: Some medications may cause changes in birth control or may affect the unborn baby.*

All Patients

Please check all that you have or have had in the past:

☐ AIDS/HIV positive
☐ Allergies
☐ Alzheimer's
☐ Anemia
☐ Angina
☐ Arthritis/Rhematim
☐ Artificial Heart Valve
☐ Asthma
☐ Autism
☐ Blood Disease
☐ Blood Thinner
☐ Cancer
☐ Chemotherapy
☐ Chest Pains
☐ Diabetes
☐ Dizziness/Fainting
☐ Drug Addiction
☐ Emphysema
☐ Epilepsy
☐ Excessive Bleeding
☐ Gastric Reflux
☐ Glaucoma
☐ Head Injuries
☐ Heart Attack year? _____
☐ Heart Disease
☐ Heart Murmur
☐ Hemophilia
☐ Hepatitis, all types
☐ High Blood Pressure
☐ High Cholestral
☐ Joint Replacement
☐ Kidney Disease
☐ Latex Sensitivity
☐ Liver Disease
☐ Lung Disease
☐ Macular Degeneration
☐ Migraines
☐ Nervous Disorders
☐ Oral Contraception
☐ Organ Transplant
☐ Pace Maker
☐ Pain in Jaw Joints
☐ Parathyroid Disease
☐ Pre-Medication
☐ Previous Biopsies
☐ Psychiatric Care
☐ Rheumatic Fever
☐ Sinus Problems
☐ Sore/Enlarged Lymph Nodes
☐ Stroke year? _____
☐ Thyroid Disease
☐ Tuberculosis
☐ Tumors/Growths
☐ Ulcers
☐ Venereal Disease
☐ Vertigo

Comments or any other illness we should know:

_____

List of Current Medications:

_____

Allergies: Have you had any allergies to any medications? ☐No ☐Yes

☐ Aspirin ☐Penicillin ☐Codeine ☐Local Anesthetic ☐Latex ☐Metals
Explain any past allergies: _____

By signing, I agree that the above information is correct & true.

X_____

Updates to History (Staff use only)

Financial Agreement

Thank you for choosing Sattler Family, Cosmetic, and Implant Dentistry. Our primary mission is to deliver the best and most comprehensive dental care available. We also understand the importance of offering payment options when completing your dental treatment.

Our office accepts the following forms of payment:

Cash, Check, VISA, Discover, AMEX or MasterCard

Convenient payment options are also available through CareCredit*.

Visit CareCredit.com on the web or speak with anyone from our front desk for more information on financing with CareCredit.

P**lease Note:**

• Sattler Family, Cosmetic, and Implant Dentistry requires payment in full at the time of your treatment.

• We can accept payments when prior arrangements are made with our business manager. However, final payment is due at the completion of your treatment.

• For patients with dental insurance- we are happy to work with your carrier to maximize your benefits and can directly bill most carriers for reimbursement for your treatment**

We gladly accept your checks. When you provide us a check as payment, you authorize us to use information from the check to process the payment. You are responsible for returned checks and agree to pay a fee of $20 plus any applicable additional bank fee.

If you have any questions please don't hesitate to ask. We are here to help you arrive at the treatment path that will best suit your needs.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

*** Subject to credit approval**

**** Should we not receive payment from your insurance carrier within 30 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.**

Appointments:

An appointment in our schedule is a bond of trust that we will be here to serve you and you will be present for treatment. We strive to create a schedule that most efficiently provides for the dental needs of all of the patients we serve. We do not "double book" your appointments. Please arrive on-time to your scheduled appointment. Late arrivals cause schedule delays for those patients who arrive promptly at their appointment time.

We respect our patients' time and make every effort to remain on schedule. Some visits are more complicated than initially anticipated, and emergencies may arise that could delay us. If we are significantly delayed; every effort will be made to notify you beforehand so you may choose to come later or reschedule. If you are going to be late, we ask that you please notify us. If you are significantly delayed, your scheduled treatment may be modified or you may be asked to reschedule your appointment.

Cancellations:

Additionally, while we understand that things may come up, it's very important that we receive notice of a change in plans at least 48-hours in advance.

Because of the level of service we provide our patients, your appointment is especially held just for you, so that we have the right amount of time for your procedure at our office. We ask that you make every effort to give us at least a 48-hour notice if you cannot make your scheduled appointment. When patients do not show for their appointment or do not give us adequate cancellation notice, we are not given the opportunity to reschedule that time with another patient who has a true dental need. We reserve the right to charge a $77.00 missed and/or broken appointment fee.

Thank you for understanding the value of our patient care we provide.

Patient Signature

HIPPA Privacy Notice Information

Confidentiality Notice

I, the patient or responsible party, understand all of the information provided to be accurately answered and I understand that it is my responsibility to notify Sattler Family, Cosmetic & Implant Dentistry of changes in any of the above information. I also realize that all of this information that I have provided is confidential and that none of the information here will be released to anyone without permission from the patient. A more complete copy of your privacy rights are available upon request.

Signed_____Date_____

Signed_____

Parent/Legal guardian 's signature if patient is under legal age

Dental Insurance Acknowledgement

I understand that dental insurance is an agreement between myself, the employee, and the insurance company. (Benefits change according to the plan between employee-employer insurance company relationship and Sattler family Cosmetic Dentistry can never be 100% sure of that coverage and/or benefits and are NOT responsible for them. Estimates may be made according to what the insurance representative provides. The patient or responsible party is ultimately responsible for all fees not covered by insurance.

In the case of minors of separated or divorced parents, it is the responsibility of the parent bringing the patient into the office to arrange appointments and keep treatment and all accounts current.

Signed_____Date_____