



SAWTOOTH DENTAL, PLLC

Eric Thomas, DDS • Stephen Dixon, DDS • Brent Sorenson, DDS

Welcome to our practice!

Thank you for giving us the opportunity to serve your dental needs.

PATIENT INFORMATION

Date _____ Home Phone (____) _____ Cell Phone (____) _____

May Sawtooth Dental, PLLC remind you of your appointment via TEXT MESSAGE and E-MAIL ? ☐ YES ☐ NO

Name _____ Preferred Name _____
LAST First Middle Initial

Address _____ Social Security Number _____

City _____ E-MAIL _____

State _____ Zip _____ ☐ Married ☐ Widowed ☐ Single ☐ Minor

Sex ☐ Male ☐ Female Age _____ Birth date: _____ ☐ Separated ☐ Divorced

Patient Employer _____ Spouse Name _____

Patient Employer Phone _____ Spouse Employer _____

Spouse Employer Phone (____) _____

Whom may we thank for referring you? _____

Emergency Contact _____ Phone (____) _____

RESPONSIBLE PARTY & PRIMARY INSURANCE

Person Responsible for the Account _____

LAST First Middle Initial

Relation to Patient _____ Birth date _____ Social Security # _____

Address (if different from patients) _____ Phone Number _____

City _____ State _____ Zip _____ Cell Number (____) _____

Policyholder Employed by _____ Business Phone Number (____) _____

Policyholder Name: _____ Birth date _____ Social Security # _____

Insurance Company _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ADDITIONAL INSURANCE

Is Patient covered by additional insurance? ☐ Yes ☐ No

Policyholder Name _____ Birthdate _____ Relation to Patient _____

Address (if different from patients) _____ Phone # (____) _____

City _____ State _____ Zip _____

Policyholder Employed by _____ Business Phone Number (____) _____

Insurance Company _____

Social Security Number _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

Are you under a physician's care now? ☐ Yes ☐ No _____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No _____

Are you required by your Physician to have antibiotics prior to dental treatment? ☐ Yes ☐ No

Have you ever had a serious head or neck injury? ☐ Yes ☐ No _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ Yes ☐ No

Are you taking any medications, pills or drugs? ☐ Yes ☐ No _____

Do you use Tobacco? ☐ Yes ☐ No

Do you use controlled substances? ☐ Yes ☐ No

Are you Pregnant/Trying to get pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No Are you taking Oral Contraceptives? ☐ Yes ☐ No

Are you allergic to any of the following? ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex

☐ Other – please explain _____

Do you have, or have you had any of the following?

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cortisone Medicine	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hemophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alzheimer's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis A	<input type="checkbox"/> Yes <input type="checkbox"/> No	Recent Weight Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anaphylaxis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Drug Addiction	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis B or C	<input type="checkbox"/> Yes <input type="checkbox"/> No	Renal Dialysis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Easily Winded	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Angina	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis/Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy or Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valve	<input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive Bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hives or Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shingles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joint	<input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive Thirst	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hypoglycemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sickle Cell Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting Spells/Dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Irregular Heartbeat	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Spina Bifida	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Transfusion	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Leukemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach/Intestinal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breathing Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bruise Easily	<input type="checkbox"/> Yes <input type="checkbox"/> No	Genital Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swelling of Limbs	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lung Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hay Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsilitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chest Pains	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Attack/Failure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cold Sores/Fever Blisters	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain in Jaw Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors or Growths	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parathyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Convulsions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Trouble/Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
						Yellow Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No

Are you interested in any cosmetic procedures? ☐ Whitening ☐ Veneers ☐ Clear Braces

Have you ever had any serious illness not listed? ☐ Yes ☐ No If yes: _____

Comments: _____

Date of last dental exam? _____ Primary Purpose for Today's visit? _____

What dental aids do you use? ☐ Floss ☐ Water Pik ☐ Mouth Rinse ☐ Electric Toothbrush

SAWTOOTH DENTAL

AUTHORIZATION & RELEASE

I understand and acknowledge that all questions have been accurately answered and that providing incorrect information can be dangerous to my health.

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered, to my child or me during the period of such dental care and/or healthcare practitioners.

I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

I acknowledge that payment is due at the time of treatment unless other arrangements have been made. I understand that I will be assessed a 22% annual finance charge on any balance over 40 days.

I acknowledge that if I do not give 24 hours notice of a cancellation I will be charged a \$25 no show fee.

I acknowledge that if I have a check returned for non-sufficient funds that I would be charged \$25 for that returned check.

SIGNATURE OF PATIENT, GUARDIAN OR PERSONAL REPRESENTATIVE

DATE

PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement*

I, _____, have received a copy of this office's Notice of Privacy Practices.

SIGNATURE OF PATIENT, GUARDIAN OR PERSONAL REPRESENTATIVE

DATE

FINANCIAL AGREEMENT

We the undersigned, individually and as agent for the patient, understand and agree, jointly and severally, to the following:

1. That if this account is sent to collections, we agree that in addition to any amount left owing to Sawtooth Dental, PLLC we will be responsible for interest at a rate of 22% annually on any past due balance, calculated from the date of service, plus court costs and reasonable attorneys' fees, with or without suit, incurred in collecting any past due balance, and a collection fee if my account is assigned to a collection agency.
2. That we specifically authorize Sawtooth Dental, PLLC or any assignee thereof, to access our credit file should this account become delinquent. We recognize that insurance is a contract between the patient and insurance company, and agree to pay all charges under this agreement regardless of any insurance coverage. This agreement shall apply to any unpaid services owed to Sawtooth Dental, PLLC in writing that is to be revoked. We have either received or refused a copy of this agreement. We agree that no oral agreements have been made and that this agreement cannot be modified orally.
3. That we acknowledge that Sawtooth Dental, PLLC, including its attorneys and assigns, may have a legitimate business purpose in calling me to discuss this account and we expressly consent that we may be contacted at any telephone number, by a live caller, and that we will bear the cost of any charges associated with such a call.
4. That we have read this agreement and understand its terms. A copy or fax of this document shall have the same legal effect as the original.

SIGNATURE OF PATIENT, GUARDIAN OR PERSONAL REPRESENTATIVE

DATE

YOUR RELATIONSHIP TO PATIENT