Basic Information

Name:	Gender:
Preferred name:	DOB:
SSN:	Marital Status:
Referral Source:	Employer:
Referred By:	Occupation:

Contact Information

Mobile Number:	Address:
Home Number:	City:
Email:	State:
	Zip Code:

Emergency Contact

Full Name:	
Phone Number	City:
Relationship	State:

Dental Insurance Information:

**** NOTICE - We are only IN NETWORK with Delta Dental, and Blue Cross Blue Shield.**

Please keep in mind everyone's insurance plans are completely different, and we do our best to have accurate and updated information.

Dental Insurance Company Name:
Policy Holder name and DOB:
Policy holder SSN:
ID Number:
Group Number:
Insurance Company address:

Patient's signature: ____

Date:_________________________

Health History

Patient Name: ____

Are you currently under the care of a physician? If yes, please name and phone number	
Please list any known allergies	
Please list any recent hospitalizations or injuries in the last year.	
Are you currently pregnant or breastfeeding?	
Alcohol or drug use?	
Do you use tobacco products?	
Epinephrine sensitivity? Yes or No	

Medical Conditions

Please list any medications you are currently taking:	
Do you have a history of heart or circulatory conditions?	
Do you have thyroid disease? Hypo or Hyper?	
Lung conditions or breathing conditions?	
Head or neck injuries?	
History of cancer? If yes, please list:	
Radiation or chemo treatments?	
Have you been diagnosed with HIV or Aids? If yes, please specify.	
Have you been diagnosed with HEP A, B or C? If yes, please specify	

Written Financial Policy

Thank you for choosing Sunlight Dental! Our primary mission is to deliver the best and most comprehensive dental care available to you. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options. Please be prepared to make payment at time of service.

Payment Options:

- Cash or Check
- Visa, Mastercard, and Discover cards are all accepted.
- Care Credit

Patient Name (printed) ______________________________________ Date_________________

Patient/Guardian signature ____

Authorization to Disclose Health Information to Family or Other

Patient's Name: ____ Date of Birth: __________________

According to the "Health Insurance Portability and Accountability Act" (HIPAA) (a section of laws enacted by the federal government); you have specific rights concerning the use of individually identifiable health information. Only individuals with a legitimate "need to know" may access, use or disclose patient information. Protected health information may be released to other covered healthcare providers without patient authorization if used for treatment, payment, healthcare operations, or for public good purposes as permitted by state and federal laws. However, any disclosures of protected health information for use outside treatment, payment and/or healthcare operations requires patient authorization. If you would like one of your family members to be able to discuss your care with your providers, you will need to list that person (or persons) on the form.

☐ **I do not authorize Sunlight Dental to disclose health information to others.**

I hereby authorize Sunlight Dental to disclose health information to the following contact(s):

Contact #1
Name: ____ Relationship to me: __________________
Home Phone: ____________________________ Alternate Phone: ________________________________

The information that may be disclosed or discussed may include the following:

- ☐ **Treatment and Progress Notes**
- ☐ **Treatment Plans**
- ☐ **Financial Records**
- ☐ **Other** (please specify) ________________________________

Once your health information has been disclosed, re-disclosure of your health information by the recipient may no longer be protected by law. You may revoke this authorization in writing at any time. Please note that cancellation by telephone must be confirmed in writing. Your revocation will not affect any disclosure made under this authorization prior to your revocation.

I understand that authorizing the disclosure of this dental information is voluntary and I can refuse to sign this authorization. I need not sign this form to ensure treatment. I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

By signing this form, I understand that Sunlight Dental may discuss past, present or future dental care issues with the above-named contacts for a year from today's date.

Signature: ____ **Date:** ____________________

Cancellation and No-Show Policy

When we reserve and set aside time for your appointments to be seen in our office, we really appreciate you keeping them. We require 24 hours of advance notice if you need to change or cancel your appointment with us. If no notice is given 24 hours a fee of $50 will be charged to your account or credit card on file. We always understand that circumstances arise, and we will always do our best to be accommodating as we know you will be accommodating with us.

By signing below, you indicate that you understand and agree to the above policy.

Print Patient Name: _________________________________

Patient Signature: __________________________________ Date: ______________