Sultan Dental Center

Patient Name: _____ Preferred Name: _____Date of Birth: _____

Home Address: _____ City & Zip _____

Home Phone: _____Cell Phone: _____ Email: _____

Authorization to leave personal health information by alternative means: Circle Applicable

Home Phone Cell Phone Email with Family/Spouse: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Who may we thank for referring you? _____

Responsible Party (Check if same as patient) ☐ Name: _____ Relationship: _____

Date of Birth: _____ Preferred Phone #: _____ Email: _____

Occupation: _____

Primary Dental Insurance Co: _____ Employer: _____

Subscriber Name: _____ Subscriber Date of Birth: _____

Alt ID or S.S. # _____ Group #: _____ Relationship to patient: _____

Secondary Dental Insurance Co: _____ Employer: _____

Subscriber Name: _____ Subscriber Date of Birth: _____

Alt ID or S.S. #: _____ Group: _____ Relationship to Subscriber: _____

Insurance Release: To the extent permitted by law, I authorize release of any information release of any information relating to all claim benefits submitted on behalf of myself and/or my dependents. I assign and authorize payment of dental benefits otherwise payable to me, directly to Sultan Dental Center. A photocopy of this document may act as authorization.

X_____ x_____x_____

Printed name (Responsible Party) Signed Name (Responsible Party) Date

Permission for appointment confirmation: We understand your time is valuable and it is sometimes challenging to receive our calls. Do you consent to reminders being sent via text, email, voicemail, and mail?

☐ Yes ☐ No

Privacy Policy: The Health Insurance Portability & Accountability Act 1996 (HIPPA) requires that all medical records and otherwise are kept strictly confidential and limits their use. I acknowledge that I have been offered a copy of Sultan Dental Center's Statement of Privacy Practices.

X_____ X_____X_____

Printed Name (Responsible Party) Signed Name (Responsible Party) Date

Sultan Dental Center

Welcome to Sultan Dental Center. We are committed to providing you, our patient, with the highest quality dental care through education, prevention, and treatment in a pleasant and comfortable environment. Good communication is key to quality care! We invite you to read the following information and familiarize yourself with our financial agreement.

Payment at time of service

We require payment at the time of service. For your convenience we accept Visa, Mastercard, American Express, personal checks, and cash. An interest free payment option is available through CareCredit- a third party lending company. We are happy to assist you with any of these options.

Third Party Payor

Full payment of your account is your responsibility. We will file your insurance claims on your behalf as a courtesy to you. Having dental insurance is not a guarantee of third-party payment. Your insurance coverage is a contract that is set up between you and the insurance company. We can only guarantee our fees and estimate your insurance benefits. We ask that you review all estimates and encourage you to contact your insurance company with questions. If you have dental insurance, we will ask you to make your copayment at the time of service. Your copayment is the dollar amount that is estimated as not payable by your insurance plan. If payment for completed treatment is not paid by your dental insurance company within 90 days, we reserve the right to request payment in full for the balance owning on your account. When your insurance carrier pays, we will gladly refund the difference to you.

Returned Payment Fee

All patients paying for balances via personal or electronic payment will be responsible for an additional fee of $35 on each check returned from the bank for insufficient funds as well as a stop payment issued on a check payment or credit card.

Broken Appointment Fee

We request a notice of 48 hour to change an appointment. A charge may be applied to your account in the amount of $50 per appointment hour, if an appointment is changed, canceled, or missed with less than 48 hours' notice.

I hereby acknowledge receipt of the above information and understand that I am completely responsible for the total payment of all procedures performed.

X_____x_____x_____

Printed Name (Responsible Party) Signature (Responsible Party) Date

Sultan Dental Center

Patient Name: _____ Date of Birth: _____

Primary Care Dr: _____ Phone #: _____

Do you have or have you had any of the following:

- ☐ Heart Condition/Disease
- ☐ Heart Valve Replacement
  - Date: _____
- ☐ Pace Maker
- ☐ Defibrillator
- ☐ High Blood/Low Blood Pressure (Circle One)
- ☐ Postural Hypotension/Vertigo
- ☐ Stroke
- ☐ Epilepsy/Seizure (circle one)
- ☐ Alzheimer's/Dementia
- ☐ Chemical Dependency
- ☐ Psychiatric Care
- ☐ Sinus Problems
- ☐ Difficulty breathing through nose
- ☐ Respiratory Disease
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Thyroid Disease
- ☐ Diabetes 1 or 2 (circle)
- ☐ Stomach or Intestinal Ulcers
- ☐ Cancer
- ☐ Chemotherapy
- ☐ HIV/AIDS
- ☐ Other Bloodborne Pathogens
- ☐ Anemia
- ☐ Blood Thinners
- ☐ Blood Disorders
- ☐ Circulatory Problems
- ☐ Arthritis
- ☐ Head/Neck Injury
- ☐ Hip/Knee replacement
  - Date: _____
- ☐ Tobacco/Vape
- ☐ Other: _____

Are you taking any MEDICATIONS or herbal supplements at this time? Please list all,

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Do you have any allergies? If so, what are the symptoms of those allergies?

Dental Care (Check all that apply)

- ☐ Are you unhappy with your smile?
- ☐ Are you apprehensive about dental treatment?
- ☐ Do you prefer nitrous oxide?
- ☐ Do you gag easily?
- ☐ Are you interested in teeth whitening?
- ☐ Do your gums bleed easily?
- ☐ Do you have difficulty chewing your food?
- ☐ Are your teeth sensitive?
- ☐ Do you clench or grind your teeth?
- ☐ Temporomandibular disorder (TMD)

Explanation of Recent Operations/ Hospitalizations? _____

Have you ever taken any biphosphate medication (Ex: Fosamax, Boniva, Actonel, ETC.) _____

Are you under the care of a Physician? If so, for what? _____

Women, please circle if any of the following apply: Contraceptives Hormones Nursing Pregnant Trying

If pregnant, when are you due: _____

X_____ x_____x_____

Printed name of responsible party Signature of responsible party Date