Sutton Dental Arts, P.C.

1729 W. Harvard Ave. Suite 5, Roseburg, OR 97471

We are pleased to welcome you to our practice. Please take a few minutes to fill out the form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Patients Name_____ Preferred Name_____

Mailing Address_____ City & Zip Code_____

Date of Birth_____ SS#_____Sex____ Marital Status_____

Employer_____ Position_____ Work Phone_____

Home Phone_____ Cell Phone_____ E-Mail_____

Please Circle Preferred Method of Contact: Home Phone Cell Phone Work Phone Email Text Message

Emergency Contact (Not living in your household)_____ Daytime Phone_____

Whom may we thank for referring you to our office?_____

Person Responsible for Account (If different then person listed above)

Name_____

Mailing Address_____ City & Zip Code_____

Date of Birth_____ SS#_____Sex_____ Marital Status_____

Employer_____ Position_____ Work Phone_____

Home Phone_____ Cell Phone_____ E-Mail_____

Own_____ Rent_____ How Long_____ Landlord & Phone #_____

Spouse's Name_____ Date of Birth_____ SS#_____

Primary Insurance

Subscriber's Name_____ Subscriber's ID#_____

Insurance Co. Name_____ Group #_____ Phone #_____

Secondary Insurance

Subscriber's Name_____ Subscriber's ID#_____

Insurance Co. Name_____ Group #_____ Phone #_____

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS & BENEFITS UNDER THIS POLICY.

I hereby instruct and direct my insurance company/s to pay by check made out and mailed to Sutton Dental Arts, P.C., 1729 W. Harvard Ave. Suite 5, Roseburg, Oregon 97471 for any professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy for payment toward the total charge for the professional services rendered. If my current policy prohibits direct payment to the Doctor or Sutton Dental Arts, P.C, I also instruct and direct you to make out the check to me and mail to the practice address; 1729 W. Harvard Ave. Suite 5, Roseburg, Oregon 97471. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, and balance of said professional service charges over and above this insurance payment. A photocopy of this assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. I authorize the Doctor to initiate a complaint to the insurance Commissioner for any reason on my behalf.

_____ _____

Patient/Legal Guardian Guarantor Signature **Date**

Sutton Dental Arts, P.C.
Health History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Your dentist is legally obligated to ask the following questions; thank you for answering them.

***Patient Name*_____ *Date of Birth* _____ *Primary Care Provider*_____**

1. Reason for today's office visit _____
2. Have there been *any changes in your general health in the past year*? Yes No
3. Are you under the care of a *physician*? Yes No
   If so, what are you being treated for? _____
4. Have you had any *illness, surgery or been hospitalized in the past 5 years*? Yes No
   If so, please describe where and when: _____
5. Do you have an *artificial joint/implant*? Yes No
   If so, please describe and when: _____
6. Have you had a heart valve replacement or vascular graft? Yes No
7. Has a physician/dentist recommend taking *antibiotics prior to dental treatment*? Yes No
8. ***For Women***: Are you *pregnant or possibly pregnant*? Yes No
   If so, what is your estimated due date (EDD)? _____

Please Mark any of the following Medical Conditions below if **have had** or **currently have** any of the following:

Had or Currently Have	Yes	No	Notes	*Had or Currently Have*	Yes	No	Notes
Abnormal Bleeding				Hay Fever/Sinus			
Alcohol Abuse				Head Injury			
Allergy to Latex				Heart Attack			
Anemia				Heart Murmur			
Anxiety/Depression				Heart Surgery			
Arthritis				High Blood Pressure			
Artificial Joint				Hormonal Therapy			
Artificial Valve				Human Papilloma Virus (HPV)			
Asthma				Irregular Pulse			
Atrial Fibrillation				Kidney Trouble			
Autoimmune Disease				Liver Disease			
Bleeding Disorder				Low Blood Pressure			
Bone Disorder				Lung Disease			
Bruise Easily				Medication Allergy			
Caner, Chemotherapy/Radiation				Migraines			
Cardiac Pacemaker				Neurological Condition			
Cardiovascular Disease				Nicotine Use			
Chest Pain/Angina				Non-Ambulatory			
Chronic Fatigue				On Dialysis			
Chronic Pain				Other Major Surgery			
Congestive Heart Failure				Psychiatric Disorder			
Congenital Disease				Respiratory Problems			
Delayed Healing				Rheumatic Fever			
Diabetes				Rheumatic Heart Disease			
Difficulty Hearing				Seizures/Epilepsy			
Difficulty Sleeping				Sleep Apnea/CPAP			
Drug Addiction				Sexually Transmitted Disease			
Emphysema/COPD				Stroke			
Eye Disease/Glaucoma				Thyroid Condition			
Fainting/Dizziness				Tuberculosis			
Gastrointestinal Condition				Ulcers/Acid Reflux			

9. Do you have any disease, condition, or handicap not listed above that you should mention? Yes No
If yes, please list:_____

Drugs and Medications

1. Are you allergic to any medications Yes No
   If so, please list and include the reaction type (i.e. stop breathing, rash)_____
_____
_____

2. Are you taking any prescriptions or over the counter medications? Yes No
   If yes, please list the name and dosage below:

Prescription Name	*Dose (i.e. mg)*	*Frequency (i.e. one time a day)*

Dental Health History

1. When was your last dental visit and with whom? _____
2. What was done at your last dental visit? _____
3. When is the last time you had a dental cleaning? _____
4. Are you presently having any dental pain? Yes No
5. Have you ever experienced any unfavorable reaction to dentistry? Yes No
   If so, please explain _____
6. Have your wisdom teeth been removed? Yes No
7. Have you ever lost or chipped any teeth? Yes No
   If so, please explain _____
8. Have you had any trauma to your head, neck, face or teeth? Yes No
   If so, please explain _____
9. Is any part of your mouth sensitive to temperature? Yes No
   If so, please explain _____
10. Is any part of your mouth sensitive to pressure? Yes No
    If so, please explain _____
11. Does your jaw or teeth ever feel uncomfortable when you awake in the morning? Yes No
12. Do you have "Tension" Headaches? Yes No
13. Are you aware of your jaw clicking or popping? Yes No
14. Are you aware of clenching or grinding you teeth? Yes No
15. Do have any type of thumb, tongue habit or chewing ice/fingernails/pens, etc.? Yes No
    If so, please explain_____
16. Are you a mouth breather? Yes No
17. Have you ever experienced chronic ringing in your ears? Yes No
18. Have you had Orthodontic Treatment? Yes No
    If so, please explain _____
19. How many times a day do you brush? _____
20. How many times a day do you floss? _____
21. Do your gums bleed when you brush? _____
22. Do you whiten your teeth? Yes No

Patient Signature _____ Date _____

Sutton Dental Arts, P.C.

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Financial Agreement

Please read entire form carefully, then sign and date the bottom.
The following defines the financial policies of this practice.

Payment is due at the time services are rendered

All co-pay and past due balances are expected at the time of service, unless a prior agreement has been made with our billing department. The front desk staff will estimate the amount you owe for procedures the doctor or hygienist has completed or those procedures which are in progress. Remember, this is only an estimate. The actual out-of-pocket expense may be less than or greater than the amount estimated and collected. You may be reimbursed or apply the excess to another date of service if we have collected too much.

Some insurance plans require the patient to pay only a percentage or co-payment directly to our office. Some plans require the patient to pay the entire amount due for that visit. Some plans will reimburse the covered amount only to the patient. We will work with your plan, and submit the form necessary to receive the reimbursement as a service to our patients.

Insurance Coverage

While filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date services are rendered.

Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract, although we may be a participating provider for the network. That means simply that, when payments are received, we will make contractual adjustments as outlined in our participation agreement with that plan or network. It is the patient's responsibility to understand the provisions of their plan. We cannot guarantee payments of all claims. If your insurance pays only a portion of your bill or rejects your claim, any contact or an explanation should be made to you in writing from your insurance company. Reduction or rejection of your claim by your insurance company does not relieve you of your financial obligation.

Major Work

Patients receiving major work (crowns, bridges, implants, dentures) or whitening kits are required to pay fifty percent of their portions the first day of the procedure to cover basic costs (i.e. Lab and Parts Fees). The remaining fees must be paid by day of delivery.

Cancellation Policy

- We ask that you allow plenty of time to get to our office for your appointment. **If you are late more than 15 minutes, you may be asked to reschedule**
- Three (3) appointment cancelations may result in a dismissal from our office.
- 48-hour reschedule notice is required. We understand life happens and appointments need to be changed.
- Cancellation less than 24 hours or no show for dental treatment appointments will result in a $200.00 cancellation fee.
- Cancellation less than 24 hours or no show for Hygiene appointments will result in a $60.00 cancellation fee.

Finance Charges

Payment is expected at time of services rendered. Any outstanding balance which is overdue by more than 90 days will be charged 18% APR. We accept cash, check, Visa, MasterCard and Discover. A payment plan is available through Care Credit. A short application will need to be completed and approved before charges can be incurred. If you are interested, please ask any of the staff members for an application.

Returned Checks

There will be a returned check fee of $35. This fee may increase depending on the bank's charges. This fee will be added to the outstanding balance and may incur finance charges if not paid within the 30 day grace period.

_____ _____

Patient/Legal Guardian Guarantor Signature **Date**

Sutton Dental Arts, P.C.

1729 W. Harvard Ave. Suite 5, Roseburg, OR 97471 (541) 672-4971

Acknowledgement Of Privacy Practices And Permission To Disclose Health Information

We may disclose your health information to a family member, personal representative, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so. Please list the individuals below who have your permission to share your health information.

Name	*Relationship to patient*	*Conditions of access*

I have received a copy of this Offices Notice of Privacy Practices

_____

Please Print Name

_____

Signature Date

_____

Or Signature of Legal Representative Date

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

□ Individual refused to sign

□ Communication barriers prohibited obtaining the acknowledgment

□ An emergency situation prevent us from obtaining acknowledgment

□ Other (Please Specify)

Sutton Dental Arts, P.C.
1729 W. Harvard Ave. Suite 5, Roseburg, OR 97471
Office: (541) 672-4971 Fax: (541) 673-7200
Email: info@suttondentalarts.com

Authorization to Release Dental Records

I hereby authorize and request Dr. _____ to release all x-rays within the last 5 years and any pertinent chart notes. Please email to info@suttondentalarts.com if possible, or mail to the address above at Sutton Dental Arts, P.C.

Patient: _____ Date of Birth: _____
Additional Family Members:

_____
_____
_____
_____
_____
_____
_____

I release Sutton Dental Arts, P.C. from my liability related to disclosure of confidential and privileged information.

_____

Patient/Legal Guardian Guarantor Signature **Date**

Sutton Dental Arts, P.C.

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Warranty Policy 2020

We are proud to provide our patients with a warranty on all of the procedures that we recommend. Any treatment that is feasible but not recommended by the doctor will be stated as excluded from the warranty coverage.

Under this policy, Sutton Dental Arts, PC, will repair, replace, or give equivalent credit for any defect in materials or workmanship, as long as the following conditions are met.

- The patient maintains recommended regular cleaning and check-up appointments not to exceed a 1 year interval.
- The defect is not a direct result of an accident, injury, or behaviors outside of normal use.
- The patient follows all required post-care orders, such as the regular use of retainers or night guards.
- The defect is reported to Sutton Dental Arts within 24 hours of the problem being discovered.

Procedures Covered Under Warranty

Crowns – 5 years from seat date.
Dentures/Partials – 1 year from delivery date if the denture or partial was made in our office.
Fillings – 5 years from the placement date. Fillings placed on the incisal or chewing edge are excluded from this warranty. Fillings placed in lieu of a recommended crown will have no warranty.
Retainers – 3 years from placement date for a bonded lingual retainer and 1 year for a removable retainer with normal wear and tear.
Sealants – 3 years from placement date.

Patient Name (printed) _____

Patient/Parent Signature _____

Date _____