Sinkule Family Dental

Thank you for choosing Sinkule Family Dentistry to assist you with your dental needs.
Please fill out the information below and don't forget to provide your signature at the end.

Patient's name _____ Date of Birth _____
If minor, name of legal guardian_____
Home phone _____ Mobile phone _____ Work phone_____
Email address:_____
Mailing address _____ City _____
State _____ Zip_____
Employer _____
Whom may we thank for referring you to our office? _____
Emergency contact Name_____ Phone#_____

INSURANCE INFORMATION: Not covered by dental insurance☐
Your SS# : _____ or Member ID#_____
Dental Insurance Co._____ Group number_____
Claims Address_____
Covered by spouse's insurance? ☐Yes ☐No Spouse's Name _____
Spouse's dental insurance company _____ Group number _____
Spouse's birthday _____ SS# or Member ID# _____

MEDICAL HEALTH HISTORY

Do you have, or have you had any of the following?
(Please check any that apply)
Are you required to Pre medicate before any Dental treatment? ☐ yes☐ no
☐Blood Problems (Anemia)
☐Blood transfusion
☐Heart murmur, mitral valve prolapse, heart defect, Pacemaker
☐Stroke
☐Bone or joint problems
☐Artificial joint or valves
☐High or low blood pressure (circle one)
☐Tuberculosis or other lung problems
☐Kidney disease
☐Hepatitis, jaundice or other liver disease
☐Diabetes TYPE 1 or TYPE 2
☐Epilepsy or Neurological disorders
☐Thyroid problems
☐Arthritis
☐Herpes or cold sores
☐AIDS or HIV positive
☐Cancer/Tumor
☐Abnormal bleeding after any surgery (heavy bleeder)
☐Hay fever or sinus trouble, Allergies
☐Asthma

Are you allergic to, or have you reacted adversely to any of the following?
☐Latex
☐Penicillin or other antibiotics
☐Local anesthetics
☐Codeine or other narcotics
☐Aspirin
Other:_____

Are you taking any of the following?
☐Aspirin
☐Anticoagulants (blood thinners e.g. Coumadin)
☐Antibiotics or sulfa drugs
☐High blood pressure medicine
☐Antidepressants or tranquilizers
☐Insulin other diabetes drugs
☐Nitroglycerin
☐Cortisone or other steroids
☐Osteoporosis (bone density) medicine
☐Natural supplements
Other:_____

Women:
Are your pregnant or plan to become pregnant ☐ yes☐ no
Taking hormones or contraceptives ☐ yes☐ no

Do you smoke, vape or use tobacco?☐ yes☐ no

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Not all services are covered by insurance. In the event your insurance plan determines a service to not be covered, you will be responsible for the complete charge. Our staff cannot guarantee your eligibility and coverage. Insurance rules and limits vary with insurance plans. If your insurance plan denies a service, you will be responsible for the charge. We do not base your treatment plan on what your insurance plan covers or does not cover. Patients are responsible for payment, co-payments, and deductibles at time of service. Any collection fees, court costs, reasonable attorney fees, or returned check fees are the responsibility of the adult person (s) named on the account. Monthly service fee of 1.5% per month or 18% per annual will be assessed on all past due accounts. Any check returned from the bank will result in a minimum $30.00 charge.

The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my own health. I authorize the dentist to release any information including the diagnosis and records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or healthcare practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.

A $30 fee will be charged for all appointment cancellations made without 24 hour notice.

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment. I therefore authorize the dentist to contact my physician.

Physician's Name: _____ Phone number:_____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

I hereby assign to Sinkule Dental any and all dental benefits otherwise payable to me for oral health treatment rendered by Sinkule Dental as described in the attached claim form. I acknowledge that I am still responsible for paying the above-referenced dentist to the extent the relevant insurer or payer does not pay the dentist in full.

1. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

2. I agree to be responsible for all costs and fees that my insurance carrier does not pay.

3. I consent to receiving x-rays and an oral examination.

4. I have received a copy of the "Notice of Privacy Practices."

Patient or Guardian Signature_____ Date _____