

CONFIDENTIAL INFO. & DENTAL HISTORY

PATIENT INFORMATION

DATE: _____

Name: _____ Birthday: _____ M__F__
Address: _____ City: _____ State: _____ Zip: _____
Home #: _____ Cell: _____ Work: _____
Social Security #: _____ Email: _____
Employer: _____ Occupation: _____

Marital Status: Single__ Married__ Divorced__ Separated__ Widowed__
Spouse, partner or parent name: _____
Who do we contact in case of emergency? _____ Phone: _____
How did you hear about our practice? _____

DENTAL INSURANCE:

**** Please allow front staff to copy your insurance card & ID.****

Policy holders name: _____ Birth-date: _____
Is your Dental Insurance through your workplace? YES _____ NO _____
Employer: _____
Insurance company: _____ Phone: _____
Insurance address: _____
Member ID: _____ Group # _____

DENTAL HISTORY

Reason for today's visit: _____
Date of last cleaning: _____ Date of last dental xrays: _____
Former dentist name: _____
Are you happy with the appearance of your teeth? _____
Have you ever been told you have periodontal disease? _____
Have you ever been told you need a PRE-MED before dental visits? _____

R. Lee Saunders, D.D.S Medical History

Patient Name:

Birth Date:

Date Created:

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, c

Are you under a physician's care now? Yes No If yes

Have you ever been hospitalized or had a major operation? Yes No If yes

Are you taking any medications, pills, or drugs? Yes No If yes

Do you take, or have you taken, Phen-Fen or Redux? Yes No If yes

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

Are you currently taking blood thinners? If yes, which one? Yes No

Women: Are you...

Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic
 Metal Latex Sulfa Drugs Local Anesthetics

Other? If yes

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

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

Have you ever had any serious illness not listed above? Yes No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date: _____

You may refuse to sign this acknowledgment

Dr. R. Lee Saunders, D.D.S.

This notice describes how information about you may be used and disclosed. This notice also describes how you can gain access to this information. Please review this document carefully.

- Dr. R. Lee Saunders, D.D.S. and attending dentists may use and disclose protected health information for treatment, payment, and healthcare operations.
 1. Examples of these include but are not limited to: Payments to insurance companies, for claims including coordination of benefits with other insurers and collection agencies. Healthcare operations for internal quality control and assurance including auditing of records.
- Dr. R. Lee Saunders, D.D.S. and attending dentists are permitted or required to use or disclose protected health information without the individuals written consent or authorization in certain circumstances.
 1. Dr. R. Lee Saunders, D.D.S. and attending dentists will not make any other use or disclose of a patient's protected health information without the individuals written consent. Authorization may be revoked at any time and it must be written.
- Dr. R. Lee Saunders, D.D.S., attending dentists, and staff may at times contact patients to provide appointment reminders, information regarding treatment alternatives, and any services that benefit the individual patient.
- Dr. R. Lee Saunders, D.D.S. and attending dentists reserve the right to change the terms of its notice and make new notice provisions. If provisions are made, each patient will be provided a new copy of the updated Notice of Privacy Practices at their next visit. An updated notice may also be mailed to the patients last known address if there is a need to use or disclose any protected health information of the patient. Any patient can obtain a copy of this notice at any time in our office.
- Any person or patient may file a complaint to the Practice and to the Secretary of Health and Human Services if they believe their privacy rights have been violated.
- It is Dr. R. Lee Saunders, D.D.S.'s policy that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance of the privacy standards.

I, _____ have read and understand this office's Notice of Privacy Practices.

Signature

Date

General Informed Consent

When it comes to dental procedures, Dr. Saunders would like all of his patients to know the risks and benefits.

1. **Drugs and medication:** Antibiotics, analgesics, and other medications can cause severe allergic reactions. It is imperative that you carefully review and thoroughly fill out your medical history to avoid any complications or allergic reactions. Risk of local anesthesia may include temporary or permanent numbness or bruising.
2. **Changes to treatment plans:** During treatment, necessary changes may have to be added due to conditions discovered while working on the teeth. The most common change being root canal therapy (RCT) following routine procedures.
3. **Removal of teeth (Extractions):** Alternatives will be explained to you such as root canal therapy (RCT), crowns, and periodontal surgery before an extraction would be considered unless treatment is deemed necessary. Some of the risks in the extraction of teeth are pain, swelling, infection, dry socket (alveolar osteitis), loss of feeling of the lips, tongue, and surrounding tissue (paresthesia). Some of these risks can last for an indefinite period of time to a limited time such as hours or days.
4. **Crowns and Bridges:** Some times it is not possible to match the color of natural teeth exactly with artificial teeth. Prior to the permanent crown(s) or bridge(s) are placed, a temporary one will be made. Temporary crowns and bridges may easily come off. Patients will need to be careful to ensure that they are kept on until the permanent crown or bridge is delivered. The final opportunity to make any changes to a new crown or bridge including the shape, fit, size, and color must be done at the crown preparation appointment.
5. **Dentures and Partials:** They are constructed of plastic, metal, and or porcelain. Some problems when wearing either of these appliances include but are not limited to: looseness, soreness, and possible breakage. Most partials require relining three- twelve months after the initial placement. If relining is needed, the cost for this procedure is not included in the initial fee.
6. **Endodontic Treatment (Root Canal/ RCT):** There is no guarantee that root canal treatment will save the tooth. Complications can occur from the treatment after the tooth has had therapy.
7. **Periodontal Loss (Bone Loss):** This is a serious condition causing gum and bone infection or loss possibly leading to the loss of teeth. Alternative treatment will be explained such as gum surgery (tissue grafting), deep scaling with root planing (SRP), and or tooth extraction(s).
8. **Implants:** This is the best long term tooth replacement option. Implants are more definitive alternative to dentures, bridges, or partials. This option involves an oral surgeon which their fees are separate than out office's fees. Implants involve several steps and can last from 2-6 months before treatment is complete. When crowns are placed, the color may not match perfectly with natural teeth.
9. **Sealants:** Sealants form a hard shield that keeps food and bacteria from getting into the grooves and pit of molars and premolars causing decay. There is no guarantee that a sealant will prevent all cavities. Sealants occasionally need to be replaced since they do not last a lifetime. Our office will warranty sealants for 2 years after they are placed, as long as the patient is seen twice a year for their prophylaxis visits.
10. **Sedative Fillings:** These fillings are temporary. They are placed if the caries is deep or near nerve exposure. If the tooth becomes symptomatic after 4-6 weeks, it is likely that the tooth will need a root canal or extraction. If the tooth is asymptomatic after 4-6 weeks, then the root has not been exposed. The sedative filling allows the tooth to lay down reparative dentin and allows the dentist to remove the decay and restore the tooth.

**** Treatment risk:** I understand that any time a restoration is performed, there is a possibility of trauma to the nerve of the tooth. This could result in varying degrees of sensitivity and complications that include but are not limited to: hot and or cold sensitivity, biting sensitivity, abscess, and pulp necrosis. Most symptoms resolve as the nerve heals. Complications may arise resulting in additional treatment. Extra treatment may include one or more bite adjustments, replacement of the restoration due to an open margin, root canal treatment, or extraction.

I have carefully read informed consent and fully understand all risks as it relates to my case.

Signature

Date

Office Payment Policies

Dr. R. Lee Saunders, D.D.S.

3200 Waterlick Rd Lynchburg, VA 24502

Phone (434) 239-8028

Fax (434) 239-0045

info@saundersfamilydentistry.com

Full payment is required when services are rendered. If your dental insurance has been verified, the deductible and amount **not** covered by insurance is due when services are rendered.

- Our office requires payment in full for crowns, bridges, root canals, and dentures **BEFORE** treatment can begin.
- A 2% (\$1.00 minimum) finance charge will be applied if payment is not received before second billing.
- If you have confirmed your appointment and miss it or no show to your appointment, a \$75 missed appointment fee will be applied.
- There will be a \$50 charge for returned checks.

All accounts that are past due will be sent to collections unless prior arrangements have been made. The patient/ responsible party will be liable for a 33.7% collection fee as well as any additional charges incurred as a result to collect this debt. These charges include, but are not limited to the following: interest charges, attorney's fees, court costs, etc.

I understand and agree to these policies. I understand and agree that I am solely responsible for the fees that are incurred for services rendered for myself and/ or any immediate family.

Signature

Date

SAUNDERS FAMILY DENTISTRY

3200 Waterlick Road
Lynchburg, Va 24502
434-239-8028

Appointment Cancellation
No Show Policy
Change of Insurance

We would like to thank you for being a patient in our office and hope you understand our office policies are designed to help provide the best care possible for our patients and to ensure time is available for every needed appointment.

Appointment Cancellations:

We understand situations occur and emergencies happen, we kindly ask you provide the office with at least 24 hours notice. This courtesy allows us time to reschedule a needed appointment for both you and other patients.

Late Cancellations:

Calling 1-2 hours before your **confirmed** appointment does not give staff time to call patients who are on the cancellation list waiting for an open appointment. Please understand someone else who could have been seen in your place is delayed unnecessarily.

No Show Policy:

Any appointment that a patient confirms and does not show up to without a courtesy call will be billed for a missed appointment.

Change Of Insurance:

As always we are here to help our patients with any concerns or questions regarding your insurance policy but it is ultimately the patients responsibility to make sure their insurance information is up to date. Please provide us with any new insurance information prior to your scheduled appointment. Failure to do so may result in denied claims or charges for a same day canceled appointment due to insurance changes.

As always, we strive to do all we can for our patients and kindly ask our patients to respectfully give us the appropriate notice when an appointment needs to be changed, failure to do so will result in a **\$75.00** charge. Thank you for your cooperation and understanding.

Sincerely,

Dr Lee Saunders & Dr Laura Saunders