Sunrise Dental Linda Jacob, DDS
1150 N Watters Rd, #104, Allen TX 75013. Ph: 972-908-3773 Fax: 972-908-3776 Email: info@sunrisedentalallen.com

Date: _____

Patient Information:

Last Name: _____ First: _____ Middle: _____
Date of Birth: _____ Age: _____ Gender: M / F Marital Status: _____
Home Phone: _____ Alternate Number: _____
Address: _____
City: _____ State: _____ Zip: _____
Social Security number: _____-_____-_____
Email: _____
Communication preference: Phone / Postcard / Email /Text (Pl circle one)

Responsible Party Information: (Parent/Guardian Information if patient is a minor)

Last Name: _____ First: _____ Middle: _____
Date of Birth: _____ Age: _____ Gender: M / F Marital Status: _____
Home Phone: _____ Alternative Number: _____
Address: _____
City: _____ State: _____ Zip: _____
Social Security number: _____-_____-_____
Driver License Number: _____
Relationship to Patient: _____
Employer: _____Occupation: _____No. of Years Employed_____
Name/Address/phone No. of Nearest relative not living with you: _____
_____

How did you hear about us? Please check below:

__ Sign ___Mail Coupon ____ Friend/Relative ____ Employer ____ Insurance Provider List
__Employee ___ Health fairs/ Screenings ___ News Paper __Yellow Pages __ Radio Ad
_____Which Station? _____ Bill Board Other:_____
Reason for Todays dental Visit_____
Date of last dental visit_____ Reason_____
Previous Dental Treatments: _____
_____
Have you had an experience in a dental office that you would like to tell us about? **YES /NO**
_____
_____

Are you apprehensive about dental treatment? **YES / NO**
Are your teeth sensitive to hot, cold, sweets, pressure? **YES / NO**
Do your gums bleed, feel tender or irritated? **YES/ NO**
Do you have discolored teeth that bother you? **YES/ NO**
Are you unhappy with the appearance of your teeth? **YES/ NO**

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Medical History:

Are you under the care of a physician(s)? **YES/ NO**

If so, what is the condition being treated? _____

The name & phone number of my physician(s): _____

Please list **ANY** medications you currently take: _____

_____

Have you had **ANY** major surgeries? (ex.: Joint Replacement/ Heart Surgery) **YES/NO**

If yes, please list the surgery and date: _____

If female, are you pregnant? **YES/ NO**

If yes, how far along? _____

Mark any of the following which you have present or had:

__Heart Disease __Heart Pacemaker __Ulcers __Thyroid Disease __Glaucoma
__High Blood Pressure __Diabetes __Emphysema __Chemo (Cancer, Leukemia)
__Pain in Jaw Joints __Blood Disease __ Scarlet Fever __Tuberculosis
__Arthritis __HIV+ __Rheumatic Fever __Anemia __ Asthma __ Rheumatism
__ Hepatitis __ Heart Murmur __Kidney Trouble __Ebola __Cortisone Medicine
__ Hemophilia __Venereal Disease __Epilepsy or Seizures __ Nervousness
__Hay Fever __Other:_____ _____

Mark any of the following medications you are allergic to:

__ Local Anesthetics __ Penicillin or other Antibiotic __ Sulfa Drugs __Aspirin
__Codeine or other narcotics __ Barbiturates, Sedatives, or sleeping pills __Iodine
__Other_____

To the best of my knowledge, all of the preceding answers are true and correct. If ever I have any change in my health, or if any medicines change I will inform my dentist at the next appointment.

_____ _____

Date Signature of Patient/ Parent/ Guardian

----------Office use only----------

Medical History Updated:

Dr._____ Date: _____

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Office Consent for Services

(Please read, initial and sign at the bottom)

_____As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement for patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

_____All emergency dental services, or any dental services performed without financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

_____Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms to assist in making collections for insurance companies and will credit any collections to the patients account. **However this dental office cannot render services on the assumption that our charges will be paid by an insurance company**.

_____I understand that, **Co-pay and deductible are ESTIMATES ONLY, based on available information from insurance companies in-network or out of network. I understand that any unpaid balance from insurance is patient's or responsible individual's obligation. Any unpaid balances are subject to collection proceedings, if not paid in full. In the circumstance where patients pay more than the network fee(for in-network covered services only) or office fee(Dentist customary fee for non-covered services and out of network fees) based on insurance estimates, refunds will be issued within 60 days of settlement of all claims submitted on behalf of patients.**

_____A service charge of 1% per month (12% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

_____I understand that any fee estimate for this dental care can only be valid for a period of six months from the date of the patient's examination.

_____In consideration for the professional services rendered to me by this practice, I agree to pay the charges for services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges or services shall be as billed unless objected to, by me, in writing, within the time of payment is due. I further agree that a waiver of any breach of anytime or condition hereunder shall not constitute a waiver of any further term or condition, and I further agree to pay all cost and reasonable attorney's fees if suit be instituted hereunder.

_____I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

_____I understand that any photography without consent is against HIPPA regulations and our office policy does not allow any videography.

_____I have read the above conditions of treatment and payments and agree to their content.

Relationship to Patient: _____

Signature: _____

Name :_____ Date: _____

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Appointment Cancellation Policy

We strive to render excellent dental care to you and the rest of our patients. In an attempt to be consistent with this, we have an **Appointment Cancellation Policy** that allows us to schedule appointments for all patients. When an appointment is scheduled, that time has been set aside for you and when it is missed, that time cannot be used to treat another patient.

Our policy is as follows:
If your appointment is not confirmed by **12PM the day prior** to your appointment, your appointment will be canceled and you can call the office at your earliest convenience to reschedule.

We require that you give our office **24 hours'** notice in the event that you need to reschedule your appointment. This allows for other patients to be scheduled into that appointment. If you miss an appointment without contacting our office within the required time, this is considered a missed appointment. A fee of $50.00 will be charged to you; this fee cannot be billed to your insurance company and will be your direct responsibility. No future appointments can be scheduled nor can records be transferred without the payment of this fee.

Additionally, if a patient is more than **10 minutes late** without prior notice approved by the office staff for a scheduled appointment, we will consider this a missed appointment and the $50.00 cancellation fee will be charged.

We understand with COVID that circumstances can be difficult to give a 24 hours' notice, if you have to cancel your appointment due to COVID exposure or positive testing, you will not be charged the fee, and your appointment can be rescheduled two weeks out from the date of cancellation.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have.

We thank you for your patronage.

I have read and understand the Appointment Cancellation Policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to time by the practice.

I, _____ (print name), have received a copy of Sunrise Dentals' Appointment Cancellation Policy.

_____ _____
Signature of Patient (Guardian) Date

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HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT FORM FOR RECEIPT OF NOT ICE OF PRIVACY PRACTICES CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date: _____ Patient Name:_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM RECEPTION AREA:

❑First Name Only ❑Proper Surname ❑Other _____

PLEASE LIST ANY OTHER PARTIES WHO ARE ACTIVELY INVOLVED IN YOUR HEALTH CARE AND WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION: (This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name:_____ Relationship:_ _____

Name:_____ Relationship:_____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

❑Cell Phone Confirmation
❑Home Phone Confirmation
❑Work Phone Confirmation
❑Text Message to my Cell Phone
❑Email Confirmation
❑**Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

❑Cell Phone Confirmation
❑Home Phone Confirmation
❑Work Phone Confirmation
❑Text Message to my Cell Phone
❑Email Confirmation
❑**Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

❑Phone Message
❑Text Message
❑Email
❑**Any of the Above**
❑**None of the Above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.**

_____ _____

Please ***print*** name of Patient

Please ***sign*** Patient / Guardian of Patient

_____ _____

Legal Representative / Guardian

Relationship of Legal Representative / Guardian