Sonnier Dental

Received Welcome Letter, Consent, & HIPAA Forms: Initials: ____________

PATIENT INFORMATION

Today's Date: ____/_____/________
Patient Name: ____
First Last
What you prefer to be called: ______________________________
Birthdate: ____________________ ☐**Male** ☐**Female** ☐**Other**
SSN #: _______________ **Driver's License #**: __________________
Mailing Address: ____
____
Phone #: __________________ **Alt Phone #**: __________________
Email Address: ____
Referred By: ____
Employer: _____________________ **Occupation**: ______________
Marital Status: ________________ **# of Children**: ______________

Dental Insurance Information

Primary Insurance____
Company Name: ____
Phone #: ____________________________
Group # ___________________ **ID #**: ________________________
Insured's Name: ____
Insured's Birthdate: _____________ **Relation**: _________________
Secondary Insurance
Company Name: ____
Phone #: ___________________ **ID #**: ________________________

EMERGENCY CONTACT

Whom Shall We Contact:
____
Relation: _____________________________
Phone #: _____________________________
Your Medical Doctor:
____
Doctor's Phone #:
____

ASSIGNMENT OF BENEFITS

I hereby authorize assignments of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for my balance not paid by my insurance company. **Initials:** ___________

Dental Health History Information

Reason for Today's Visit:

☐ Emergency visit ☐ Comprehensive exam ☐Consultation ☐ Cleaning ☐ Other

Please indicate any of the following problems that you are having:

(Y-N) discomfort, clicking or popping in the jaw (Y-N) broken teeth and/or lost fillings (Y-N) bad breath
(Y-N) blisters/sores in or around the mouth (Y-N) ringing in the ears (Y-N) teeth grinding
(Y-N) red, swollen or bleeding gums (Y-N) stained teeth

Oral and Pharyngeal Cancer Checklist

Check all that apply:

☐ **soreness or a feeling that something is caught in the throat** ☐ **a lump or thickening in the oral soft tissues**
☐ **numbness of the tongue or other areas of the** ☐ **difficulty moving the jaw or tongue**
☐ **difficulty chewing or swallowing** ☐ **hoarseness** ☐ **ear pain**
☐**swelling of the jaw that causes dentures to fit poorly or become uncomfortable mouth**

Last Dental Exam and Dental X-Rays: ___________________ **Last Dental Cleaning**: __________________
Times a Day you brush: _________ **Times a Week you floss**: _________ **Soft Bristle Brush**: **Y or N**
Do you have any questions or concerns about previous dental work rendered or recommended? **Y or N**

Medical History and Information

What medications and/or vitamin supplements are you currently taking?

☐**None** ☐**Pain Medication** ☐ **Antibiotics** ☐ **Aspirin** ☐ **Blood Thinners** ☐ **Insulin** ☐ **Inhaler**

☐ **Other:** ____

List allergies dental or non-dental related: ☐ **None** ☐ **Penicillin/Amoxicillin** ☐ **Codeine** ☐ **Latex** ☐ **Food**

☐**Other:** ____

Do you require antibiotic prophylaxis prior to dental appointments? Y or N (certain joint replacements, heart conditions/surgeries and cancer treatment) Medical clearance advised.

Do you use tobacco? **Y or N** **How long**? ________________ **How often**? ______________________

For Women:

Are you pregnant? **Y or N** **Are you nursing**? **Y or N** **Are you taking hormonal replacements**? **Y or N**

Do you have or have you had any of the following diseases, medical conditions or procedures answer YES or NO to all:

(Y-N) High/Low Blood Pressure	(Y-N) Cancer/Tumor Growth	(Y-N) Leukemia	(Y-N) Heart Attack/Stroke
(Y-N) Chemotherapy/Radiation	(Y-N) Joint Replacement	(Y-N) Rods/Pins	(Y-N) Scarlet Fever
(Y-N) Heart Surg/Pacemaker/Stent	(Y-N) Mitral Valve Prolapse	(Y-N) Hepatitis	(Y-N) Rheumatic Fever
(Y-N) Congestive Heart Failure	(Y-N) Congenital Heart Defect	(Y-N) Breast Surgeries	(Y-N) Covid- 19
(Y-N) Diabetes/Hypoglycemia	(Y-N) Blood/Bone Marrow Transfusion	(Y-N) Tuberculosis	(Y-N) Seizures/Epilepsy
(Y-N) Heart Disease/Angina	(Y-N) HIV/AIDS/ARC	(Y-N) Shingles	(Y-N) Arthritis/Gout
(Y-N) GI Problems/Ulcers	(Y-N) Emphysema/Asthma	(Y-N) Jaw Pain/TMJ	(Y-N) Bruise Easily
(Y-N) Severe/Frequent Headaches	(Y-N) Dizziness/Fainting	(Y-N) Chest Pains	(Y-N) Lung Disease
(Y-N) Respiratory Problems	(Y-N) Back/Neck Problems	(Y-N) Allergies	(Y-N) Thyroid Problems
(Y-N) Psychiatric Problems	(Y-N) Alcohol/Drug Abuse	(Y-N) Nervousness	(Y-N) Sinus Problems
(Y-N) Cosmetic Surgery	(Y-N) Eating Disorder	(Y-N) Sleep Apnea	(Y-N) Dental Anxiety
(Y-N) Liver Problems	(Y-N) Kidney Problems	(Y-N) Organ Transplant	(Y-N) Lupus

Office and Patient Relationship

- We are here to discuss any questions or concerns regarding our services. Successful treatment works best if there is a mutual understanding between the provider, staff and the patient.
- It is important that you understand and agree to all treatment rendered understanding that treatment plans can change. When treatment changes you will be made aware prior to procedures being done.
- I authorize the staff and the provider to perform any necessary services needed during diagnosis and treatment. I also authorize the release of any information needed to process insurance claims.
- It is important that you understand all treatment rendered payment in full for all services rendered at the time of visit, unless other financial arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collections agency fees, interest charges and any other expenses incurred in collecting your debt.
- I understand that if my treatment is beyond the scope of this office, I will be referred to the appropriate specialist that the provider recommends and my records would be forwarded to the specialist.
- I understand the above information and guarantee this form was completed accurately to the best of my knowledge and I understand it's my responsibility to inform the office of any changes to the information I provided.

Signature: ____ **Date:** ______________________

Patient or Parent/Guardian

Annual Updates (Office Use)

Initials: _______ Date: _________ Initials: ________ Date: _________ Initials: ________ Date: __________
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