



SONTERRA DENTAL

CENTER FOR COSMETIC &
COMPREHENSIVE DENTISTRY

Thank you for choosing Sonterra Dental. If you have any questions, please ask us - we are happy to help.

Patient Registration

First Name:		Last Name:		Preferred Name:	
Address:				City:	
State:	Zip:	Email:			
Cell Phone: ()		Home Phone: ()		Work Phone: () Ext:	
Birth Date: / /		Age:		<input type="radio"/> Male <input type="radio"/> Female	
Marital Status: <input type="radio"/> Married <input type="radio"/> Single <input type="radio"/> Divorced <input type="radio"/> Separated <input type="radio"/> Widowed					
Preferred Contact: <input type="radio"/> Phone Call <input type="radio"/> Text <input type="radio"/> Email <input type="radio"/> Mail					
Reason for this visit:					
How did you hear about Sonterra Dental?:					
Employer:			Employment Status: <input type="radio"/> Full Time <input type="radio"/> Part Time <input type="radio"/> Retired		
Last Dental Visit:			Do you have current x-rays to bring?: <input type="radio"/> Yes <input type="radio"/> No		
Previous Dentist:			Preferred Pharmacy:		
Emergency Contact: Name:		Relationship:		Phone Number: ()	

Responsible Party: <input type="radio"/> Self <input type="radio"/> If Different...					
First Name:		Last Name:		Relationship to patient:	
Address:				City:	
State:	Zip:	Phone Number: ()			

Do you have dental insurance?: <input type="radio"/> No <input type="radio"/> Yes Please bring your insurance card to the first visit					
Subscriber's Name:				Birth Date: / /	
SS#:		Insurance Company:			Group #:
Employer:			Are you covered under more than one plan?: <input type="radio"/> Yes <input type="radio"/> No		
I hereby assign directly to Woods Woolwine, DDS all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I certify that the information that I have provided is true and correct to the best of my knowledge. I agree to inform Dr. Woolwine of any changes in my health status or the above information.					
_____ Signature of Patient, Guardian or Personal Representative				_____ Date	

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Health History

Sonterra Dental is concerned with every patient's overall health. While we primarily treat the area in and around the mouth we are aware of how good oral health effects your overall health and vise-versa. Health problems that you may have, or medication you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now? Yes No If yes, please explain _____
- Have you ever had a major operation or been hospitalized? Yes No If yes, please explain _____
- Have you ever had a serious neck or head injury? Yes No If yes, please explain _____
- Are you taking any drugs, medications or pills? Yes No If yes, please explain _____
- Do you take, or have you taken, Redux or Phen-Fen? Yes No If yes, please explain _____
- Have you ever taken Boniva, Fosamax, Actonel or any other medications that contains bisphosphonates? Yes No If yes, please explain _____
- Are you on a special diet? Yes No If yes, please explain _____
- Do you use tobacco? Yes No If yes, please explain _____
- Do you use controlled substances? Yes No If yes, please explain _____
- Women: Are you...
 Pregnant/Trying to get pregnant Nursing Taking oral contraceptive Hormone replacement therapy

Are you allergic to any of the following?

- Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Other: _____

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

- | | | | |
|---|---|---|--|
| <input type="radio"/> Aids/HIV | <input type="radio"/> Cortisone Medicine | <input type="radio"/> Hemophilia | <input type="radio"/> Renal Dialysis |
| <input type="radio"/> Alzheimer's Disease | <input type="radio"/> Diabetes | <input type="radio"/> Hepatitis A | <input type="radio"/> Rheumatic Fever |
| <input type="radio"/> Anaphylaxis | <input type="radio"/> Drug Addiction | <input type="radio"/> Hepatitis B or C | <input type="radio"/> Rheumatism |
| <input type="radio"/> Anemia | <input type="radio"/> Easily Winded | <input type="radio"/> Herpes | <input type="radio"/> Scarlet Fever |
| <input type="radio"/> Angina | <input type="radio"/> Emphysema | <input type="radio"/> High Blood Pressure | <input type="radio"/> Shingles |
| <input type="radio"/> Arthritis/Gout | <input type="radio"/> Epilepsy or Seizures | <input type="radio"/> Hives or Rash | <input type="radio"/> Sickle Cell Disease |
| <input type="radio"/> Artificial Heart Valve | <input type="radio"/> Excessive Bleeding | <input type="radio"/> Hypoglycemia | <input type="radio"/> Sinus Trouble |
| <input type="radio"/> Artificial Joint | <input type="radio"/> Excessive Thirst | <input type="radio"/> Irregular Heartbeat | <input type="radio"/> Spina Bifida |
| <input type="radio"/> Asthma | <input type="radio"/> Fainting Spells/Dizziness | <input type="radio"/> Kidney Problems | <input type="radio"/> Stomach/Intestinal Disease |
| <input type="radio"/> Blood Disease | <input type="radio"/> Frequent Cough | <input type="radio"/> Leukemia | <input type="radio"/> Stroke |
| <input type="radio"/> Blood Transfusion | <input type="radio"/> Frequent Diarrhea | <input type="radio"/> Liver Disease | <input type="radio"/> Swelling of Limbs |
| <input type="radio"/> Breathing Problem | <input type="radio"/> Frequent Headaches | <input type="radio"/> Low Blood Pressure | <input type="radio"/> Thyroid Disease |
| <input type="radio"/> Bruise Easily | <input type="radio"/> Genital Herpes | <input type="radio"/> Lung Disease | <input type="radio"/> Tonsillitis |
| <input type="radio"/> Cancer | <input type="radio"/> Glaucoma | <input type="radio"/> Mitral Valve Prolapse | <input type="radio"/> Tuberculosis |
| <input type="radio"/> Chemotherapy | <input type="radio"/> Hay Fever | <input type="radio"/> Pain in Jaw Joints | <input type="radio"/> Tumors or Growths |
| <input type="radio"/> Chest Pains | <input type="radio"/> Heart Attack/Failure | <input type="radio"/> Parathyroid Disease | <input type="radio"/> Ulcers |
| <input type="radio"/> Cold Sores/Fever Blisters | <input type="radio"/> Heart Murmur | <input type="radio"/> Psychiatric Care | <input type="radio"/> Venereal Disease |
| <input type="radio"/> Congenital Heart Disorder | <input type="radio"/> Heart Pace Maker | <input type="radio"/> Radiation Treatments | <input type="radio"/> Yellow Jaundice |
| <input type="radio"/> Convulsions | <input type="radio"/> Heart Trouble/Disease | <input type="radio"/> Recent Weight Loss | <input type="radio"/> Family History of Diabetes |

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

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 _____ DATE _____



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Office Information

We would like to welcome you to our office, and are happy you have chosen us for your dental care. Our primary goal and responsibility is to help our patients obtain good dental health and make your visit to our office a very positive experience. So that we can focus our time and energy on your care, we have prepared this letter to inform you of our office policies.

Appointments

When you make an appointment with us we consider your time as “confirmed” or reserved. As a courtesy, we will be happy to call you prior to your visits to see if you have any questions regarding your appointment. Should a scheduling conflict arise, please give our office at least **48 hours notice** so that we may reschedule you properly as well as serve our other patients. Because late cancellations may prevent us from being able to appoint another patient during your time, failure to notify our office in a timely manner may result in a **\$75 Rescheduling Fee**.

Financial Policy

Payment is expected at the time of service. If you have insurance, you will be expected to make an estimated payment for that portion not covered by your insurance plan. In addition to cash and check, we accept most major credit cards. If special arrangements are needed, please talk to our office prior to receiving service. We recognize that under unusual circumstances an account balance may be incurred. Sonterra Dental requires that all outstanding balances be paid in full within 30 days after receipt of statement. If not paid in full, an interest rate of 1.5% monthly (18% annually) or a minimum late charge of \$10 will accrue.

Dental Insurance

As a courtesy to our patients who have dental insurance we are happy to submit the necessary forms. We will fully attempt to *help you receive full insurance benefits; however, we ask that you read your policy carefully. We can only estimate your coverage in good faith but cannot guarantee coverage due to the complexities of insurance contracts.* Your estimated patient portion will be collected at the time of service. If your insurance policy does not cover as expected, final responsibility for any unpaid balance will be yours. Please keep us informed of any insurance changes such as policy name, insurance company address, or a change of employment.

We sincerely thank you for your support and belief in our office. If you have any questions, our staff is always available to answer them.

I have read the above, and I understand and agree to the office policies.

Signature of Patient or Responsible Party

Date