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: ○ Male ○ Female

Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Preferred Contact: ○ Phone Call ○ Text ○ Email ○ Mail

Reason for this visit:

How did you hear about Sonterra Dental?:

Employer: Employment Status: ○ Full Time ○ Part Time ○ Retired

Last Dental Visit: Do you have current x-rays to bring?: ○ Yes ○ No

Previous Dentist: Preferred Pharmacy:

Emergency Contact: Name: Relationship: Phone Number: ( )

Responsible Party: ○ Self ○ If Different…

First Name: Last Name: Relationship to patient:

Address: City:

State: Zip: Phone Number: ( )

Do you have dental insurance?: ○ No ○ 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?: ○ Yes ○ 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?

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

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 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 will result in a $50/hour (hygiene) and $100/hour (Dr) 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 Printed Name