Watson Dental Associates

Dr. Jacob Sonn DMD

MEDICAL HISTORY

Date: _______________

Patient Name: ______________________________ DOB: ________________

Email ____

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:

Are you under a physician's care now? Yes No Physician name/ph#:__________________

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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, _____________________________

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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 on a special diet? Yes No

Do you use tobacco? 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 ☐ Local Anesthetics

☐ Sulfa drugs ☐ Latex ☐ Other? ____

Do you use controlled substances? Yes No If yes, _____________________________

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

AIDS/HIV Positive	Yes No	Cortisone Medicine	Yes No	Hemophilia	Yes No	Radiation Treatments	Yes No
Alzheimer's Disease	Yes No	Diabetes	Yes No	Hepatitis A	Yes No	Recent Weight Loss	Yes No
Anaphylaxis	Yes No	Drug Addiction	Yes No	Hepatitis B or C	Yes No	Renal Dialysis	Yes No
Anemia	Yes No	Easily Winded	Yes No	Herpes	Yes No	Rheumatic Fever	Yes No
Angina	Yes No	Emphysema	Yes No	High Blood Pressure	Yes No	Rheumatism	Yes No
Arthritis/Gout	Yes No	Epilepsy/Seizures	Yes No	High Cholesterol	Yes No	Scarlet Fever	Yes No
Artificial Heart Valve	Yes No	Excessive Bleeding	Yes No	Hives or Rash	Yes No	Shingles	Yes No
Artificial Joint	Yes No	Excessive Thirst	Yes No	Hypoglycemia	Yes No	Sickle Cell Disease	Yes No
Asthma	Yes No	Fainting Spells/Dizziness	Yes No	Irregular Heartbeat	Yes No	Sinus Trouble	Yes No
Blood Disease	Yes No	Frequent Cough	Yes No	Kidney Problems	Yes No	Spina Bifida	Yes No
Blood Transfusion	Yes No	Frequent Diarrhea	Yes No	Leukemia	Yes No	Stomach/Intestinal Disease	Yes No
Breathing Problems	Yes No	Frequent Headaches	Yes No	Liver Disease	Yes No	Stroke	Yes No
Bruise Easily	Yes No	Genital Herpes	Yes No	Low Blood Pressure	Yes No	Swelling of Limbs	Yes No
Cancer	Yes No	Glaucoma	Yes No	Lung Disease	Yes No	Thyroid Disease	Yes No
Chemotherapy	Yes No	Hay Fever	Yes No	Mitral Valve Prolapse	Yes No	Tonsillitis	Yes No
Chest Pains	Yes No	Heart Attack/Failure	Yes No	Osteoporosis	Yes No	Tuberculosis	Yes No
Cold Sores/Fever Blisters	Yes No	Heart Murmur	Yes No	Pain in Jaw Joints	Yes No	Tumors or Growth	Yes No
Congenital Heart Disorder	Yes No	Heart Pacemaker	Yes No	Parathyroid Disease	Yes No	Ulcers	Yes No
Convulsions	Yes No	Heart Trouble/Disease	Yes No	Psychiatric Care	Yes No	Venereal Disease	Yes No
COPD	Yes No	Congestive Heart Failure	Yes No	Hard of Hearing	Yes No	Yellow Jaundice	Yes No

Have you ever had a serious illness not listed? Yes No If yes, _____________________________

Comments: ____

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____

DENTAL HISTORY:

Have you had braces? Yes No

Do you have dental pain? Yes No

What is your primary dental concern? ____

How long since your last dental cleaning? ____

Have you ever received detailed brushing and flossing instructions? Yes No

SEE BACK SIDE→

Have you ever had trauma to head, neck, TMJ? Yes No
Have you ever experience any of the following problems in your jaw:
- Clicking? Yes No
- Pain (joint, ear, side of face)? Yes No
- Difficulty opening or closing? Yes No
- Difficulty chewing? Yes No

Do you have frequent headaches? Yes No
Do you clench or grind your teeth? Yes No
Do you bite your lips or cheeks frequently? Yes No
Have ever had any difficult extractions? Yes No
Have you ever had prolonged bleeding following extractions? Yes No
Do your gums bleed when brushing or flossing? Yes No
Are your teeth sensitive to hot or cold liquids/foods? Yes No
Are your teeth sensitive to sweet or sour liquids/foods? Yes No
Do you have any sores or lumps in or near your mouth? Yes No

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 my patients') health. It is my responsibility to inform the dental office of any changes in medical status. By signing this form I give consent for examination and x-rays.

X ____ Date: ____________________________
Signature of Patient, Parent or Guardian

FINANCIAL POLICY

Thank you for choosing our office as your dental health care provider. We are committed to provide you with the highest quality care, so that you may fully attain optimum oral health. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment.

Payment is due at the time service is provided. We ask that you pay the deductible and co-payment. Our office accepts cash, personal checks, debit cards, Visa, MasterCard, Discover, and Flexible Spending cards.

A finance charge will be added to all charges that are 90 days old. Our monthly finance charge is a minimum of $25.00 or 5% of your outstanding balance, whichever is greater.

In the event of non-payment, you will be responsible for any collection and legal fees.

Please note: Returned checks will be subjected to an additional fee of $25. In case it becomes necessary for our office to enlist a collection service and/or legal assistance, you will be responsible for any collection and/or legal charges incurred up to 35%.

Do you have insurance?

~ As a courtesy, we will help you process all of your insurance claims. Insurance benefits are **ESTIMATED** based upon the information from the insurance company. It is not a guarantee of payment.

~ All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental provider, our relationship is with you, our patient, not with your insurance company.

~ We will cooperate fully with the regulations and requests of your insurance company that assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our financial policy.

I HAVE READ, UNDERSTAND, AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

_______________________________	_______________________________
Patient Name	Date
_______________________________	_______________________________
Name of Parent or Guarantor, if minor	Signature of Patient or Guarantor

Watson Dental Associates – Dr. Jacob Sonn D.M.D.

Acknowledgement of Receipt of Notice of Privacy Practices
Consent for Use and Disclosure of Health Information

PATIENT: PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.
Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, or the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.
We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

I have been given the opportunity to review and receive a copy of this office's Notice of Privacy Practices and Consent form. I understand that by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations. - You May Refuse to Sign This Acknowledgment.

____

Print name of Patient, Parent, Guardian or Personal Representative

____

Signature of Patient, Parent, Guardian or Personal Representative

____________________________ ____

Date **Relationship to Patient**

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the office. Please understand that the revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ____Individual refused to sign
- ____Communications barriers prohibited obtaining the acknowledgement
- ____An emergency situation prevented us from obtaining acknowledgement
- ____Other(Please Specify)____

Watson Dental Associates
Dr. Jacob Sonn DMD
Broken Appointment Policy

Please note our broken appointment policy:

As of November 9th, 2020, there will be a $25.00 charge for any appointment that is not cancelled 24 hours in advance. Therefore, if you are unable to keep your scheduled appointment, please kindly give us at least 24 hour advanced notice. We reserve the right to drop any patient after the second broken appointment.

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care and our policies.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

Patient Name Date

Name of Parent or Guarantor, if Minor Signature of Patient or Guarantor