

Sunset Dental

1780-6 Chandlers Lane
Sunset Beach, NC 28468
910-575-6300

Medical Alert For Office Use

Thank you for visiting Sunset Dental. We want your visit to be pleasant and comfortable. Please help us by completing this form.

Patient Information

Name _____
LAST FIRST MIDDLE INITIAL NICKNAME

Address _____
STREET

CITY STATE ZIP

Employer _____ Drivers License _____

Birth date _____ Email Address _____

Phone: Home (____) _____ Social Security # _____

Work (____) _____ May we contact you at work? Y/N May contact you via email? Y/N

Mobile(____) _____ Male Female

Emergency: Name _____ Phone (____) _____

Insurance

Primary Dental Carrier

Subscriber Name _____ Social Security # _____ DOB _____

Employer _____ Insurance Co. _____

Insurance Co. Phone # _____ Group # _____

Relation to patient _____

Secondary Dental Carrier

Subscriber Name _____ Social Security # _____ DOB _____

Employer _____ Insurance Co. _____

Insurance Co. Phone # _____ Group # _____

Relation to patient _____

Insurance Authorization Statement (Sign & Date)

I hereby authorize payment directly to Sunset Dental of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs and dental treatment. I hereby authorize Sunset Dental to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history is correct to the best of my knowledge.

Signature _____ Date _____

If Patient is Under 18

Responsible Party _____ Relation to Patient _____

Address _____
STREET

CITY STATE ZIP

Telephone (____) _____

Other Information

How did you hear about us? _____

What was the reason for today's visit? _____

Do you love your smile? _____

Is there anything you would like to change? _____

Why did you leave your last dentist? _____

What did you like most about your last dentist? _____

Medical History and Information

Conditions

- | | |
|--|---|
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> Heart Surgery |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hepatitis A |
| <input type="checkbox"/> Angina Pectoris | <input type="checkbox"/> Hepatitis B |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hepatitis C |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Joint Replacement |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Pace Maker |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Psychiatric Problems |
| <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Radiation Therapy |
| <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Facial Surgery | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Fever Blisters | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> HIV+ Aids | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Ulcers |

Allergies

- Aspirin
- Codeine
- Dental Anesthetics
- Erythromycin
- Latex
- Metals
- Penicillin
- Sulfa
- Tetracycline

Other _____

Y N

Do you Smoke
or use Tobacco?

If Female

Y N

Are you taking Birth
Control Pills?

Are you pregnant?
If yes, # of weeks _____

Are you Nursing?

Please list any medications
you are currently taking: _____

Treatment Authorization Form

I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary or advisable including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my medical condition.

Payment for all treatment and services rendered are my responsibility.

PATIENTS SIGNATURE

DATE

If patient is a child or requires a guardian:

PARENT/GUARDIAN SIGNATURE

DATE

Sunset Dental
George S. Jones, III, DMD, PA
1780-6 Chandlers Lane
Sunset Beach, NC 28468
910-575-6300

Financial Arrangements

All patients, please read the following...

Payment is expected for all services at the time the service is provided. If treatment requires multiple appointments, payment may be divided over the number of appointments. Cash, personal checks, Mastercard and Visa are accepted. If an extended payment plan is desired, please ask us about the CareCredit program.

I understand and agree that all services rendered to me, my dependents, or others assigned by me to my account are charged directly to me. I further understand I am personally responsible for payment. If I suspend or terminate care and treatment, any fees for services rendered will be immediately due and payable. Should the fees for the professional services not be paid in accordance with the provisions herein, reasonable attorney's fees, plus applicable financial charges and disbursements, allowances, and costs provided by law shall be included in the computation of the amount due. Finance charges may be applied to all past due amounts at the rate of 1.5% per month (18% annual rate). If the account is in default and turned over for collection, a collection fee will be added.

If you have dental insurance...

As a courtesy, we will file your claim for you. We may accept direct payment from most insurance companies. We will estimate your deductible and the portion not covered by your insurance, which is due at the time of treatment. Our estimates may be different than your insurance company's calculations; therefore, the amount due to our office may be adjusted accordingly. All services rendered are charged directly to the patient, and the patient is ultimately responsible for the account regardless of the insurance coverage. Any insurance claims denied or remaining unpaid after 60 days will automatically become the responsibility of the patient.

We are only in network with Delta Dental, no others

We do not accept Medicaid or NC Choice

Patient / Guardian Signature

Date

Sunset Dental
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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You May Refuse To Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

Please Print Name

Signature

Date

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
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please specify)

