



We Welcome You

Take a moment to fill out this form so we can know you better.

Our New Patient

Legal Guardian Name (if patient is under 18) _____

Patient Name _____ M F SS# _____

DOB _____ Age _____ Employer/School _____

MAILING ADDRESS

City _____ State _____ ZIP _____

Street _____ APT _____ 1 Phone _____

2 Phone _____ E-mail _____
 Cell Work Home

EMERGENCY CONTACT PERSON - Name _____ Relation to Patient _____

City _____ State _____ ZIP _____

Street _____ APT _____ 1 Phone _____

2 Phone _____ E-mail _____
 Cell Work Home

HOW DID YOU HEAR ABOUT US?

Friend/Relative TV/Radio Internet Search Print Advertisement Driving By Mailer

Full Name _____ OTHER (Please Specify) _____

What Brought You to Us?

Visiting today because, _____

SERVICES YOU'RE INTERESTED IN

Do you require/request sedation dentistry? Yes No Don't Know Learn more

- Orthodontics (braces)
- Cleaning & Exam
- Tooth Replacement (implant/bridge)
- Replacing Silver Fillings
- Teeth Whitening

CONSENT TO PROCEED

I Authorize Sealy Dental Doctors or assistants as they may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or any minor or other individuals for which i have responsibility, including arrangement and/or administration of any sedative, restorative, palliative, therapeutic or surgical treatments. I understand that the administration of local anesthetic may cause an untoward reaction or side effect(s), which may include numbness, bruising and muscle soreness. I do voluntarily assume any and all risks, including the risk of substantial and serious harm, if any, which maybe associates with general preventative and operative treatment procedures in hopes of obtaining the potential desired result, which may or may not be achieved, for my benefit or my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions. Further, I understand that meritless and frivolous claims for medical/dental malpractice have an adverse effect upon the cost and availability of healthcare and may result in irreparable harm to a healthcare provider. As additional consideration for professional care provided to me, I, the patient/guardian and or my representative agrees not to advance, directly, or indirectly, any false, meritless, and/or frivolous claim(s) of medical/dental malpractice case or cause of action be initiated or pursued. I and/or my representative agree to use expert witness(es) who practice primarily in the same specialty as Doctor. Furthermore, I agree that these expert witnesses will adhere to the guidelines and/or code of conduct defined for expert witnesses by the American Dental Association. In further consideration for this Sealy Dental Doctors agree to the same stipulations.

Signature of patient, legal guardian or authorized agent

Date

Witness

Date

Your Medical History

SERIOUS ILLNESS, OPERATIONS or HOSPITAL VISITS IN THE PAST 5 YEARS

Explain _____

ALLERGIES

- Local Anesthetics Penicillin or Other Aspirin Codeine, Valium or Other Sulfa Drugs
 Latex Iodine Barbiturates, sedatives or sleeping pills Nitrous Oxide Other _____

FOR WOMEN

Pregnant or Trying Yes No Nursing Yes No Birth Control/Hormone Replacement Yes No

PHARMACEUTICAL HISTORY

- Fosamax (Bisphosphonates) Boniva Actonel
Plavix Coumadin (Warfarin) Jantoven Aclatsa

LIST ALL CURRENT MEDICATIONS *(including over the counter)*

DISEASES OR PROBLEMS

- | | | |
|---|---|--|
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> AIDS/HIV Infections | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Rapid Weight Loss |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fainting/Seizures | <input type="checkbox"/> Recurrent Infections |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Gastrointestinal Dis | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Headache/Migrane | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Sores/Ulcers |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Stomach Ulcers |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer/Chemotherapy | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Chest Pain Upon Exertion | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mental Health Dis | <input type="checkbox"/> Sexually Transmitted Diseases |
| <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Mitralvalve Prolapse | |

NAMES AND PHONE NUMBERS OF CURRENT DOCTORS PROVIDING CARE

I hereby certify that the above answers to the following questions are accurate to the best of my knowledge. Since a change of medical condition or medications can effect dental treatment, I understand the importance of and agree to notify the dentist of any changes at any subsequent visit.

Signature of patient, legal guardian or authorized agent

Date

Patient Account Authorization

PERSON ULTIMATELY RESPONSIBLE FOR THE ACCOUNT

Name _____

City _____ State _____ ZIP _____

Street _____ APT _____

Drivers License# _____ Phone _____

Insurance Information *(if applicable)*

PRIMARY DENTAL INSURANCE

Company Name _____ Phone _____

Address _____

Phone _____ Insured ID# _____

Insurance Group# _____ Plan/Local/Policy# _____

Insured Name _____ Relation _____

Your DOB _____ Insured Employer _____

SECONDARY DENTAL INSURANCE

Company Name _____ Phone _____

Address _____

Phone _____ Insured ID# _____

Insurance Group# _____ Plan/Local/Policy# _____

Insured Name _____ Relation _____

Your DOB _____ Insured Employer _____

Dental Insurance is a contract between a patient/guardian and the insurance company and in no way absolves the patient/guardian of full responsibility of the charges incurred. Estimates of insurance payment made by this office are considered a guideline only. We can make no guarantee of the insurance payment(s) estimated. We are pleased to help process insurance forms, help maximize your insurance benefits and are glad to help answer any questions you may have about your treatment or treatment estimates.

FINANCE CHARGES: A monthly charge of 1.5% (18% annually) will be added to all account balances not paid within 60 days of services. A late fee of \$10/month will be assessed to all past due accounts.

I have read, understand and agree to the above policies. In the even of default, I agree to pay all cost of collection as well as court costs and reasonable attorney's fees in the event legal action is taken.

Signature of patient, legal guardian or authorized agent

Date

Witness

Date

Mutual Agreement to Maintain Privacy

The Dentists at Sealy Dental Center and the patient listed below agree to maintain privacy of the patient as outlined in the HIPAA form. The Dentists take pride in being able to extend a greater degree of privacy than is required by HIPPA, state confidentiality mandates and common law.

Federal and State privacy laws are complex. Unfortunately, some dental offices try to find loopholes around these laws. For example, HIPPA forbids dentist from receiving money for selling lists of patients or protected health information to companies to market their products or services directly to patients without authorization. Some dental practices, though, can lawfully circumvent this limitation by having a third party perform the services, the patient can still be targeted with the unwanted marketing information. Sealy Dental Center believes this is improper and my not be in the patient's best interest. Accordingly, the Dentists agree not to provide any list to an outside company for marketing anything other than our office or be paid for selling patient lists or protected health information to any party for the purpose of marketing directly. Regardless of legal privacy loopholes, Sealy Dental Center will never attempt to leverage its relationship with the patient by seeking patient's consent for marketing products for other companies in consideration for treatment and the above notes patent protection.

Patient agrees to refrain from directly or indirectly publishing or airing commentary upon Sealy Dental Center or the dentists, expertise and/or treatment; The sole exceptions being communication to a confidential dental-peer review body; to another healthcare provider; to a licensed attorney; to a governmental agency; in the context of a legal proceeding; or unless mandated by law. Publishing is intended to include attribution by name, by pseudonym, or anonymously. If patient does prepare commentary for publication about Sealy Dental Center and/or our dentists or employees, the patient exclusively assigns all intellectual property rights, including copyrights, to Sealy Dent Center for any written, pictorial, and/or electronic commentary. This assignment is in further consideration for additional privacy protections provided by Sealy Dental Center. This assignment shall be operative and effective at the time of creation (prior to publication) of the commentary. Sealy Dental Center has invested significant financial and marketing resources in developing the practice. In addition, patient will not denigrate, defame, disparage, or cast aspersions upon Sealy Dental Center or its dentists; Patient will use all reasonable efforts to prevent any member of their immediate family or acquaintance from engaging in any such activity. Published comments on web pages blogs, and/or mass correspondence, however well intended, could severely damage the practice.

Our dentist feel strongly about patient's privacy as well as the practices right to control its public image and privacy. Both Dentists and patient will work to prevent the publishing or airing of commentary about the other party from being accessed via internet, blogs or other electronic print or broadcast media without prior written consent. Finally, this agreement shall be in force and enforceable (and fully survive) for a period of the longer of **(a)** five years from Dentist's last date of service to the patient or **(b)** three years beyond any termination of the dentist-patient relationship. As a matter of office policy Dentists are requiring all patients in the practice sign the Mutual Agreement to Maintain Privacy so as to establish that any anonymous or pseudonymous publishing of airing of commentary will be covered by the agreement for all patients.

Patient and Dentists acknowledge that breach of this Agreement may result in serous, irreparable harm. In addition to compensation for consequential damages patient and Dentist agreee to the right of equitable relief (including but not limited to injective relief). Should a breach of this agreement result in in litigation, the prevailing party in the litigation shall be entitled to reasonable costs, expenses, and attorney fees associated with the litigation.

Patient has been given the opportunity to ask questions and receive satisfactory and adequate explanations.

Signature of patient, legal guardian or authorized agent

Date

Witness

Date