SFD SANGO FAMILY DENTISTRY

Patient's Name _____ **Date** _____

Signature _____

For Office Use Only
Medical Alerts:

Sex: ☐

If female, please answer the following:

Y	N	
❑	❑	Are you taking Birth Control Pills?
❑	❑	Are you pregnant? If Yes, # of weeks ☐
❑	❑	Are you nursing?

Please answer the following:

Y	N		
❑	❑	Do you smoke or use tobacco?	Height ☐
For Office Use Only			
BP ☐		Heart Rate ☐	Weight ☐

Y	N	Conditions
❑	❑	Abnormal Bleeding
❑	❑	Alcohol Abuse
❑	❑	Allergies
❑	❑	Anemia
❑	❑	Angina Pectoris
❑	❑	Arthritis
❑	❑	Artificial Bones
❑	❑	Artificial Heart Valve
❑	❑	Asthma
❑	❑	Blood Transfusion
❑	❑	Cancer-Chemotherapy
❑	❑	Colitis
❑	❑	Congenital Heart Defect
❑	❑	Cosmetic Surgery
❑	❑	Diabetes
❑	❑	Difficulty Breathing
❑	❑	Drug Abuse
❑	❑	Emphysema
❑	❑	Epilepsy
❑	❑	Fainting Spells
❑	❑	Fever Blisters
❑	❑	Frequent Headaches

Y	N	Conditions
❑	❑	Glaucoma
❑	❑	Hay Fever
❑	❑	Heart Attack
❑	❑	Heart Surgery
❑	❑	Hemophilia
❑	❑	Hepatitis A
❑	❑	Hepatitis B
❑	❑	High Blood Pressure
❑	❑	HIV+ AIDS
❑	❑	Kidney Problems
❑	❑	Liver Disease
❑	❑	Low Blood Pressure
❑	❑	Mitral Valve Prolapse
❑	❑	Pace Maker
❑	❑	Pneumocystitis
❑	❑	Psychiatric Problems
❑	❑	Radiation Therapy
❑	❑	Rheumatic Fever
❑	❑	Seizures
❑	❑	Shingles
❑	❑	Sickle Cell Disease
❑	❑	Sinus Problems

Y	N	Conditions
❑	❑	Stroke
❑	❑	Thyroid Problems
❑	❑	Tuberculosis
❑	❑	Ulcers
❑	❑	Venereal Disease
❑	❑	Yellow Jaundice

Y	N	Allergies
❑	❑	Aspirin
❑	❑	Codeine
❑	❑	Dental Anesthetics
❑	❑	Erythromycin
❑	❑	Jewelry
❑	❑	Latex
❑	❑	Metals
❑	❑	Penicillin
❑	❑	Tetracycline

Other

_____

_____

_____

Medications:

Y N

❑ ❑ **Is there any disease, condition, or problem that you think this office should know about that is not covered above?**
If yes, please describe below:

_____

_____

_____

_____

Sango Family Dentistry

Guest's Information:

Mr./Mrs./Miss _____ Birthdate _____ SS# _____
(Last) (First) (Middle) M-D-Y

Phone:_____ / _____ Address _____
(Home) (Work) Number and Street City/State Zip

Cell:_____ E-Mail:_____

Employer_____ Occupation_____

Name of Spouse/Parent/Legal Guardian_____ SS # _____ Birthdate _____

How did you hear about our office? _____

Responsible Party/Military Sponsor if Applicable:

Mr./Mrs./Miss _____ Birthdate _____ SS# _____
(Last) (First) (Middle) M-D-Y

Phone:_____ / _____ Address _____
(Home) (Work) Number and Street City/State Zip

Employer_____ Occupation_____

Military Only Duty Phone # _____ Duty Station_____

Insurance Information/Primary:

Dental Insurance _____ If Yes, Name of Company _____ Group # _____
(Y or N)

Name of Insured Sponsor_____ SSN# or ID# _____

Insurance Information/Secondary:

Dental Insurance _____ If Yes, Name of Company _____ Group # _____
(Y or N)

Name of Insured Sponsor_____ SSN# or ID# _____

To avoid misunderstanding regarding dental insurance, we wish our guests to know that all services rendered are charged to the guest and that the guest is personally responsible for the fees. We will assist you in preparing necessary forms and submit to your insurance company to help you obtain your benefits from them. We do not render our services on the basis that your company will pay the fee. **All services rendered are cash, check, Mastercard, VISA, or Am. Express unless otherwise arranged.** Our office works on an appointment system. If it is necessary for you to change an appointment, please give us as much notice as possible so that we can accommodate other guests. If your appointment is failed without notice, a fee may be charged on a case by case basis for lost time we were not able to make available to another patient.

We respect your time and will make every effort to treat you in a timely fashion. Occasionally an emergency may put us behind schedule. In such a situation we will keep you informed and present you with the option of rescheduling your appointment if necessary.

Consent for Treatment

The following information is not presented to worry you, but rather to conform to the principles of "Informed Consent". Any local injected anesthetic or oral surgical procedure may result in certain post-operative effects. Usually these effects are limited to discomfort, bleeding, swelling, and less frequently, infection. On rare occasions, numbness of the lips, chin, tongue, prolonged healing, injury to other teeth, broken jaws, sinus openings, and injury to the ligaments of the jaw joint may occur. The utmost care will be taken to minimize the potential for the untoward complications.

Assignment and Release

"I have read and understand the above explanation. This is to certify that I, the undersigned, consent to the performing of the dental and oral surgical procedures agreed to be necessary or advisable, including the use of local anesthetics as indicated." I assign all dental insurance benefits directly to Sango Family Dentistry. **I understand that I am financially responsible for all charges whether or not paid by the insurance company. Charges for all the collection of delinquent accounts, including collection agency charges, court costs, and or reasonable attorney's fees will be added to the total balance.** I hereby authorize that Sango Family Dentistry to release all information to secure payment of benefits. I authorize the use of this signature on all insurance claim submissions.

Guest's Signature_____ Date _____
(Parent or Guardian signature if guest is a minor.)

SANGO FAMILY DENTISTRY
OFFICE POLICIES

WELCOME!
We are so glad that you have chosen to entrust us with your dental health it is our goal to provide the best possible care for you in a comfortable and caring atmosphere!

OFFICE HOURS
Our regular office hours are 8:00am to 5:00pm Monday through Thursday and some Fridays. We are closed Saturday, Sunday and most holidays. When the office is closed we have an answering system in place with emergency contact information. The first appointment of the day and the last appointment of the day (8am and 4pm) are the MOST requested time slots. We will do our very best to work with you in regards to your work and school. Since these two appointment times are in high demand, canceling or not showing up would result in us no longer being able to schedule you at those times.

CANCELATIONS
We require 48 hours notice to cancel or reschedule an appointment. In the case of an emergency or unexpected illness we understand the need to reschedule. In the case of missing a confirmed appointment, last minute cancellation or multiple cancels or reschedules there will be a missed appointment fee charged to your account. Upon rescheduling missed appointments you may be required to make a deposit to hold future appointments. Also, due to the amount of time involved for certain procedures it may be required that a deposit be made in order to schedule the appointment. We do not double book our schedule. Your appointment time is reserved especially for you in order for our team to best serve you. Your clinician prepares the treatment room prior to your arrival; please help us keep costs down by avoiding missed appointments, last minute cancellations and tardiness. Thank you for your attention to this matter.

HYGIENE APPOINTMENTS
At your hygiene (cleaning) appointment we will schedule your next visit. We will send you an email or text message reminding you of your appointment 2 to 3 weeks prior to the appointment date. Please check your schedule at that time and make arrangements to ensure that you will be able to keep your appointment with your hygienist. You will receive another courtesy reminder a few days before the appointment that will ask you to reply to confirm. For scheduling purposes, please confirm all scheduled appointments with our office via text, phone or email. Our office will contact you regarding confirmation of your appointment. If we have no response of your confirmation, your appointment time and date will be subject to change.

TREATMENT APPOINTMENTS
Upon scheduling an appointment for treatment, a deposit of 50% of your ***estimated*** out of pocket is collected; your remaining ***estimated*** out of pocket cost for your treatment is collected at the time of service. We have found that this makes paying for dental care easier for our patients.

INSURANCE
As a courtesy, we will file your insurance for you with your insurance carrier. Your employer, human resources department or insurance company should supply you with an information packet on your policy. The packet explains your policy and in it you will read about your maximums, deductibles, limitations and percentages. *All out of pocket estimates and co-pays we quote are* ***ESTIMATES****. We cannot guarantee that your insurance company will pay your insurance claims.* Your estimated portion is due and required at the time we provide your service. To help with your out of pocket expenses we also offer Care Credit to allow you to make monthly payments. We also accept all major credit cards.

I have read and understand the above information. I understand that I am financially responsible for all charges whether or not paid by my insurance company. I understand that I am responsible for keeping the appointments I have made. I hereby authorize Dr. Robert H Galbraith, DDS and Dr. Mark Hower, DDS to release my information to the insurance company to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

GUEST SIGNATURE_____DATE_____

Patient Financial Agreement
with Sango Family Dentistry

I understand that as a recipient of dental care I, the undersigned, am responsible for all charges regardless of my circumstances for reimbursement. Full payment is due at the time of delivery of service. I agree that the determination of the professional services to be rendered by my doctor and the fees to compensate the doctor for these services are matters which concern my doctor and me. I understand that I have the primary duty and obligation to pay my doctor for services provided, notwithstanding any contract I may have with any third party payer (for example, insurance company, employer, etc.).

The undersigned hereby authorizes the release of any and all information or documents to all parties related to obtaining my insurance benefits for claims submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my doctor and all necessary parties to submit claims to obtain benefits, for services rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as if the undersigned had personally signed the particular claim.

I hereby authorize my insurance company to pay and hereby assign directly to Robert Galbraith, D.D.S or Mark Hower, D.D.S all benefits. I understand that I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid will be credited to my account, in accordance with my insurance company's assignment. Any unpaid charges are my responsibility. Any credits due you will be refunded in a timely manner.

Patient balances are due immediately and are not contingent upon receiving a statement. Insurance companies provide an explanation of benefits outlining payments and patient balances.

If I default and my account is referred to a collection agency or attorney, I will be responsible for all costs of collecting monies owed, including interest, court costs, collection, collection agency and attorney fees. Any and all advance collection fees incurred by the practice will be included in my final bill.
Payment may be made with cash, check, or credit card. There is a $25.00 service charge for a returned check.

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO KNOW WHAT THE TERMS OF MY INSURANCE ARE, AND IN COMPLIANCE WITH THOSE TERMS, AGREE TO THE FOLLOWING:

1. Providing this office with complete and accurate billing information including, but not limited to, a current insurance card and authorization numbers. I am responsible for all visits and procedures not properly authorized.
2. I will pay all applicable co-pays and outstanding patient balances as they become due. All co- pays and patient balances are due at each visit.

Signature of Financially Responsible Party: Date:

_____ _____

_____
Print Name

ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGMENT

I HAVE RECEIVED A COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICES.

PRINT NAME _____

SIGNATURE _____

DATE _____

FOR OFFICE USE ONLY

WE ATTEMPTED TO OBTAIN WRITTEN ACKNOWLEDGMENT OF OUR NOTICE OF PRIVACY PRACTICES, BUT ACKNOWLEDGMENT COULD NOT BE OBTAINED BECAUSE:

1.____ INDIVIDUAL REFUSED TO SIGN

2.____COMMUNICATION BARRIERS PROHIBITED OBTAINING ACKNOWLEDGMENT

3.____AN EMERGENCY SITUATION PREVENTED OBTAINING ACKNOWLEDGMENT

4.____OTHER (PLEASE SPECIFY) _____