Sierra Oaks DENTAL

On behalf of our staff and ourselves, we welcome you to our family of fine patients. It is our hope that your dental visit will be prompt and pleasant so that in the future you will want to refer your friends and family. If at any time you have questions, we appreciate the opportunity to answer them.

ACQUAINTANCE FORM

TODAY'S DATE:

Name _____ Marital Status _____
First MI Last

What Do You Prefer To Be Called? _____ **Birthdate** _____

Address _____
Street City Zip

Preferred Phone _____ **Social Security No.** _____ **Drivers Lic. No.** _____

Alternate Phone _____ Employer _____ Occupation _____

Email Address _____

Spouse's Name _____ Spouse's Occupation _____

Name & Phone of Relative or Close Friend _____

Emergency Contact _____ Relation _____ Phone _____

Who May We Thank for Referring You to Our Office _____

DENTAL INSURANCE INFORMATION

Primary Dental Ins. Co. _____ Employer _____ Group No. _____

Insured's Name _____ SS#/I.D.# _____ D.O.B. _____

Covered Dependents & D.O.B. _____

Secondary Insurance (if any)

Dental Ins. Co. _____ Employer _____ Group No. _____

Insured's Name _____ SS#/I.D.# _____ D.O.B. _____

Covered Dependents & D.O.B. _____

FINANCIAL POLICY

In order to keep our fees as low as possible, we ask that payment be made at the time of service. **Insurance is a method of partial payment and does not influence our treatment planning.** As a courtesy, we will submit claims on your behalf. If after 30 days, the insurance has not paid,we will bill you for the total amount. Each dental plan varies and not all services are covered, therefore you are ultimately responsible for the total amount of all dental treatment. For your convenience, we will provide you with an estimate prior to scheduling any treatment. We accept cash, checks, all major credit cards and CareCredit.

CANCELLATION POLICY

Cancellation Policy If you are unable to keep the appointment you scheduled, we require a 48–hour notice for cancellations or a $50.00 charge may be incurred. We realize that emergencies do occur and we will be flexible under those rare circumstances.

Acknowledgement of receipt of notice of Privacy Practices and Dental Materials Fact Sheet.

X _____
Patient Signature (Parent or Guardian) Date

X _____
Patient Signature (Parent or Guardian) Date

PATIENT NAME: _____

MEDICAL HISTORY

Current medical doctor_____ Phone_____

Are you now under the care of a physician? If yes, please explain. _____ ☐ Yes ☐ No

Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No

Have you ever received a blood transfusion? When? _____ ☐ Yes ☐ No

Have you ever had any complications following dental treatment? ☐ Yes ☐ No

Are you pregnant? If so when are you due? _____ ☐ Yes ☐ No

Are you taking or have you ever taken medications for Osteoporosis (i.e. Bisphosphonates)? ☐ Yes ☐ No

_____

Do you have an allergy or sensitivity to latex? ☐ Yes ☐ No

Have you ever had an allergic reaction? If yes please list your allergies _____ ☐ Yes ☐ No

Have you ever been instructed to take antibiotic pre-medication before dental treatment? Why? _____ ☐ Yes ☐ No

Are you taking any medications, pills, drugs or over the counter medications? ☐ Yes ☐ No

Please list each mediation and reason for taking it.

_____ _____

_____ _____

_____ _____

Do you have or have you ever had any of the following conditions? Please **CIRCLE Y** or **N** for each condition listed:

Allergies/Hay fever/Asthma	Y N	Diabetes, Type____	Y N	Heart Surgery, Date____	Y N	Recreational Drug Use	Y N
Alzheimer's/Dementia	Y N	Dizziness/Fainting	Y N	Hepatitis, Type_____	Y N	Respiratory Problems	Y N
Anemia	Y N	Dry Mouth	Y N	Herpes/ Fever Blisters	Y N	Rheumatic Fever	Y N
Arthritis	Y N	Eating Disorders	Y N	High/Low Blood Pressure	Y N	Rheumatism	Y N
Arrhythmia	Y N	Emphysema/COPD	Y N	HIV/AIDS	Y N	Shortness of Breath	Y N
Artificial Heart Valve/Stent	Y N	Epilepsy/Seizure	Y N	Kidney Problems/UTI	Y N	Sinus Problems	Y N
Artificial Joints	Y N	Excessive Bleeding	Y N	Liver Disease/Jaundice	Y N	Stomach Problems	Y N
Covid 19	Y N	Gastric Reflux/GERD	Y N	Mental Disorders	Y N	Stroke, Date_____	Y N
Autoimmune Disease	Y N	Glaucoma	Y N	Nervous Disorders	Y N	Thyroid Disease	Y N
Blood Disorders	Y N	Gout	Y N	Osteoporosis	Y N	Tobacco Use	Y N
Cancer, Date_____	Y N	Head Injuries	Y N	Pacemaker	Y N	Tuberculosis/Lung Disease	Y N
Canker Sores	Y N	Heart Attack, Date____	Y N	Parathyroid Disease	Y N	Tumors/Growths	Y N
Chemical/Alcohol Dependency	Y N	Heart Disease/Murmur	Y N	Psychiatric Care	Y N	Ulcers/Colitis	Y N
Congenital Heart Lesion	Y N	Other	Y N	Radiation/Chemotherapy	Y N	Venereal Disease	Y N

Notes: _____

_____

_____

_____

Have you ever had any other serious illness or condition not circled above?_____ ☐ Yes ☐ No

Do you wish to talk to the doctor privately about any problem?_____ ☐ Yes ☐ No

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I have any change in my health, I will inform the doctor at the next appointment without fail.

X_____Date_____

Patient Signature (Parent or Guardian)

X_____Date_____B.P. _____

Reviewed by Doctor

PATIENT NAME: _____

DENTAL HISTORY

Name/phone of previous dentist _____ Date of last visit? _____ Comments

Do you have a specific dental problem or any discomfort?	☐ Yes	☐ No	_____
How would you describe your present dental health?	_____		
Do your gums ever bleed?	☐ Yes	☐ No	_____
Do you brush on a routine basis?	☐ Yes	☐ No	_____
Do you floss on a routine basis?	☐ Yes	☐ No	_____
Have you ever had a bad experience in a dental office?	☐ Yes	☐ No	_____
Do you ever brux or grind your teeth?	☐ Yes	☐ No	_____
Have you ever had gum surgery and/or scaling and root planing?	☐ Yes	☐ No	_____
Have you ever had orthodontic treatment (tooth straightening)?	☐ Yes	☐ No	_____
Do you ever have clicking/popping or discomfort in the jaw joints (TMJ)?	☐ Yes	☐ No	_____
Have you ever been diagnosed with sleep disorders or Sleep Apnea?	☐ Yes	☐ No	_____
Do you use a CPAP?	☐ Yes	☐ No	_____

PLEASE SELECT ONE BOX ON EACH LINE

My mouth is	❑ very comfortable	❑ mostly comfortable	❑ uncomfortable
The appearance of my smile	❑ is excellent	❑ could be better	❑ is not a concern
The dentistry recommended to me has	❑ always been done	❑ occasionally been done	❑ never been done
My dental health is	❑ excellent	❑ fair	❑ poor
I receive Fluoride through water or supplements	❑ yes	❑ no	
I have a history of established dental care, where I have regular dental check ups and cleanings	❑yes	❑no	

COMMITMENT LETTER

Our Commitment
At Sierra Oaks Dental Group, we are committed to excellence. We feel that you deserve nothing less when it comes to your health. We use the best materials and techniques available in order to provide you with the quality you have come to expect from us.

We believe that our relationship with you, as with all relationships, needs open and clear communication. We will try to communicate all of your dental needs and estimate your financial information as soon as it becomes evident. We want you to be as informed as possible to help you in your decisions concerning your dental health.

We understand how valuable your time is, so we make every effort to remain on time. We do not double book our appointments. We feel that you deserve our complete and focused attention so that we may provide the best care possible. Your reserved time is exclusively yours.

Your Commitment
We want you to be comfortable with our team. If you have any questions about your dental treatment, financial or insurance questions, or any concerns at all, we ask that you notify us as soon as possible. We will be glad to clarify any uncertainties that may arise.

Your portion of your treatment is expected at the time of your services. For your convenience we do accept many forms of payment including cash, check, VISA, Mastercard, American Express, and we also offer third party financing, which includes both interest free programs and extended financing.

Your scheduled appointment is reserved exclusively for you. We have a **(2) business day [(48) hour] cancellation policy in order to provide you with this personalized attention.** We understand that circumstances may arise that require an appointment to be rescheduled. We are happy to change your appointment time if a (2) business day [(48) hour] notice is given. If sufficient notice is not given, your account will automatically be charged a **$50.00 missed appointment fee.** We ask that you make every effort to keep your reserved time.

By signing this you are agreeing that you have read and understand the Cancellation Policy and Commitment Agreement of the practice and you agree to uphold your end of the agreement in its entirety.

_____ _____
Print Patient Name Witness

_____ _____
Patient Signature Date

AUTHORIZATION FOR USE AND IMAGE RELEASE

For and in consideration of my engagement as a patient in the dental practice of Dr. Peter Kim and participating Doctors at Sierra Oaks Dental Group, I hereby grant Dr. Peter Kim, Sierra Oaks Dental Group, heirs, legal representatives and assigns, and those acting with its authority and permission, the absolute right and permission to copyright in its name or otherwise, to use, re-use, publish, re-publish, reproduce or circulate photographs and/or video of myself, in whole or in part, without restrictions as to alterations, in conjunction with my own name or any assumed name, or reproduction thereof, made through any and all media now or hereafter known, for illustration, promotion, or any purpose whatsoever. I further consent to the use of any text used in conjunction therewith. In addition, I authorize Dr. Peter Kim and Sierra Oaks Dental Group, its employees and agents, to use and disclose my name, face, voice, video or film image and my personal health information including the treatment I am receiving or have received in the dental practice of Dr. Peter Kim at Sierra Oaks Dental Group.

I hereby waive any right that I may have to inspect or approve the finished product, or products and the text, copy, or other matter which may be used in conjunction therewith, or to the use to which it may be applied. I agree that this release validates use of my photographs, videos, and audio in any means, including but not limited to, promotional materials, contests or advertising and including but not limited to, the use of such images and audio on products, and for the purpose of trade, and I hereby consent to the use of any printed, graphic, photographic, electronic, computer generated, or any other accompanying matter in any media form.

I hereby agree to release, discharge and agree to save harmless Dr. Peter Kim and Sierra Oaks Dental Group, heirs, legal representatives and assigns, and all persons acting under its permission or authority, or those for whom it is acting, from any liability by virtue of blurring, distortion, alteration, optical illusion, electronic manipulation, or use in composite form, whether intentional or otherwise, that may occur during publication or in any subsequent processing thereof, including without limitation any claims for libel or invasion of privacy. I hereby warrant that I have read the above authorization, release, and agreement prior to its execution and I am fully familiar with the contents thereof. This release shall be binding upon me, my heirs, my legal representatives and assigns.

Understanding that dental practice of Dr. Peter Kim, Sierra Oaks Dental Group are relying thereon, I hereby represent and warrant that I am at least 18 years of age and am of lawful age to contract and am competent to contract in my own name insofar as this agreement is concerned.

I do not have to sign this authorization. When my information is used or disclosed pursuant to this authorization it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPPA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Dr. Peter Kim, Sierra Oaks Dental Group has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at: Sierra Oaks Dental Group, 3406 American River Dr., Suite A, Sacramento, CA 95864.

“I acknowledge that I have received the Authorization for Use and Image Release”

_____	_____	_____
Name (print)	Signature	Date
_____	_____	_____
Witness (print)	Signature	Date