New Patient Dental Paperwork

Sendero Dental Studio

30901 gateway Place, Suite F5, Rancho Mission Viejo, CA 92694
Phone: 949-371-8533 **Email:** Admin@senderodental.com

Patient Information

Date: _____

***Patient Name:** _____

***Date of Birth:** _____ **SS#** _____

***Address:** _____

***City:** _____ **State:** _____ **ZIP:** _____

***Phone:** _____ **Email:** _____

***Employer/Occupation:** _____

Emergency Contact

***Name:** _____ **Relationship:** _____

***Phone:** _____

Communication Consent (Email & Texts/SMS)

By Signing below, I consent to receive communications from **Sendero Dental Studio** related to my dental care, including appointment reminders, billing statements, insurance notifications, treatment information, and office updates via the methods selected below. I understand that standard and data rates may apply.

- **Email Consent:** _____ **Yes** _____**No –**
- **Preferred Email:** _____
- **Text/SMS Consent:** _____**Yes** _____**No –**
- **Mobile Phone # for Texts:** _____

I Understand that I may revoke this consent at any time by notifying the office in writing.

Patient/ Guardian initials: _____ **Date:** _____

Dental Insurance Information

***Primary Insurance:** _____

***Subscriber Name:** _____

***Subscriber DOB:** _____ **ID #:** _____

***Secondary Insurance (if any):** _____

*** Medical Insurance:** _____

*** Medical Insurance ID#:** _____

-I understand that dental insurance is a contract between myself and my insurance carrier. Verification of benefits is not a guarantee of payment, and I am responsible for all charges not covered by insurance.

Initials: _____ **Date:** _____

Financial policy & Insurance Acknowledgment

- I understand that dental insurance is a contract between myself and my insurance carrier, not between the insurance company and the dental office.
- I understand that verification of benefits is provided as a courtesy only and is **not a guarantee of payment or coverage.**
- I understand that I am financially responsible for **all charges**, including deductibles, copayments, coinsurance, non-covered services, and any balance remaining if my insurance determines services to be **out of network**.
- I authorize payment of insurance benefits directly to **Sendero Dental Studio** when applicable.
- I understand that any balances not paid by insurance are my responsibility and agree to pay such balances in a timely manner.

Patient initials: _____ **Date:** _____

Out-Of-Network Consent

*-I acknowledge that **Sendero Dental Studio may be an out-of-network provider** with my dental insurance plan. I understand that out-of-network services may result in higher out-of-pocket costs or reduced insurance benefits. I accept full financial responsibility for all services rendered regardless of my insurance company's determination.*

-I Confirm that I have had the opportunity to contact my insurance carrier to verify network status and benefits prior to my scheduled appointment.

Patient Initials: _____ **Date:** _____

Dental History

***Reason for today's visit:** _____

_____

_____

***Last dental visit:** _____

***Previous dentist/office:** _____

Have you ever experienced any of the following? (Check all that apply)

Tooth Pain: _____ *Bleeding Gums:* _____ *Gum Disease:* _____
Sensitivity to hot/cold: _____ *Loose teeth:* _____ *Bad Breath:* _____
Jaw pain/clicking: _____ ***Headaches:*** _____ *Grinding or clenching:* _____
Sores or lesions: _____ *Difficulty chewing:* _____

- **Do you require antibiotics prior to dental treatment?** _____**Yes,** _____**No**
- **Are you anxious about dental treatment?** _____ **Yes,** _____**No**

Medical History

- **Primary Care physician:** _____ **Phone:** _____
- **Date of last physical exam:** _____

Do you have, or have you ever had, any of the following? (Check all that apply)

Heart Disease: _____ *High Blood Pressure:* _____ *Stroke:* _____ *Pacemaker:* _____
Diabetes: _____ *Thyroid disorder:* _____ *Asthma:* _____*COPD:* _____
Sleep apnea: _____ *kidney disease:* _____ *Liver disease:* _____ *Cancer:* _____
Radiation therapy: _____ *Chemotherapy:* _____ *Osteoporosis:* _____ *Arthritis:* _____
Autoimmune disorder: _____ *Bleeding disorder:* _____ *Anemia:* _____
HIV/AIDS: _____ *Hepatitis (A/B/C):* _____ *Tuberculosis:* _____ *Seizures:* _____
Fainting/dizziness: _____ *Mental health condition: (anxiety, depression, etc):* _____

Please explain any conditions checked:

_____

_____

_____

_____

_____

Medications

- **List all current medications (including dosage):**

_____

_____

_____

- **Are you taking blood thinners? Yes _____ No_____**
  If yes, please list: _____

Allergies

No known Allergies: _____ Amoxicillin:_____ Penicillin: _____ Latex:_____
Aspirin:_____ Ibuprofen: _____ Codeine: _____ Local anesthetics: _____
Metals: _____ Other: _____

Women Only

- **Are you pregnant or nursing? Yes_____ No _____**

Social History

- **Do you smoke or vape? Yes _____ No _____ Former _____**
- **Do you use alcohol? Yes _____ No_____**
- **Do you use recreational drugs? Yes _____ No _____**

Credit Card on file authorization

To help streamline billing and reduce outstanding balances, **Sendero Dental Studio requires a credit/debit card to be securely kept on file.**

- I **authorize Sendero Dental Studio** to charge my card on file for any balance not paid by insurance, including copays, deductibles, coinsurance, non-covered services, missed appointment fees, and outstanding balances after insurance processing.
- I understand I will receive notice prior to any charge when applicable.
- I may revoke this authorization in writing; however, I understand that doing so may require payment at time of service.

Card Type: Visa _____ MasterCard _____ AmEx _____ Discover _____
Name on Card: _____
Last 4 digits of card: _____
Expiration Date: _____/_____

Cardholder Signature: _____ **Date:** _____

Consent and Acknowledgement

I certify that the information provided is complete and accurate to the best of my knowledge. I will inform the dental office of any changes to my medical history. I authorize the dental team to perform necessary diagnostic procedures and dental treatment as indicated.

- Patient/ Guardian Signature: _____
- Date: _____

HIPPA Notice of Privacy Practices Acknowledgement

I acknowledge that I have received and reviewed the **HIPPA Notice of Privacy Practices from Sendero Dental Studio**, which explains how my health information may be used and disclosed and how I can access the information.

Patient / Guardian Initials: _____ **Date:** _____

Missed Appointment / Late Cancellation Policy

- Appointments must be cancelled or rescheduled at least **24 hours in advance**.
- Missed appointments or late cancellations will result in a **fee of $75 for Hygiene appointments and $150 for doctor appointments.**
- Repeated missed appointments may require **prepayment for future appointments.**
- Fees for missed appointments are the **responsibility of the patient, parent or guardian and are not covered by insurance.**

Patient/ Guardian Initials: _____ **Date**: _____

Office Use only – reviewed by: _____ **Date:** _____

Notes: _____