White Sage Dentistry® of Salem – Shruti Jadeja, DDS **Today's Date:** ________________

Patient Information

Name: ____ **Birth Date:** ____________________
Last First MI Nickname

Gender: ❒ Male ❒ Female **Family Status:** ❒ Married ❒ Single ❒ Other **Social Security Number:** ____________________

Address: ____
Street Apt # City State ZIP

Home Phone: ____________________ **Work Phone:** ____________________ ext ________

Cell Phone: ____________________ **E-mail address:** ____________________

Occupation: ❒ Homemaker ❒ Retired ❒ Full-time Student ❒ Other: ____________________

Employer & Address: ____

Responsible Party Information

Name: ____ **Birth Date:** ____________________
Last First MI Nickname

Relationship to Patient: ❒ Patient ❒ Spouse ❒ Parent❒ Legal Guardian

Gender: ❒ Male ❒ Female **Family Status:** ❒ Married ❒ Single ❒ Other **Social Security Number:** ____________________

Address: ____
Street Apt # City State ZIP

Home Phone: ____________________ **Work Phone:** ____________________ ext ________

Cell Phone: ____________________ **E-mail address:** ____________________

Occupation: ____________________ **Employer & Address:** ____________________

Insurance Information

Primary Insurance:

Name of Insured: ____ **Is Insured a patient?** ❒ Yes ❒ No
Insured's Birth Date: ________________ **Relationship to Patient:** ❒ Patient ❒ Spouse ❒ Parent ❒ Legal Guardian
Insurance: ____________________ **Group #:** ____________ **ID#:** ____________
Insured's Address (if different than patient's): ____

Secondary Insurance:

Name of Insured: ____ **Is Insured a patient?** ❒ Yes ❒ No
Insured's Birth Date: ________________ **Relationship to Patient:** ❒ Patient ❒ Spouse ❒ Parent ❒ Legal Guardian
Insurance: ____________________ **Group #:** ____________ **ID#:** ____________
Insured's Address (if different than patient's): ____

Referral Information

Whom may we thank for referring you to our practice? Please give us their name, so we can thank them!
❒ Another patient ❒ Newspaper ❒ Postcard ❒ Letter ❒ Insurance ❒ Friend/Relative ❒ Other: ____________________
Name of Person or office who referred you: ____

ADULT HEALTH HISTORY

***White Sage Dentistry*®. | Shruti Jadeja, DDS**

Name: ____ Date of Birth: ____________

Height: ____________ Weight: ____________ Date of last medical exam: ____________________

List any medications you are taking currently, including vitamins, herbs, OTC, birth control pills: ____________

____

Are you allergic to, or have you reacted adversely to, any of the following:

Aspirin: ❒ Yes ❒ No Codeine: ❒ Yes ❒ No
Penicillin: ❒ Yes ❒ No Erythromycin: ❒ Yes ❒ No Latex: ❒ Yes ❒ No
Local Anesthetic: ❒ Yes ❒ No Nitrous Oxide: ❒ Yes ❒ No

Other (please describe): ____

Are you allergic to any foods? ❒ Yes ❒ No

If yes, please list: ____

Are you in good health? ❒ Yes ❒ No
Has there been any change in your health in the past year? ❒ Yes ❒ No
Are you under the care of a Physician? ❒ Yes ❒ No
If yes, for what condition(s)? ____

Physician's name: ______________________________________ Specialty: ________________

Have you had any serious illness, operation or been hospitalized in the past 5 years? ❒ Yes ❒ No

If yes, for what condition(s)? ____

Do you smoke? ❒ Yes ❒ No

If yes, # of Packs per day: ______________ For how many years: ______________

Do you have a history of alcohol abuse and/or drug use? ❒ Yes ❒ No

If yes, please explain: ____

Are you using any recreational drugs? ❒ Yes ❒ No

If yes, please list____

Has your physician ever told you to take antibiotics prior to dental visits? ❒ Yes ❒ No

Have you ever had complications following dental treatment? ❒ Yes ❒ No

PLEASE CONTINUE ON PAGE TWO

Name: ______________________________ Date of Birth: ____________

Do you have, or have you had, any of the following disease or problems? Please check all that apply.

Condition	Yes	No	Condition	Yes	No
Anemia	❒ Yes	❒ No	HIV/AIDS	❒ Yes	❒ No
Angina	❒ Yes	❒ No	Jaundice	❒ Yes	❒ No
Arthritis	❒ Yes	❒ No	Kidney trouble	❒ Yes	❒ No
Artificial heart valve(s)	❒ Yes	❒ No	Liver disease	❒ Yes	❒ No
Artificial joints or grafts	❒ Yes	❒ No	Low blood pressure	❒ Yes	❒ No
Asthma	❒ Yes	❒ No	Pacemaker	❒ Yes	❒ No
Bleeding disorders	❒ Yes	❒ No	Painful joints	❒ Yes	❒ No
Bronchitis	❒ Yes	❒ No	Persistent diarrhea	❒ Yes	❒ No
Cancer	❒ Yes	❒ No	Pneumonia	❒ Yes	❒ No
Chronic cough	❒ Yes	❒ No	Psychiatric problems	❒ Yes	❒ No
Chronic heartburn	❒ Yes	❒ No	Radiation therapy	❒ Yes	❒ No
Compromised immune system	❒ Yes	❒ No	Recent weight loss	❒ Yes	❒ No
Congenital heart defect	❒ Yes	❒ No	Respiratory problems	❒ Yes	❒ No
Coronary disease	❒ Yes	❒ No	Rheumatic heart disease	❒ Yes	❒ No
Diabetes	❒ Yes	❒ No	Rheumatism	❒ Yes	❒ No
Emphysema	❒ Yes	❒ No	Sexually transmitted disease	❒ Yes	❒ No
Epilepsy/seizures	❒ Yes	❒ No	Severe “gag” reflex	❒ Yes	❒ No
Fainting spells	❒ Yes	❒ No	Sinus problems	❒ Yes	❒ No
Frequent urination	❒ Yes	❒ No	Sleep apnea	❒ Yes	❒ No
Gastric reflux	❒ Yes	❒ No	Stroke	❒ Yes	❒ No
Glaucoma	❒ Yes	❒ No	Swollen glands	❒ Yes	❒ No
Hay fever/allergies	❒ Yes	❒ No	Thyroid problems	❒ Yes	❒ No
Heart attack	❒ Yes	❒ No	TMJ disorder	❒ Yes	❒ No
Heart murmur	❒ Yes	❒ No	Tuberculosis	❒ Yes	❒ No
Hepatitis	❒ Yes	❒ No	Ulcers	❒ Yes	❒ No
High blood pressure	❒ Yes	❒ No			

Are you taking Bisphosphonates (e.g., Fosamax, Boniva) currently? ❒ Yes ❒ No

Have you ever taken Bisphosphonates? ❒ Yes ❒ No

If yes, when did you stop taking them: ______________________________

Women: Are you currently pregnant? ❒ Yes ❒ No

If yes, what is your due date: ______________________________

Are you nursing? ❒ Yes ❒ No

Is there any possibility that you might be pregnant? ❒ Yes ❒ No

I understand that withholding any information about my health could seriously jeopardize my safety. I have reviewed this health history form carefully and have answered all questions truthfully to the best of my knowledge. I will inform the doctors of any changes in my health.

______________________________ ______________________________

Signature of Patient or Legally Authorized Representative — Date

______________________________ ______________________________

Printed Name of Patient or Representative — Relationship to Patient

Financial Policy

Shruti Jadeja DDS, LLC

We appreciate you choosing us as your dental health care team. Your optimal oral health is of utmost importance to us. We have found that a clear understanding of your financial obligations in advance of your dental care helps us provide you with an overall pleasant experience that you very well deserve! Please read the following information carefully to prevent potential misunderstandings and ask us any questions you might have. We are here to answer them in the best possible way we can!

Patients with a Dental benefit plan

Your dental benefit plan is a contract between you and the benefit providing company you pay premiums to. Benefits and coverage for different procedures can vary significantly from plan to plan. The dental benefit plan is not designed to provide 100% coverage, but rather to assist you with investing in your dental care. The cost of the treatment is your responsibility regardless of the benefits and coverage.

As a courtesy to you, we are happy to submit claims to your dental benefit provider on your behalf.

Patients without a Dental Benefit plan

For our patients without a dental benefit plan the fees for service can be paid in one of the following methods;

1. Single payment:

   Entire fee for the service will be due at the time of appointment. This is applicable to one appointment procedures such as fillings, extractions, prophylactic teeth cleaning, complete exam, limited exam, etc.

2. Two payments:

   1/3 portion due when reserving time with the Doctor/hygienist, with remaining amount due by second appointment. Multiple payment method is only applicable to procedures with multiple steps. (For Example: Crowns, Bridges, Dentures, Partials, Periodontal therapy (deep cleaning), etc.)

3. Three payments:

   1/3 portion due when reserving time with the Doctor, 1/3 payable between the appointments, 1/3 payable at the completion of the procedure. Multiple payments are only applicable for procedures with multiple steps.

4. Term Loan:

   We also offer third party (12month) no interest financing options through CareCredit. We would love to help you with the application!

Returned checks:

The fee for a returned check is $35.00 per occurrence, and the loss of the privilege to write another check at our office.

Minor patients:

If your child under the age of 18 is being cared for at our practice, please plan to be present at his/her appointment. If an unforeseen event were to occur that would not allow you to be present for the visit, please contact our office prior to the scheduled appointment to make necessary payment arrangements.

Late arrival:

We value your time and do our very best to see you on your scheduled time. We understand that unforeseen events occur; however, we expect and appreciate your timely arrival for your scheduled appointment. In the event of your late arrival, we may not be able to perform all the scheduled procedures or may need to reschedule your visit out of respect for the patients scheduled after you.

Missed appointments:

When you schedule your appointment, our entire team reserves that time for you! Any scheduled appointment is a confirmed appointment. We do make a courtesy call to you two days prior to your scheduled appointment as a reminder. In case of unforeseen circumstances we expect a notice of 48 hours to make a change to your appointment. A pattern of missed appointments may result in the dismissal from our practice.

Signature____ **Date**_______________

CONSENT FOR SERVICES

White Sage Dentistry ® Salem | Shruti Jadeja, DDS

Welcome to White Sage Dentistry! We are excited that you have chosen our office to help you to great oral health. We appreciate the trust you have placed in us, and we will do our best to provide the high-quality dental care that you expect and deserve. We believe you should receive prompt attention and excellent service. We believe a satisfied patient returns for additional services and refers others to the office that they feel would benefit from our services.

By signing, you hereby authorize the Doctors and/or their assignees to take radiographs, study models, photographs or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of your dental needs. Additionally, you give permission for such items to be used for purposes of research, education, marketing or publication in professional journals. In addition, unless you notify our office otherwise, we may use your written comments in material to promote White Sage Dentistry and/or the Doctors.

By signing, you hereby authorize the Doctors and/or their assignees to perform any and all forms of treatment, medication and therapy that may be indicated. By signing, you also indicate your understanding that the use of anesthetic agents embodies a certain risk.

By signing, you hereby authorize White Sage Dentistry the Doctors and/or their assignees to release information to third party payers about your treatment, and to other health practitioners involved in your care.

By signing, you hereby agree to assign all insurance benefits to White Sage Dentistry and/or the Doctors.

By signing, you hereby grant your permission to White Sage Dentistry the Doctors or their assignees to contact you at home or at work to discuss matters related to your care.

I have read and understand the above conditions and agree to their content.

____ _______________________

Signature of Patient or Legally Authorized Representative — Date

____ _______________________

Printed Name of Patient or Representative — Relationship to Patient

Emergency Contact: In the event of an emergency, whom should we contact?

____ ____________________ ______________

Name — Relationship — Phone Number

ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

White Sage Dentistry® Salem | Shruti Jadeja, DDS

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires that health care providers give patients a copy of the office's Notice of Privacy Practices and make a good faith effort to obtain an acknowledgement of receipt of the Notice.

You may refuse to sign this acknowledgement form.

By signing this form I confirm that I have received a copy of this office's Notice of Privacy Practices.

______________________________________ ____________________

Signature of Patient or Legally Authorized Representative Date

______________________________________ ____________________

Printed Name of Patient or Representative Relationship to Patient

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 prevented us from obtaining the acknowledgement
- ❒ An emergency situation prevented us from obtaining the acknowledgement
- ❒ Other (Please specify): ____

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