SANDIA EIGHTS
DENTAL CARE

Patient Information

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, please don't hesitate to ask.

Patient Name: _____ Today's Date: _____

Social Security No: _____ Date of Birth: _____ Age: _____ Sex: _____

Driver's License #: _____ State Issued: _____

Home Address, City, State, Zip: _____

Phone #: _____ Cell Phone: _____ Email: _____

Billing address (*If different from above*): _____

Employer/Occupation: _____ Business Phone #: _____

Spouse's Name: _____ Spouse's Phone #: _____

Emergency Contact/Phone # (*other than spouse*): _____

Name of Pharmacy: _____

Pharmacy Cross streets: _____

Health History Form

SANDIA EIGHTS DENTAL CARE

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: *Last* *First* *Middle*

Do you have any of the following diseases or problems: *(Check DK if you Don't Know the answer to the question)*	Yes	No	DK
Active Tuberculosis	☐	☐	☐
Active Covid-19	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis/Covid-19	☐	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information *Please mark (X) your responses to the following questions.*

	Yes	No	DK
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐
If yes, how often? (*Check one:*) DAILY / WEEKLY / OCCASIONALLY			
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	No	DK
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam:

What was done at that time?

Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

	Yes	No	DK
Are you now under the care of a physician?	☐	☐	☐
Physician Name: Phone: *Include area code* ( )			
Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

If yes, what condition is being treated?

Date of last physical exam:

	Yes	No	DK
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what was the illness or problem?

	Yes	No	DK
Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐

If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:

Continued on back

Medical Information

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

(Check DK if you Don't Know the answer to the question)

	Yes	No	DK
Do you wear contact lenses?	☐	☐	☐
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐	☐
Date: _____ If yes, have you had any complications? _____			
Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease?	☐	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia®, Zometa®, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	☐	☐	☐
Date Treatment began: _____			

	Yes	No	DK
Do you use controlled substances (drugs)?	☐	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)?	☐	☐	☐
If so, how interested are you in stopping? *Circle one:* VERY / SOMEWHAT / NOT INTERESTED			
Do you drink alcoholic beverages?	☐	☐	☐
If yes, how much alcohol did you drink in the last 24 hours? _____			
If yes, how much do you typically drink i n a week? _____			

WOMEN ONLY Are you:

Pregnant?	☐	☐	☐
Number of weeks: _____			
Taking birth control pills or hormonal replacement?	☐	☐	☐
Nursing?	☐	☐	☐

Allergies. Are you allergic to or have you had a reaction to:
To all **yes** responses, specify type of reaction.

	Yes	No	DK
Local anesthetics _____	☐	☐	☐
Aspirin _____	☐	☐	☐
Penicillin or other antibiotics _____	☐	☐	☐
Barbiturates, sedatives, or sleeping pills _____	☐	☐	☐
Sulfa drugs _____	☐	☐	☐
Codeine or other narcotics _____	☐	☐	☐
Metals _____	☐	☐	☐
Latex (rubber) _____	☐	☐	☐
Iodine _____	☐	☐	☐
Hay fever/seasonal _____	☐	☐	☐
Animals _____	☐	☐	☐
Food _____	☐	☐	☐
Other _____	☐	☐	☐

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

	Yes	No	DK
Cardiovascular disease	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Other congenital heart defects	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion	☐	☐	☐
If yes, date: _____			
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐

	Yes	No	DK
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐

	Yes	No	DK
Glaucoma	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders	☐	☐	☐
If yes, specify: _____			
Sleep disorder	☐	☐	☐
Do you snore?	☐	☐	☐
Mental health disorders	☐	☐	☐
Specify: _____			
Recurrent Infections	☐	☐	☐
Type of infection: _____			
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/ migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☐	☐	☐

Name of physician or dentist making recommendation:

Phone: *Include area code*
( )

Do you have any disease, condition, or problem not listed above that you think I should know about?	☐	☐	☐

Please explain:

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: Date:

Signature of Dentist: Date:

FOR COMPLETION BY DENTIST

Comments:

SANDIA EIGHTS
DENTAL CARE

Office Policy and Consent Form

Please remember that we are here to serve you in a comfortable and professional atmosphere. Our goal is to provide you with the very best quality of dental care.

Office Policies and Appointments:

- Your appointment time is set aside especially for you. We ask for the courtesy to Doctor Leon, the hygienists and to our other patients that you keep your scheduled appointments. We also ask that you are on time, or it may result in a rescheduled appointment. ***If you must miss an appointment, we REQUIRE a 48 hour notice. Cancellations, last minute rescheduling or failure to show can result in a broken appointment charge of $65. This policy will be strictly enforced due to our high volume of patients. Initials:_____***
- Our office will provide two-week reminder calls as well as two-day confirmation calls to you. At the time the confirmation call is made, if a message is left, it is confirming your appointment unless we hear otherwise from you.
- All adult patients/guardians will be responsible for their children's fees incurred at the time of their services.
- We are able to work out payment arrangements if needed. Please ask to speak to the financial coordinator. We ask that if you do utilize this service that you be fair in honoring your commitments. A $25 late fee will be added to your account after the 15th day.
- Any time a procedure is done by Dr. Leon, we require a consent form to be read, understood and signed before the treatment is started. At this time, any questions may be directed to Dr. Leon and/or assistant.
- Every year, we require a patient update form to be filled out so that we are notified of any health changes, insurance changes, address or phone number changes.

Insurance and Payment Policy:

- **For patients with Dental Insurance:**
  Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. We will gladly file your claim for you at no charge; however, we ask that your deductibles and your estimated portions be paid as services are rendered. **Please keep in mind, *although we gladly file dental insurance claims as a courtesy to you, ANY AND ALL ACCOUNT BALANCES ARE ULTIMATELY YOUR RESPONSIBILITY.***
  Initials_____
- ***FEES FOR SERVICE AT OUR OFFICE WILL BE REQUESTED AT THE TIME OF YOUR VISIT UNLESS A PAYMENT PLAN WAS PREVIOUSLY DISCUSSED AND PUT INTO PLACE.***
- Please note, for your convenience, we do accept VISA, Master Card, Discover, American Express and Care Credit as well as checks and cash. We do charge a $25 returned check fee.

CONSENT : I have read and understand all the above information. The undersigned hereby authorizes Doctor Leon to perform those diagnostic and treatment procedures, including local anesthesia and sedation, deemed necessary. If I ever have any change in my health or change in my medication, I will inform Doctor Leon at the next appointment. FOR INSURED PATIENTS, my signature below authorizes assignment of insurance benefits to Doctor Leon and authorizes the release of dental records to my insurance company.

_____ _____

Printed Patient Name **Date**

_____

Patient Signature

SANDIA HEIGHTS
DENTAL CARE

HIPAA Privacy Policy

This notice describes how Medical/Dental information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

We understand that the privacy of your personal information is important to you. As your Dental office, we believe your right to privacy is a fundamental part of your treatment; such as, we want you to understand our privacy practices and procedures. Should you have any questions regarding these policies please do not hesitate to call the office at 505-332-8025.

INFORMATION WE COLLECT ABOUT YOU

We collect personal information about you and your family as part of our new patient process, during the course of your care, and from other health care entities you utilize such as, other Dentists and specialists, imaging facilities, laboratories and your insurance company. This personal information includes items such as your name, address, phone number, birth date, social security number, employer, health history, insurance policy and coverage information and any information you provide. During the course of your treatment we will collect Dental information regarding diagnosis, treatment plans, progress and any test results or films.

HOW YOUR INFORMATION IS USED

The personal and health information gathered may be used and disclosed with your general consent for purposes of treatment, payment, or routine healthcare operations. This means we may send your information to other Dentists or facilities involved in your treatment as well as to your insurance company or a collection agency to obtain payment. Any other uses of your information require a signed authorization by you, the patient or guardian and can be revoked at any time with a written request. Sandia Heights Dental Care does not sell patient information to marketing or pharmaceutical companies. In certain cases of public health interest we may be required to disclose certain information to local, state or national health organizations or government agencies.

We may contact you to provide appointment reminders or information about treatment.

SAFEGUARDING YOUR PERSONAL AND HEALTH INFORMATION

We are required by law to (1) make sure that medical information that identifies you is kept private,(2) provide you with our privacy policy, (3) follow the terms laid out in the privacy policy. As a means of protecting your privacy, we restrict access to your personal and health information to only those employees that require the information to complete their jobs and provide quality service to you.

Sandia Heights Dental Care maintains physical, electronic and procedural safeguards to comply with state and federal regulations that guard your personal and health information. If you feel your privacy has been violated you have the right to file a complaint with the Department of Health and Human Services. The complaint in no way influences your course of treatment with Sandia Heights Dental care.

CHANGES IN OUR OFFICE POLICY

All new patients will review a copy of our office policy. Sandia Heights Dental Care occasionally reviews its office policy and reserves the right to amend it. Notification of changes will be available at the front desk prior to the effective date of any changes.

YOUR RIGHT TO RESTRICT USE OF INFORMATION

You have the right to request restrictions to our uses or disclosures of your personal or health information, although we are not required to agree to those restrictions. Once you request has been processed it will remain in effect until you request a change.

PATIENT ACKNOWLEDGEMENT

_____ _____

Printed Patient Name **Date**

_____

Patient Signature

SANDIA EIGHTS
DENTAL CARE

Non-Covered Services Dental Consent Form

I understand that some services may not be considered eligible to be covered by my dental benefits (e.g., services, and/or supplies may be determined to not be dentally necessary, non-covered or investigational) by my dental insurance provider. I understand that my dental insurance coverage has certain restrictions and limitations, such as authorization requirements, waiting periods, as well as non-covered service. **Examples of these may include, but are not limited to:**

- Fluoride (Due to age limitations/frequency)
- Porcelain Crowns/Porcelain Margins on Crowns
- Composite Resin Fillings
- Inlays/Onlays
- Sealants (Due to age limitations/frequency)
- Arestin (Anti-Microbial Agent)
- Lab Fees
- Mouth Guards/ Occlusal Splints
- X-Rays/Procedures (Not covered due to insurance frequency or history)

I understand that I am fully responsible for any and all related charges if they are not covered by my dental insurance.

Signature of person Financially Responsible Date

SANDIA HEIGHTS
DENTAL CARE

PERMISSION TO SHARE MEDICAL/DENTAL INFORMATION

The addendum to the Sandia Heights Dental Care Privacy Policy is used to detail the specific people that we may share your personal medical information with. All of the guidelines and policies detailed in the signed Privacy Policy, regarding the safeguard of your information, will be observed in all cases. This list will contain the **ONLY** people with whom we will share your information with the exception of the professionals detailed on our Privacy Policy.

INFORMED CONSENT

I understand that my medical and dental records are closely protected under federal law, and I give Sandia Heights Dental Care, Dr. Monique Leon, and her associates permission to obtain or share my medical and dental information the following:

Name/Relationship:

1. _____
2. _____
3. _____

Signature of Patient/Guardian: _____

Date: _____

SANDIA HEIGHTS
DENTAL CARE

Authorization and Consent to Send Encrypted Patient Information

By Email and Other Electronic Means

Until I inform you in writing to stop, I authorize Sandia Heights Dental Care to transmit patient information relating to all my treatment, health, or payments by email or other electronic means that are encrypted, to me or someone I designate, or to other health care providers, health plans and others involved in my treatment, or Sandia Heights Dental Care healthcare operations. The patient information that may be emailed may include x-rays, health history, diagnosis, treatment and payment records.

I understand that:

- I do not have to sign this form
- My treatment, payment, enrollment and eligibility of benefits will not be affected by my decision about signing this form
- If I do not sign this form, Sandia Heights Dental Care may use other ways to send my information, such as US Mail, or may ask me to send the information to third parties myself
- There is some risk that emails and other electronic messages may be improperly acquired by hackers or received by unintended recipients. If that happens, the information may be redisclosed and no longer protected by privacy law
- Sandia Heights Dental Care does not email such sensitive personal information and Social Security number, credit card number, diagnosis and drivers license unless the patient insists

I can tell you in writing to stop emailing my patient information at any time, but if I do so, this will not affect emails that Sandia Heights Dental care already sent before receiving my written instructions to stop.

Patient Name (Please Print): _____

Patient Signature: _____ Date: _____

Please check your preferred method of communication, notification of balances and receipt of billing statements (please check all that apply):

_____ Mail

_____ E-mail

_____ Text Message