MANGILAO
DENTAL CLINIC

Hafa Adai! Welcome to our clinic!

At Mangilao Dental Clinic, we strive to redefine dentistry by providing exceptional dental care while elevating the patient experience. With Dr. Sarah Clegg, you will always receive honest and judgement-free recommendations, and top-notch treatment personalized to your needs. In return, we kindly ask for you to review and initial the information below to indicate your understanding and introduce you to our practice philosophies and policies!

New Patient Exams

Initial _____

Your first visit will always consist of an exam, and for that x-rays are required. This allows for us to listen to your concerns and to properly diagnose and develop your treatment plan. Comprehensive exams check the entire mouth and determine the type of cleaning best suited for your needs, while limited exams focus on one problem. No matter what your needs, every effort is made to get you started on the right path!

Payments and Insurance

Initial _____

Payment for treatment is due the day services are rendered. It is our goal, however, to assist all of our patients in obtaining the dental treatment they need. We offer several payment options including cash, debit card, credit card, and split payments for larger treatments. For patients with dental insurance, we will file the appropriate claim forms and request copayments as needed.

Appointment Policy

Initial _____

Appointments are reserved just for you, so that we may provide quality, focused care in a relaxed setting. To avoid disruptions in your care and our schedule, we have a strict appointment policy:

- Patients are reminded of their appointments by phone **2 weeks** before, and again **2 days** in advance.
  - Kindly provide a verbal confirmation in order to reserve Dr. Clegg's full attention
- **Please provide at least 48 hours advance notice of a cancellation or change**
  - Last minute changes, no shows, or broken appointments will result in the following restrictions:
    - Same day visits bookings, you may walk-in or call-in to check for same-day openings
    - All future appointment bookings will require a $50 advanced deposit
- **Late arrivals will result in schedule restrictions**
  - Late arrivals greatly disrupt our schedule and our ability to see you will not be guaranteed
  - Continued excessive lateness will be counted as a broken appointment
- **Family appointments require a live person confirmation 48 hours prior**
  - If we cannot reach you and do not hear from you, the appointment will no longer be guaranteed.
  - Family scheduling privileges will be lost if those booked do not comply with above policies.
- **Certain treatment appointments will require an advanced payment to schedule**
  - In the instance where a large block of time is reserved, prepayment will be needed. A broken appointment or excessive lateness will result in a $50 missed visit fee deducted from the balance

We appreciate your cooperation and understanding.
Please do not hesitate to ask us any questions, we are here to assist!
Si Yu'os Ma'åse!

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PATIENT REGISTRATION FORM

Name: _____ Preferred Name:_____

Mailing Address: _____ City:_____ Zip: _____

Birth Date:_____Social Security #:_____ Sex: M / F

Home #: _____Mobile #: _____Other #:_____

Email:_____Marital Status (circle): Married / Single / Child

What is the best way we may contact you (circle)? Home # / Mobile # / Email / Post Mail

How did you first hear of our clinic? _____

Whom may we thank for referring you to our practice? _____

Your last dental clinic: _____Date last seen:_____

In case of an emergency, whom should we contact? Name: _____

Relationship: _____ Home #:_____ Mobile #:_____

Insurance Information (Primary)

Primary Insurance: _____Insurance ID#:_____

Name of Insured:_____Relationship to Patient:_____

Employer: _____ Birthdate:_____Social Security #:_____

Insurance Information (Secondary)

Secondary Insurance: _____Insurance ID#:_____

Name of Insured:_____Relationship to Patient:_____

Employer: _____ Birthdate:_____Social Security #:_____

Acknowledgement of Notice of Privacy Practices

State and federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with a Notice of Privacy Practices. If you prefer a paper copy, please ask a team member for a copy of our Notice.

I acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me.

Patient Name: _____Signature:_____Date:_____

Relationship to patient (if minor) _____Date:_____

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MEDICAL HISTORY

1. Have you been under the care of a medical doctor during the past two years? Yes / No

If yes, please explain_____

2. Are you currently taking any medications? Yes / No

If yes, please list (use back if necessary)_ _____

3. Do you have any allergies to any medications, to latex, or to local anesthesia? Yes / No

If yes, please indicate_____

4. Women: Are you pregnant, trying to get pregnant or breastfeeding? Yes / No

If yes, please indicate how many weeks along _____

5. Do you smoke, chew tobacco, or chew betelnut? Yes / No

6. Have you ever had or currently have any of the following:

	Yes	No		Yes	No		Yes	No
High Blood Pressure			Bleeding Disorders			Epilepsy/Seizures		
Diabetes			Take Blood Thinners			Asthma		
Jaw Joint Pain			Stroke			Respiratory Condition		
Sinus Problems			Cancer			Kidney Disease / Failure		
Artificial Joints			Chemotherapy			Liver Disease		
Heart Valve Replacement			Radiation Therapy			Eating Disorder		
Heart Surgery			HIV/AIDS			Drug/Alcohol Addiction		
Endocarditis			Hepatitis A, B, or C			Mental Health Condition		
Congenital Heart Defects			Tuberculosis			Dental Anxiety		
Heart Attack			Gastric Reflux			Cortisone Medication		
Heart Disease/Condition			Anemia			Osteoporosis		
Pacemaker			Dizziness/Vertigo			Surgery or Hospitalization		
Bisphosphonate Medication: Actonel, Aredia, Fosomax, Reclast, Zometa, Boniva, or Didronel?								

7. If you answered yes to any of the above, please provide details on condition and/or stage of treatment if applicable.

_____

_____

8. Please describe any other conditions you have or have had that were not listed above.

_____

_____

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Mangilao Dental Clinic Financial Policy

At Mangilao Dental Clinic, it is our goal to help our patients in obtaining the dental care they deserve. Our policy requires that payment for treatment is due upon **check-in** on the day services are rendered, unless prior arrangements were made. To assist you with these payments, we offer several payment options to you. Please read the following carefully. Our financial specialist will answer any questions you may have, and assist you in selecting the appropriate financial plan for your needs.

1. Our office accepts cash payments, debit cards, and credit cards through MasterCard and Visa.
2. **Dental Insurance:** We accept many local and off-island insurances. As a courtesy, we help you process all your insurance claims. However, please keep the following in mind:
    a. Dental insurance plans are a contract between you, your employer, and your insurance company. We will do our best to ESTIMATE your coverage. Depending on your type of insurance plan, it is possible that not all dental services will be covered. Ultimately all charges you incur are your responsibility regardless of insurance coverage. It is essential that you read and understand your coverage and pay special attention to any preauthorization requirements and exclusions.
    b. The ESTIMATED co-payment is due on the date of service. If a balance remains after we receive payment from your insurance carrier, we will notify you within 30 days. Failure of your insurance carrier to reimburse our office within 60 days will result in billing you directly for the remaining balance. If a refund is owed, you will be contacted directly to pick up a refund check.
3. **Payment Plans:** Mangilao Dental Clinic will, on a case to case basis, allow payment plans to be established. The patient will have to sign a contract with the treating doctor. Payment will need to be an **automatic** credit card payment on a weekly, bi-weekly, or monthly basis. The patient will need to leave a copy of their credit/debit card and will be charged on the dates arranged on the contract. The payments will continue to be charged until the payment is paid in full.

Should the patient default on his/her financial responsibility, Mangilao Dental Clinic will turn over the patients debt to a collection agency and an additional 33.33% will be added to the patient's outstanding balance.

By signing below, I have read and understood financial options available to me. I also acknowledge that I am financially responsible for any co-payments and payments not paid by my insurance.

Name: _____ **Signature:** _____

Relationship to patient (if minor) _____ **Date:** _____

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COVID-19 SCREENING FORM

Please read the following questions carefully	Circle the answer that applies to you	
Are you experiencing any of the following symptoms: • Coughing • Sore throat • Fever or chills • Loss of taste/smell • Shortness of breath • Muscle or body aches • Diarrhea • Congestion • Headaches	**YES**	**NO**
To your knowledge, have you, or anyone in your household been exposed to anyone positive for COVID-19 in the last 14 days?	**YES**	**NO**
Are you or anyone in your household awaiting results of a COVID-19 test?	**YES**	**NO**

Please inform the front desk if you circled yes to any of the following. We ask you to please avoid contact with other patients and go straight home. If symptoms persist, please see your primary doctor or call public health for further instructions.

Thank you for helping us protect you and other patients at this time.

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Pediatric Care at our clinic

At Mangilao Dental Clinic, our top priority is to provide a dental experience to children that avoids a traumatic experience. Oftentimes, a child that is put through too much, too soon, can develop a lifelong fear of dentists and severe dental anxiety. For that reason, we focus strongly on parent education, preventative dentistry, and dental techniques that minimize the use of physical restraints.

In order for us to treat your child, we ask for your full cooperation in providing the best experience possible for your child, as well as the safest. As a policy, ages 6 and under will be planned for nitrous oxide during any dental treatment, which will help encourage a calm and relaxing experience. In some cases, depending on behavior, Dr. Clegg may also need to plan this for older children as well.

It is important for us to carefully control the environment during pediatric visits, and for that reason we may request for you to stay back in the waiting room during your child's care. At all times, however, parents or guardians must always remain in the clinic at hand to be available if needed.

Despite our best efforts, there still may be some children that require a greater level of care and expertise than we can provide. Uncooperative children in need that do not respond to our techniques will be referred to a Pediatric Specialist. Furthermore, we will always put your child's best interests first. Should any of our philosophies not align, we would be happy to assist with locating a more suitable dental home for your child to be seen! Thank you once again for your cooperation and please do not hesitate to ask any of our team members questions!

Sincerely,
Dr. Clegg and the Mangilao Dental Clinic team
Si Yu'os Ma'åse!

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