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, in order to 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*, no exceptions. This is necessary for us to properly diagnose conditions and develop your treatment plan. It is also the law. *Comprehensive* exams check the entire mouth and determine the type of cleaning best suited for your needs, while *limited* exams focus on one problem. *Same day treatment is NOT GUARANTEED on exam visits, and is subject to available time.*

Payments and Insurance

Initial _____

Payment for treatment is due the day services are rendered. Along with our treatment estimates, we offer several payment options including cash, debit card, credit card, financing, 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 _____

Communication regarding your appointment is very important. Our 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, please review *how to contact us* and note that we have a strict appointment policy.

- **Patients are reminded of their appointments 2 weeks before, and again 2 days in advance.**
  - Be sure to provide accurate contact information, and kindly provide a response to our reminder.
  - *We are reachable by Phone, Email, and Messaging (whatsapp, facebook, and instagram)*
- **Please provide at least 48 hours advance notice of a cancellation or change**
  - Last minute changes, no shows, or broken appointments will result in appointment restrictions
  - Appointment availability will be limited to same day or walk-in openings, and scheduled appointment bookings will require a $50 treatment deposit to reserve time.
    - Further broken appointments will result in the loss of this deposit
- **Please check in *on time or early* for your appointment**
  - Late arrivals disrupt our schedule and *our ability to see you will not be guaranteed.*
  - Continued excessive lateness will result in appointment restrictions.
- **Family appointments require a confirmation *response* at least 48 hours prior**
  - If we cannot reach you and do not hear from you, the appointments 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**
  - When a large block of time or major procedure is reserved, prepayment will be requested.
  - Broken appointments / excessive lateness will result in a $50 missed visit deduction
- **Please do not bring any guests to your appointment**
  - In light of COVID-19, HIPAA laws, and limited space, additional guests will not be permitted back during appointments except for special needs cases. Please plan accordingly.

We appreciate your cooperation and understanding.
Please do not hesitate to ask us any questions. 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? _____
Name of 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 I have reviewed the above personal information for accuracy and that a copy of this office's Notice of Privacy Practices has been made available to me.

Patient Name: _____ Signature:_____

Name and 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. Are you a patient with special needs or a disability? Yes / No
   If yes, please indicate _____
5. Women: Are you pregnant, trying to get pregnant or breastfeeding? Yes / No
   If yes, please indicate how many weeks along _____
6. Do you smoke, chew tobacco, or chew betelnut? Yes / No
7. 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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Financial Policy

At Mangilao Dental Clinic, it is our goal to help our patients in obtaining the dental care they deserve. In order to ensure a smooth process with treatment, please read carefully to be mindful of our financial process.

Our policy requires that payment for treatment be **due upon check-in** on the day services are rendered, unless prior arrangements were made. In some instances, an advanced deposit may be required to schedule your visit. If changes in treatment occur during your visit, we will always inform you of your financial responsibility prior to proceeding with any changes. We accept the following methods of payment:

1. **Cash, Debit Card, and Credit Cards:** MasterCard, Visa, and Discover are accepted amongst others

2. **Dental Insurance:** We accept many local and off-island insurances. As a courtesy, we help patients process all insurance claims. However, please keep in mind:

    - Dental insurance plans are a contract between you, your employer, and your insurance company. While we do our best to ESTIMATE your coverage and copay, actual coverage may vary. For the most accurate estimate, patients must provide us with detailed information and history.

    - Estimated co-payments are due on or prior to the date of service. If a balance remains after receiving payment from the insurance carrier, or if your insurance fails to reimburse our office within 90 days, we will notify you immediately and bill you directly for the remaining balance. If a refund is owed, you will be contacted directly for arrangements.

    - Ultimately, all final charges incurred are the patient's responsibility *regardless* of insurance coverage. It is essential that you provide us with correct information, read and understand your coverage, and pay special attention to any pre-authorization requirements and exclusions.

3. **Payment Plans:** Our office accepts incremental payments towards treatment before scheduling. We also help obtain financing and may allow payment plans to be established with a financial agreement case by case. Payments occur on a credit card automatically on a regular basis until paid in full.

Our treatment coordinators can help with arrangements and assist you in selecting the best financial plan for your needs! They are also always available to assist with any questions about charges and services rendered.

All efforts will be made to contact patients regarding any remaining balances to resolve debts. Please note that failure to clear debts after a reasonable amount of time will be considered a default on financial responsibility. A patient's debt will be turned over to a collection agency and an additional 33.33% will be added to the outstanding balance.

By signing below, I have read and understood the above policies and the financial options available to me. I also acknowledge that I am financially responsible for my treatment, and 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 Notice

At Mangilao Dental Clinic, our top priority is to provide a dental experience for 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 invasiveness. 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. Some important things to note:

- As a policy, children ages 7 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 require parents to stay back in the waiting room during a child's treatment. Parents may be present during the initial examinations to discuss all aspects of treatment.
- At all times parents or guardians must always remain in the clinic at hand to be available if needed. If not able to be present, an authorization will be required for the person taking the child to their appointment.
- 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.

We will always put your child's best interests first and so we are unable to make exceptions to these important points. 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!

I acknowledge that I have read the above policies and accept them as a condition for my child to be seen at Mangilao Dental Clinic.

Patient Name: _____

Parent Guardian Name:_____ **Signature:**_____

Relationship to patient _____ **Date:**_____