Southern Dentistry

Thank you for visiting Southern Dentistry. We want your visit to be pleasant and comfortable. Please help us by completing this form.

Patient Information

Name _____
LAST FIRST MIDDLE INITIAL NICKNAME

Address _____
STREET

_____
CITY STATE ZIP

Birth Date_____ Drivers License_____

Marital Status M S D W Email _____

Phone: Home (___) _____ Pharmacy Preference _____

Work (___) _____ Social Security # _____

Mobile (___) _____

Emergency Contact _____
NAME PHONE

Insurance

Primary Dental Carrier

Subscriber Name _____ Social Security # _____ DOB _____

Employer _____ Insurance Co _____

Insurance Co Phone #_____ Group # _____

Relation to patient _____

Insurance Authorization Statement (Sign and Date)
I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs and dental treatment. I hereby authorize the Dental Office to administer such medication and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history is correct to the best of my knowledge.

Signature _____

Date _____

If Patient is Under 18

Responsible Party _____ Relation to Patient _____

Address _____
STREET

_____
CITY STATE ZIP

How did you hear about us? _____
What is your reason for today's visit? _____
Do you have any interest or concerns about your visit? _____
Are you concerned with the lines and wrinkles on your face? _____
Do you have a problem with snoring? _____
Are you happy with the color of your teeth? _____
Would you like to straighten your teeth? _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication

Are you under a physician's care now?	○ Yes ○ No	If yes
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes
Are you taking any medications, pills, or drugs?	○ Yes ○ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes
Are you on a special diet?	○ Yes ○ No	
Do you use tobacco?	○ Yes ○ No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Do you use controlled substances?	○ Yes ○ No	If yes
Other?	☐	If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	○ Yes ○ No	Cortisone Medicine	○ Yes ○ No	Hemophilia	○ Yes ○ No	Radiation Treatments	○ Yes ○ No
Alzheimer's Disease	○ Yes ○ No	Diabetes	○ Yes ○ No	Hepatitis A	○ Yes ○ No	Recent Weight Loss	○ Yes ○ No
Anaphylaxis	○ Yes ○ No	Drug Addiction	○ Yes ○ No	Hepatitis B or C	○ Yes ○ No	Renal Dialysis	○ Yes ○ No
Anemia	○ Yes ○ No	Easily Winded	○ Yes ○ No	Herpes	○ Yes ○ No	Rheumatic Fever	○ Yes ○ No
Angina	○ Yes ○ No	Emphysema	○ Yes ○ No	High Blood Pressure	○ Yes ○ No	Rheumatism	○ Yes ○ No
Arthritis/Gout	○ Yes ○ No	Epilepsy or Seizures	○ Yes ○ No	High Cholesterol	○ Yes ○ No	Scarlet Fever	○ Yes ○ No
Artificial Heart Valve	○ Yes ○ No	Excessive Bleeding	○ Yes ○ No	Hives or Rash	○ Yes ○ No	Shingles	○ Yes ○ No
Artificial Joint	○ Yes ○ No	Excessive Thirst	○ Yes ○ No	Hypoglycemia	○ Yes ○ No	Sickle Cell Disease	○ Yes ○ No
Asthma	○ Yes ○ No	Fainting Spells/Dizziness	○ Yes ○ No	Irregular Heartbeat	○ Yes ○ No	Sinus Trouble	○ Yes ○ No
Blood Disease	○ Yes ○ No	Frequent Cough	○ Yes ○ No	Kidney Problems	○ Yes ○ No	Spina Bifida	○ Yes ○ No
Blood Transfusion	○ Yes ○ No	Frequent Diarrhea	○ Yes ○ No	Leukemia	○ Yes ○ No	Stomach/Intestinal Disease	○ Yes ○ No
Breathing Problems	○ Yes ○ No	Frequent Headaches	○ Yes ○ No	Liver Disease	○ Yes ○ No	Stroke	○ Yes ○ No
Bruise Easily	○ Yes ○ No	Genital Herpes	○ Yes ○ No	Low Blood Pressure	○ Yes ○ No	Swelling of Limbs	○ Yes ○ No
Cancer	○ Yes ○ No	Glaucoma	○ Yes ○ No	Lung Disease	○ Yes ○ No	Thyroid Disease	○ Yes ○ No
Chemotherapy	○ Yes ○ No	Hay Fever	○ Yes ○ No	Mitral Valve Prolapse	○ Yes ○ No	Tonsillitis	○ Yes ○ No
Chest Pains	○ Yes ○ No	Heart Attack/Failure	○ Yes ○ No	Osteoporosis	○ Yes ○ No	Tuberculosis	○ Yes ○ No
Cold Sores/Fever Blisters	○ Yes ○ No	Heart Murmur	○ Yes ○ No	Pain in Jaw Joints	○ Yes ○ No	Tumors or Growths	○ Yes ○ No
Congenital Heart Disorder	○ Yes ○ No	Heart Pacemaker	○ Yes ○ No	Parathyroid Disease	○ Yes ○ No	Ulcers	○ Yes ○ No
Convulsions	○ Yes ○ No	Heart Trouble/Disease	○ Yes ○ No	Psychiatric Care	○ Yes ○ No	Venereal Disease	○ Yes ○ No
Yellow Jaundice	○ Yes ○ No						

Have you ever had any serious illness not listed	○ Yes ○ No	If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X_____ Date:_____

SOUTHERN DENTISTRY INSURANCE AND FINANCIAL POLICIES AND INFORMATION

We at Southern Dentistry are pleased that you have insurance benefits to help with the cost of your dental care. We would like to help you obtain the maximum use of these benefits. As a courtesy we will file your primary insurance claims for you. With this in mind, please read the information on this form so that we can work together to ensure this benefit.

ACCEPTING YOUR INSURANCE AND WHAT THEY WILL PAY

We currently accept many major insurance plans. Although we can maintain computerized histories of payment by a given company, they do change. Therefore, it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is **ONLY AN ESTIMATE.** If you would like to know your exact benefit we will be happy to file a pre-treatment estimate with your insurance company prior to treatment. This does delay treatment but will give you the exact out of pocket figures you may require.

WHY YOU MAY RECEIVE A STATEMENT

We base the patient portion of your bill on our most current data, but there are many factors that can affect your estimate quoted. There may be outstanding claims from another office or even changes in the way your insurance company pays. We will always work with you to find out why your insurance company didn't pay as expected.

WHY YOUR INSURANCE MAY NOT PAY AND YOUR RESPONSIBILITY

We will bill your insurance as a courtesy. If, for any reason, your insurance company refuses to pay, you are responsible for the remaining balance. **IT IS IMPORTANT TO REMEMBER THAT YOUR INSURANCE PLAN IS A CONTRACT BETWEEN YOU AND THEM. OUR OFFICE IS NOT AND CANNOT BE A PART OF THAT LEGAL CONTRACT. ULTIMATELY YOU ARE RESPONSIBLE FOR ALL CHARGES INCURRED AT OUR OFFICE.**

FINANCIAL OPTIONS

Southern Dentistry does request payment in full for your estimated portion at the time of service. We accept cash, check, Mastercard, VISA, American Express, and Discover. If you are in need of an extended financial option we also work with Care Credit. Care Credit offers "same as cash" loan options designed to meet your financial and treatment needs. Please ask any of our staff members for more information or an application.

AMALGAM DOWNGRADES

Due to health and cosmetic concerns, we do not do silver fillings in our office. Some insurance companies have decided to downgrade the fee for a white filling to that of a silver filling. If this is true for your insurance company, they will make you responsible for the difference between the two. As a courtesy, we have used the information that your insurance company has provided to create an estimate of what your financial responsibility will be for this procedure.

PAST DUE BALANCES

Balances that are greater than 4 months old may be subject to an 8% monthly finance charge.

MISSED APPOINTMENTS

If you are unable to keep your appointment, then we ask that you give us at least 24 hours notice. If we do not receive proper notice, then you will be charged a $45 cancellation/no show fee.

We welcome you to our family and look forward to helping you achieve the healthy, beautiful smile you want and deserve. If there is anything we can do to make your visits more pleasant, please do not hesitate to tell one of our staff members.

I have read and understand and accept the terms of the above outlined policies for insurance handling and financial commitments that I may incur as a result of treatment at Southern Dentistry

_____ _____

Print Name **Signature**

Southern Dentistry

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You May Refuse To Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

AUTHORIZATION TO RELEASE/DISCUSS INFORMATION

Southern Dentistry has the authority to discuss health and dental information regarding patient named _____ with the following individuals:

_____ _____

_____ _____

_____ _____

Southern Dentistry

AUTHORIZATION TO TREAT PATIENT

I authorize the staff of Southern Dentistry to perform such treatments that are necessary to maintain optimal oral health. I understand that details regarding individual treatments will be discussed with me and that I will have the opportunity to ask questions until I sufficiently understand the treatment prescribed.

Please Print Name of Patient

Patient Signature (parent/guardian if under 14)

Date

TREATMENT OF MINORS

Complete if patient is under 14 years of age

In case parent or guardian cannot be present, the following individuals have authority to make treatment decisions for this minor. This includes permitting treatment as previously planned, and also listening to suggestions of doctor and changing previously recommended treatment.

Please Print Name of Patient

Parent or Guardian Signature