Patient Name: _____ Name you would like to be called: _____

Address: _____ City/St/Zip: _____

Birth date: _____ Age:_____ SS#: _____ Minor Single Married Divorced Widowed Partnered

Gender: M ☐ F ☐ Home ph: _____ Cell/alternate ph: _____

Employer: _____ Occupation: _____ Wk ph: _____

Spouse name: _____ If patient is a child, list parent name: _____

Email: _____Who referred you to our office? _____

Emergency contact name: _____Ph:_____

Primary Dental Insurance		Secondary Dental Insurance	
Subscriber name		Subscriber name	
Subscriber SSN		Subscriber SSN	
Subscriber DOB		Subscriber DOB	
Relationship to Subscriber	☐ Self ☐ Spouse ☐ Child ☐ Other	Relationship to Subscriber	☐ Self ☐ Spouse ☐ Child ☐ Other
Employer Name		Employer Name	
Employer Phone		Employer Phone	
Insurance Co.		Insurance Co.	
Group #		Group #	
Phone #		Phone #	

MEDICAL HISTORY

Primary Dr. Name: _____

Medications you are currently taking:

_____

_____

Allergies: ☐ Latex ☐ Local Anesthetics ☐ Sulfa Drug

☐ Codeine ☐ Epinephrine ☐ Aspirin ☐ Penicillin ☐ Iodine

☐ Other: _____

Are you currently under the care of a physician? ☐ Yes ☐ No

If yes, please explain: _____

If you have had any operations in the last five years, please explain:

_____

WOMEN: Are you pregnant or trying to get pregnant? ☐ Yes ☐ No

Do you have to take antibiotic premedication before dental treatment? ☐ Yes ☐ No

Are you currently under the care of pain management? Yes No

Please mark the box if you have or have had any of the following:

☐ AIDS/HIV positive	☐ Alzheimer's disease
☐ Anemia	☐ Arthritis
☐ Artificial heart valve	☐ Artificial joint
☐ Asthma	☐ Blood disease
☐ Blood transfusion	☐ Cancer
☐ Chemotherapy	☐ Diabetes
☐ Drug addiction	☐ Emphysema
☐ Epilepsy/seizures	☐ Hay fever/allergies
☐ Heart attack	☐ Heart murmur
☐ Heart pacemaker	☐ Heart problems
☐ Heart stent	☐ Hepatitis A
☐ Hepatitis B or C	☐ Herpes
☐ High blood pressure	☐ Kidney disease
☐ Liver disease	☐ Low blood pressure
☐ Lupus	☐ Mitral valve prolapse
☐ Psychiatric care	☐ Radiation treatments
☐ Renal dialysis	☐ Rheumatic fever
☐ Sexually transmitted disease	☐ Smoker
☐ Stroke	☐ Thyroid disease

☐ **Please list any other medical conditions not mentioned above:**

_____

_____

BISPHOSPHONATE THERAPY: YES NO

If you have ever been treated for metastatic breast or prostate cancer, multiple myeloma, or hypercalcemia with the IV chemotherapy drugs AREDIA (pamidronate) or ZOMETA (zoledronate) OR if you have ever been treated for osteoporosis with the drugs FOSAMAX (alendronate), DIDRONEL (etidronate), ACTONEL (risedronate), BONIVA or SKELID (tiludronate) **CHECK THE BOX ABOVE LABELED BISPHOSPHONATE THERAPY AND BRING THIS TO OUR ATTENTION IMMEDIATELY!**

Authorization and Release

I certify that I have read and understand the information on this form to the best of my knowledge. The questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. If there are any changes in my medical health, I will notify Southern Dental Associates prior to any future treatment. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____Date: _____Relationship to Patient: _____

Signature of patient (or parent/guardian if minor)

CONSENT TO TREATMENT

I hereby consent to necessary dental treatment with the understanding that there are certain risks associated with any medical or dental procedure that may be performed at this or any medical or dental office. Post-treatment complications that may arise include but are not limited to discomfort, swelling, bruising (hematoma), bleeding, infection, numbness, dry socket (osteitis), instrument separation, etc.

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

_____Date: _____Relationship to Patient: _____
Signature of patient (or parent/guardian if minor)

FINANCIAL AGREEMENT

PAYMENT POLICY: Payment is due at the time services are rendered. If you have insurance, your estimated portion plus deductible is due at the time of service. If no insurance is involved, payment is expected at each visit. We accept cash, personal checks with proper ID, money orders, debit cards, Visa, MasterCard, Discover, and American Express. If there is a balance and the charges have been on the account for over 90 days, you agree to pay Southern Dental Associates 18% finance charge per month on the unpaid balance until paid in full. You will be responsible for any and all costs incurred in the collection of your debt (i.e. collection agency/court fees and/or attorney fees). Financing is available through Care Credit with approval. Fees will apply for a returned check. In the case of divorced parents, it is your responsibility to have financial arrangements made according to the divorce decree before treatment begins.

DENTAL INSURANCE: As a courtesy we will gladly file claims and accept assignment of benefits from your dental insurance. You must provide all necessary information to verify your dental coverage and file claims. Your insurance policy is a contract between you and the insurance company. We are NOT a party to that contract. You are responsible to pay our fees, not what your insurance company allows or considers "usual, customary and reasonable" (UCR). Although we may estimate your benefits we are not responsible for their accuracy. Knowledge of your benefits (maximums, limitations, exclusions, waiting periods, etc) is YOUR responsibility. Receiving our services indicates your acceptance of responsibility to pay regardless of our estimate. All charges not paid by your insurance company are your responsibility regardless of the reason for nonpayment. Not all services we provide are covered benefits. Treatment provided in another dental office during your current plan year may alter your co-pay for services in our office. In such cases, we are not able to track whether or not you have reached your maximum. Please call your insurance company if this applies to you. There are many factors in determining patient responsibility where two insurance companies are involved. We will provide you with the most accurate information but CANNOT guarantee your out of pocket expense. Please understand that our responsibility is to provide you with treatment that best meets your needs, not try to match your care to insurance plan limitations.

BROKEN APPOINTMENTS: To reschedule or cancel an appointment, you must notify us at least 24 hrs in advance to avoid a fee of up to $50.00 (fee based on appointment length and/or number of appointments missed). Missed or broken appointments prevent others from receiving the dental care they deserve. We reserve the right to terminate professional treatment of any patient when scheduled appointments are not kept.

I have read and understand this document in its entirety; outlining the office and financial policies of Southern Dental Associates and agree to these terms.

_____Date: _____Relationship to Patient: _____
Signature of patient (or parent/guardian if minor)