

Patient Name: _____ Name you would like to be called: _____
 Address: _____ City/St/Zip: _____
 Birth date: _____ Age: _____ SS#: _____ Minor Single Married Divorced Widowed Partnered
 Sex: 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 Insurance		Secondary Insurance	
Subscriber name		Subscriber name	
Subscriber SSN		Subscriber SSN	
Subscriber DOB		Subscriber DOB	
Relationship to Subscriber	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	Relationship to Subscriber	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> 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

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

- | | |
|---|--|
| <input type="checkbox"/> AIDS/HIV positive | <input type="checkbox"/> Alzheimer's disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Artificial heart valve | <input type="checkbox"/> Artificial joint |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Blood disease |
| <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Drug addiction | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Epilepsy/seizures | <input type="checkbox"/> Hay fever/allergies |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Heart murmur |
| <input type="checkbox"/> Heart pacemaker | <input type="checkbox"/> Heart problems |
| <input type="checkbox"/> Heart stent | <input type="checkbox"/> Hepatitis A |
| <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Liver disease | <input type="checkbox"/> Low blood pressure |
| <input type="checkbox"/> Lupus | <input type="checkbox"/> Mitral valve prolapse |
| <input type="checkbox"/> Psychiatric care | <input type="checkbox"/> Radiation treatments |
| <input type="checkbox"/> Renal dialysis | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Sexually transmitted disease | <input type="checkbox"/> Smoker |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Please list any other medical conditions not mentioned above: | |

BISPSPHONATE THERAPY

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 BISPSPHONATE 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.

Signature of patient (or parent/guardian if minor) _____ Date: _____ Relationship to Patient: _____

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)