SOUTH COAST
FAMILY DENTISTRY

Welcome!

Thank you for choosing us to help you with your smile!

About You

Please answer all questions

Name: _____ Today's Date: ____/____/_____

❒ Male ❒ Female I Prefer to be Called: _____

Birthdate: ____/____/_____ Your Age: _____ Soc. Sec #: _____-_____-_____
(This information is required in order for us to bill your insurance)

Home Phone #: _____ Mobile Phone #: _____
E-Mail Address: _____

Mailing Address: _____
City: _____ State: _____ Zip Code: _____

Patient's Employer: _____ Work Phone #: _____

Work Address: _____
City: _____ State: _____ Zip Code: _____

How would you like us to remind you of your appointments?
❒Home Phone ❒Mobile Phone ❒Text Message

Is your account associated with a parent, or spouse?
❒Parent ❒Spouse ❒Not Applicable

Spouse or Parent Name: _____

Parent or Spouse Employer: _____ Work Phone #: _____

Patient's Emergency Contact: _____ Phone #: _____

Whom can we thank for referring you? _____

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Responsible Party

Person Responsible for This Account: _____ Marital Status: ❒Single ❒Married
Relationship to the Patient: _____

Birthdate: ____/____/_____ Soc. Sec #: _____-_____-_____

Home Phone #: _____ Mobile Phone #: _____

Mailing Address: _____
City: _____State: _____ Zip code: _____

Driver's License #: _____ State: _____

Employer: _____ Work Phone #: _____

Please indicate your preferred method of payment:
❒Cash ❒Personal Check ❒ Credit Card ❒ I wish to discuss the Office's payment plan

Insurance Information

Name of Insured (Subscriber): _____ Relationship to Patient: _____
Birthdate: ____/____/_____ Soc. Sec. #: _____-_____-_____ Union or Local #: _____

Employer: _____Work Phone #: _____ Date Hired: ____/____/_____
Work Address: _____
City: _____ State: _____ Zip Code: _____

Insurance Company: _____ Group #: _____ Policy ID #: _____
Insurance Billing Address: _____
City: _____ State: _____ Zip Code: _____

Is the patient covered by additional insurance?
❒Yes ❒No (If 'yes', please complete the following):

Name of insured (subscriber): _____ Relationship to patient: _____
Birthdate: ____/____/_____ Soc. Sec. #: _____-_____-_____ Union or Local #: _____

Employer: _____Work Phone #: _____ Date Hired: ____/____/_____
Work Address: _____
City: _____ State: _____ Zip Code: _____

Insurance Company: _____ Group #: _____ Policy ID #: _____
Insurance Billing Address: _____
City: _____ State: _____ Zip Code: _____

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Health History

Patient Name: _____ Birthdate: ____/____/_____

Have you seen a dentist within the last 12 months? ❒Yes ❒No

Who was your last dentist? _____ Phone #: _____

Have you been under the care of a physician in the last 5 years? ❒Yes ❒No

Reason for Care: _____

Name(s) of Your Primary Physician(s):

1. _____ Phone #: _____ 2. _____ Phone #: _____

Indicate whether you have experienced any of the following conditions. Please circle 'yes' or 'no' in each field – this will help us ensure accurate records:

Anemia	No	Yes	Cancer	No	Yes
Epilepsy	No	Yes	If yes, which form(s)?		
Hepatitis, any form	No	Yes	Previous Biopsies	No	Yes
Asthma	No	Yes	Slow-Healing Mouth Sores	No	Yes
HIV Positive / AIDS Related Complex	No	Yes	Other Infections	No	Yes
Emphysema / other Respiratory Illness	No	Yes	Recurrent Illness	No	Yes
Abnormal Heart Condition	No	Yes	Liver Disease (including Jaundice)	No	Yes
Kidney Disease	No	Yes	Joint Replacement	No	Yes
Psychosis	No	Yes	If yes, which joint?		
Heart Attack, Heart Disease, or Heart Surgery	No	Yes	If 'yes', Date of Surgery:		
Date of Incident or Surgery:			Abnormal bleeding from cut	No	Yes
Venereal Disease	No	Yes	Unintentional weight loss/ gain	No	Yes
Diabetes	No	Yes	Latex Sensitivity	No	Yes
Hemophilia	No	Yes	Glaucoma	No	Yes
Hypertension	No	Yes	Illegal Drug Use	No	Yes

Do you take an antibiotic prior to dental treatment? ❒Yes ❒No

Have you ever taken a bisphosphonate* medication? ❒Yes ❒No

*'Bisphosphonates' are typically prescribed to treat bone cancer or osteoporosis

Are you currently pregnant or breastfeeding? ❒Yes ❒No

If 'yes', what is your baby's birthdate or expected delivery date? ____/____/_____

Do you smoke, or use other forms of tobacco? ❒Yes ❒No

Are you allergic to any medications? Please list them here: _____

Please list any medications you are taking: _____

_____

The information listed above is complete and accurate to the best of my knowledge

Patient or Guardian Signature: _____ **Date Signed**: ____/____/_____

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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I authorize the doctors and/or his staff to disclose specific health and dental information regarding:

_____
(Name of Patient)

to: _____
_____
_____

for the purpose of scheduling, diagnosing, and resolution of the account and treatment. By initialing the spaces below, I specifically authorize the release of the following information:

_____ Diagnosis of treatment
(Initial to authorize)

_____ Account resolutions
(Initial to authorize)

_____ Scheduling appointments
(Initial to authorize)

I have reviewed, and I understand this authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law

Signature: _____

Date: _____

Authorization and Release

I authorize the dentist or staff to release any information including the diagnosis and the records of any treatment or examination rendered to me or my dependent during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist 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: _____

Date: _____

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:

_____
(Name of Patient or Guardian)

_____
(Signature)

_____
(Date)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgement.

☐ An emergency prevented us from obtaining acknowledgment.

☐ Other (Please Specify)

_____
_____

Acknowledgment of Collection Fee Policy

If it is necessary to refer this account for collection, buyer agrees to pay seller reasonable attorney's fees and collection costs including any collection fees charged by a collection agency, even though no suit or action is filed. If a suit or an action is filed the amount of such reasonable attorney's fees or collection charges shall be fixed by the court or courts in which the suit or action including any appeal therein, is tried, heard, or decided. A finance charge of 9% annual interest will be charged monthly on any account balance over 90 days. For any payment plan over 90 days 9% annual interest on the payment plan total from the start of the payments.

Signature: _____

Date: _____