Welcome!

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

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:

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

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

Have you ever taken a bisphosphonate? ❑ 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: ___/___/______

Guardian Name (if applicable): ____________________

About You

Please answer all questions

Name: ______________________________ Today's Date: ______________

"I Prefer to be Called..."______________________ Birthdate: ___/___/_____ Your Age: _________

Soc. Sec. #: _____-_____-_________ Gender: ❑ Male ❑ Female ❑ Other ______________

(This information is required in order for us to bill your insurance)

Home Phone #: ______________________ Mobile Phone #: ______________________

Email 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 appointment?

❑ 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? ______________________________

Responsible Party

Person Responsible for This Account: ____________________ Marital Status: ❑ Single ❑ Married

Relationship to 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.#: ___-___-___ Subscriber's Gender: ❑ Male ❑ Female ❑ Other ________

Employer: ____________________ Union or Local#: ________ Date Hired: ________

Work Address: ____________________ Work Phone: ____________________

City: ____________________ State: ______ Zip Code: ____________________

Insurance Company: ____________________ Group #: ____________ Policy ID #: ____________

Insurance Billing Address: ____________________

City: ____________________ State: ______ Zip Code: ____________________

Is this patient covered by additional insurance?

❑ Yes ❑ No (If 'yes', please complete the following):

Name of Insured (Subscriber): ____________________ Relationship to Patient: ____________________

Birthdate: ___/___/___ Soc. Sec.#: ___-___-___ Subscriber's Gender: ❑ Male ❑ Female ❑ Other ________

Employer: ____________________ Union or Local#: ________ Date Hired: ________

Work Address: ____________________ Work Phone: ____________________

City: ____________________ State: ______ Zip Code: ____________________

Insurance Company: ____________________ Group #: ____________ Policy ID #: ____________

Insurance Billing Address: ____________________

City: ____________________ State: ______ Zip Code: ____________________

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 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: __________

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: __________

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgment

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 acknowledgment of receipt of our Privacy Practices, but acknowledgment could not be obtained because:

- ❑ Individual refused to sign.
- ❑ Communication barriers prohibited obtaining the acknowledgment
- ❑ An emergency prevented us from obtaining acknowledgment.
- ❑ Other (please specify): ____________________

____

____

Communication Preferences & Consent

In addition to physical mail, billing statements can be sent by email, or by text-message to a smartphone with internet access. If you do not indicate a preference below, statements will be sent by U.S. mail.

I prefer to receive statements & other correspondence by:

❑ *Email* ❑ *Mail* ❑ *Text/Call (see below)*

Sign & date the following agreement to authorize statements by text-message. If you wish to receive statements by mail or email, you are not required to sign this consent.

I consent to the following: South Coast Family Dentistry or its service providers may contact me to provide information regarding health care, payment, my account, or insurance, at the phone number I have provided, or numbers which can be reasonably associated with my account (such as caller ID, or other means) using artificial or prerecorded voice or telephone equipment that may be capable of automatic dialing or text (SMS) messaging. I agree to promptly alert South Coast Family Dentistry whenever my telephone number changes, or I stop using a certain telephone number.

Patient Name: ______________________________

Signature: ____________________ Date: __________