

Southpoint Dental Center

Patient Information

Last Name First Name MI Preferred Name

Date of Birth ____/____/____ Sex () M () F SSN _____ Marital Status _____
M D Y

Cell Phone _____ Home Phone _____ E-mail _____

Mailing Address: _____
City State Zip

May we leave medical and/or appointment information on your answering machine or phone? () Yes () No
Preferred daytime contact method? () Home Phone () Cell Phone () Work Phone () E-mail () Text Message
What pharmacy would you like prescriptions phoned in to? _____

Employer Name _____ Work Phone _____

In case of emergency, who should be notified: _____
Name Phone

Were you referred to our office? _____ By Whom? _____

Insurance Information: Do you have dental insurance? () Yes () No

Dental Insurance Carrier: _____ Thru Employer: _____

Name of Insured (Policy Holder) _____ Date of Birth ____/____/____ Member ID# _____
M D Y

Secondary Insurance Carrier: _____ Thru Employer: _____

Name of Insured (Policy Holder) _____ Date of Birth ____/____/____ Member ID# _____
M D Y

Financially Policy / Release of Information

I understand that Southpoint Dental Center does not determine my insurance benefits, and that any and all charges not paid by my insurance company for any reason will be 100% my responsibility.

I certify the information given by me is correct and I have read and consent to the terms of the financial agreement. I certify that I am the patient or am otherwise authorized to execute this document and accept its terms on behalf of the patient. I assume individually all financial responsibility by signing below.

I authorize the release of medical information to consultants and specialists referred to if needed, as necessary to process insurance claims, and prescriptions.

() I authorize payment directly to Southpoint Dental Center of all insurance or health plan benefits.

Or

() I will pay all services in full and would like all insurance benefits sent directly to me if possible.

By my signature below, I understand and accept the above policies and consent for dental treatment.

Patient or Responsible Party **Signature:** _____ Date ____/____/____

PERSONAL INFORMATION

Southpoint Dental Center

Thank you for choosing Southpoint Dental Center for your dental care. We will do our best to provide you with the highest quality dental services. We feel it is very important for you to understand what we expect regarding appointments, billing, and payment.

_____ **(Initial)** *We expect you to call if you can't keep your appointment:* If you are unable to keep an appointment, it is important to give us at least 24 hours notice so that we may give that time to another patient urgently waiting to get in. If you 'no show' for an appointment you will be assessed a charge. This charge is your responsibility; Insurance companies will not pay for missed appointments. If you've missed several appointments, we may ask you to transfer your care to another office.

We are happy to see private-pay patients: If you do not have insurance, you will need to make arrangements to pay for your treatment. Payment is required at all first visits. We accept cash, checks, Visa, Mastercard, and Discover. We offer a 5% discount for patients that pay at the time of service (3% if paying with a credit card). We are also contracted with some dental financing companies that help patients pay for larger amounts by spreading payments out over time. Please ask about these options as we can help you get set up before services are even performed.

We have contracts with some insurances: Southpoint Dental Center is currently contracted with the major insurance companies employers in the Walla Walla area use. We are not a preferred provider, however, for all insurances. If you are not sure if we are a preferred provider on your insurance please do not hesitate to ask us, or call your insurance to find out. We will work with you to obtain your benefits even if we are not preferred providers, but some insurance companies may pay a lower rate or not pay anything at all if you receive treatment from a dentist not signed up with them.

Your co-pay must be paid at the time of your visit: If your insurance company has a co-payment or deductible payment for the services you are receiving that payment must be paid at the time of your visit.

There is a service charge for returned checks: If your check is returned by the bank for non-sufficient funds, we will charge an additional \$25 service charge to your account. You will be asked to pay the amount of the bad check plus the service charge in cash or money order within 10 days. If we do not receive payment within 10 days and your account has not been cleared by then, we will flag your account and begin an internal debt collection process. In the future we will no longer be able to accept checks from you.

We expect you to keep your account current: We make every effort to help you know ahead of time what services will cost you, and arrange for payment. As a courtesy we also try to estimate what your insurance will cover, but cannot guarantee what they will pay, and will not be responsible if your benefits are different then we have anticipated. We do charge interest on account balances that are not paid within 30 days of billing you. If your account is over 30 days old, and you have not at least contacted us we will flag your account and begin an internal debt collection process. If we do not receive any response from you after this happens, your account will be sent to a professional collection agency and we will ask you and your family to transfer your care to another office.

We can't bill your insurance without billing information: We are happy to bill your insurance for services you have received from us. To do this, you must provide us with your most current insurance information at the time of your first visit, and any time your insurance changes. We promise to do our part to get payment from your insurance company but if they do not pay, the charges you have incurred will be your responsibility.

Signed _____ Date _____

OFFICE INFORMATION

Southpoint Dental Center

Patient's Name: _____

Answers to the following questions will allow us to provide the care appropriate for your particular needs. Your answers are for our records only and will be considered **confidential**.

1. Are you having any discomfort at this time? Yes () No ()
2. Have you ever had any serious trouble associated with previous dentistry?
Yes () No ()
Any Details? _____
3. Does dental treatment make you nervous?
No () Slightly () Moderately () Extremely ()
4. Date of last dental visit: _____ Date of last cleaning _____
Frequency of cleaning visits: _____
5. What do you do on a daily basis to keep your mouth healthy? _____

6. On a scale of 1 – 10 how would you rate the health of your gums? _____
7. Have you ever been treated for periodontal disease? Yes () No ()
8. Do you have or have you recently had any of the following:

MOUTH

Bleeding, sore gums	(Y) (N)
Unpleasant taste/bad breath	(Y) (N)
Burning tongue/lips	(Y) (N)
Frequent blister, lips/mouth	(Y) (N)
Swelling/lumps in mouth	(Y) (N)
Ortho treatments (braces)	(Y) (N)
Biting cheeks/lips	(Y) (N)
Clicking/popping jaw	(Y) (N)
Difficulty opening or closing jaw	(Y) (N)

TEETH

Loose teeth	(Y) (N)
Sensitive to hot	(Y) (N)
Sensitive to cold	(Y) (N)
Sensitive to sweets	(Y) (N)
Sensitive to biting	(Y) (N)
Food impaction	(Y) (N)
Clenching/grinding	(Y) (N)
Shifting in bite	(Y) (N)
Change in bite	(Y) (N)

9. Have you ever had a broken tooth? Yes () No ()

Any Details? _____

Please continue on other side

DENTAL QUESTIONNAIRE

Dentistry has changed rapidly over the last few years and many people have questions about new choices available to them. In order for us to give you all the information you would like, we need to know what is important to **you**.

1. I... am satisfied with the appearance of my smile
 wish _____ was
different about the appearance of my smile

2. I... am interested in tooth whitening
 am not interested in tooth whitening

3. I... have seen or heard of something about dentistry that I would like more
information about. _____

4. I... will do anything to keep my natural teeth
 want to keep my teeth but I have a certain budget of time and/or
money that I am willing to spend on them

5. I... have set goals for my oral health with a previous dentist
 want to set goals concerning my dental health

6. I think my present state of dental health on a scale of 1 to 10 is: _____

7. What things are most important to you about your dental health?

8. What is most important to you about the type of fillings and or restorations in
your mouth?
 long lasting
 natural looking
 metal free
 low cost.

9. What is important to you when selecting a dental practice?

10. What do you expect from your dentist?

Thank you for selecting Southpoint Dental Center! We are pleased to have you here and look forward to working with you to achieve your dental goals.

SOUTHPOINT DENTAL CENTER

NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our privacy officer.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

Patient or legally authorized individual signature

Date

Time

Printed name if signed on behalf of the patient

Relationship
(parent, legal guardian, personal representative)

This form will be retained in your medical record.

Last Update: 04/14/03



SOUTHPOINT

DENTAL CENTER

1129 South Second Ave., Suite A, Walla Walla, WA 99362 (509) 522-2522

Consent to Dental Photography

In connection with dental services, which I am receiving from Dr. Eric R. Gustavsen, DDS, I agree and consent to allow the photographs to be used for dental records, research, education, public relations, patient counseling or other purposes.

I further agree and consent that the photographs relating to my dental care may be published and re-published, either separately or in connection with each other in dental photo albums, professional journals, the practice website, or dental books.

Patient Name (please print) _____

Signature of Patient or Guardian _____ Date _____

Signature of Witness _____ Date _____