Southpoint Dental Center

______________________________ ______________________ _____ Date of Birth ____/____/____
Last Name First Name MI M D Y

Sex ( ) M ( ) F SSN _______________Cell Phone _______________ Home Phone _________________

Mailing Address: ____
City State Zip

Marital Status ___________ How did you learn about our office? _______________________________________

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

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

Dental Insurance Carrier:____________________________________ Thru Employer:_______________________

Name of Insured (Policy Holder) ____________________ Date of Birth ____/____/____ SSN________________
M D Y

Group#_________________ Member ID#_____________________

Office and Financial Policies and Information

Missed appointment fee: If you are unable to keep an appointment, it is important to give us at least 2 business days' notice. The charge for a missed appointment, or late notice cancellation is $50. 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.

NSF checks: If your check is returned by the bank for non-sufficient funds, we will add 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. In the future we will no longer be able to accept checks from you.

We make every effort to help you know ahead of time what services will cost you, and arrange for payment. We do charge 12% annual interest on account balances that are not paid within 30 days of billing. Accounts over 90 days old without payment arrangements will be sent to a professional collection agency and we will ask you and your family to transfer your care to another office.

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 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.

I certify the information given by me is correct to the best of my knowledge. 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.

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

Patient or Responsible Party Signature:____________________________________ Date _____ / _____ / _____

HEALTH HISTORY

In order to render optimum health service it is necessary to become acquainted with the vital information related to each patient. All information provided is for our records only and will be considered **confidential**. Please provide:

Your physician's name: _______________________________ date of last examination: _________Blood Pressure:_______

1. Have you ever had an allergic reaction in a dental office? ……………………………………………………….( ) Yes ( ) No
2. Are you allergic to (i.e., itching, rash, swelling of hands, feet or eyes) or made sick by novacaine, sulpha drugs, penicillin, aspirin, codeine or any drugs or medications? Please List: ____
3. Are you on blood thinners, or have you ever had any excessive bleeding requiring medical treatment. …..( ) Yes( ) No
4. Have you ever had any surgery – minor or major: ………………………………………………………………..( ) Yes ( ) No
5. Have you been a patient in the hospital during the past two years? For what reason? ……………………..( ) Yes ( ) No
6. Have you been under the care of a medical doctor during the past two years? ……………………………..( ) Yes ( ) No
7. Have you taken any medication or drugs during the past two years? …………………………………………..( ) Yes ( ) No
8. List all current medications:____
9. Please indicate if you have ever had any of the following:

- ❑ Heart disease or surgery
- ❑ Angina pectoris
- ❑ High blood pressure
- ❑ Heart murmur
- ❑ Rheumatic fever
- ❑ Congenital heart lesions
- ❑ Scarlet fever
- ❑ Artificial heart valve
- ❑ Heart pacer
- ❑ Artificial joint
- ❑ Anemia
- ❑ Stroke
- ❑ Kidney trouble
- ❑ Ulcers
- ❑ Emphysema
- ❑ Tuberculosis
- ❑ Asthma
- ❑ Hay Fever
- ❑ Sinus trouble
- ❑ Allergies or hives
- ❑ Diabetes
- ❑ Thyroid disease
- ❑ X-ray or Cobalt treatment
- ❑ Chemotherapy
- ❑ Cancer, Leukemia
- ❑ Arthritis
- ❑ Rheumatism
- ❑ Cortisone medicine
- ❑ Glaucoma
- ❑ Headaches
- ❑ AIDS
- ❑ HIV
- ❑ Hepatitis A (infectious)
- ❑ Hepatitis B (serum)
- ❑ Hepatitis C
- ❑ Liver disease
- ❑ Yellow jaundice
- ❑ Blood transfusion
- ❑ Drug addiction
- ❑ Hemophilia
- ❑ Venereal disease (syphilis, gonorrhea)
- ❑ Cold sores
- ❑ Epilepsy or seizures
- ❑ Fainting or dizzy spells
- ❑ Nervousness
- ❑ Psychiatric treatment
- ❑ Bruise easily

10. When you walk upstairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired? ……………………………………………………………………………..……..( ) Yes ( ) No
11. Have you been advised to take an antibiotic premedication before dental treatment by your physician or surgeon because of artificial joints or heart issues? Yes ( ) No ( )

    Dr's name ____
    Medication____
    For how long? Life______________Other_________________

12. Do you have any disease, condition, or problem not listed? ………………………………………………….( ) Yes ( ) No
13. ***Women:*** *Are you pregnant now? ( ) Yes ( ) No Are you taking oral contraceptives? ( ) Yes ( ) No*
    Please be advised that antibiotics may render oral contraceptives ineffective.

To the best of my knowledge, all of the preceding answers are true and correct.

Date	Patient's Signature	Staff Signature

ACKNOWLEDGEMENT OF RECEIPT
OF STATEMENT OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Southpoint Dental Center. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Southpoint Dental Center reserves the right to change the privacy practices currently described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed or otherwise transmitted to me.

ADDITIONAL DISCLOSURE AUTHORIZATION:

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare Information to the person(s) identified below. (I understand that the default answer is "NO". Without indicating "YES in answer to each individual question, personal protected (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)

Spouse only	__Yes __No
Any Member of my immediate family: (Spouse, Children, Children's Spouses)	__Yes __No
Any Member of my extended family: (Parents, Grandchildren)	__Yes __No
Other:____________________________	__Yes __No

Name of patient (please print) ____

Signature of Patient ____Date________________

Patient's personal representative (please print) ____

Personal Representative's signature: ____

Representative's Telephone Number___________________________________Date________________

OFFICE USE ONLY BELOW THIS LINE

Acknowledgement Not Obtained

Provided Prior to Treatment? __Yes __No Date Statement provided: _____________

Reason for not obtaining patient signature:
- __Needed more time to review Statement
- __Wanted to consult another person before signing
- __Physically unable to sign
- __No reason offered
- __Other: