SOUTHAVEN
DENTAL CARE

Welcome To Our Office!

PLEASE COMPLETE THE FRONT AND BACK PAGE

Thank you for choosing Southaven Dental Care as your dental care provider. We are committed to providing you the best possible dental car
If you have any problems or questions while completing the form below, we will be happy to help.

Patient Name _____ (Last / First / MI) Goes by (Nickname) _____

Address _____ Apt. # _____

City _____ State _____ Zip _____

Date of Birth _____ Age _____ Home Phone( ) _____ Cell Phone( ) _____

Full Time Student? ☐ Yes ☐ No School Attending _____

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Male ☐ Female

How did you hear about our office? _____

Other family members seen by us? _____

Person Responsible for Account

Name _____ Employer _____

Address _____ Position _____

City/State/Zip _____ Work Phone ( ) _____

Phone ( ) _____ Social Sec. # _____

Relationship to Patient _____ DL# _____ Date of Birth _____

Today's visit will be paid by ☐ Cash ☐ Check ☐ Credit Card

Patient's Employment Information

Employer _____ Position _____

Work Phone ( ) _____ Patient's Social Sec. # _____

Patient's DL # _____

Primary DENTAL Insurance

Insured's Name _____

Address _____

_____

Date of Birth _____

Social Sec. # _____

Insurance ID# _____

Employer _____

Name of Ins. Co _____

Ins. Co. Phone # _____

Secondary DENTAL Insurance

Insured's Name _____

Address _____

_____

Date of Birth _____

Social Sec. # _____

Insurance ID# _____

Employer _____

Name of Ins. Co _____

Ins. Co. Phone # _____

Do You Have A Personal Physician? ☐ Yes ☐ No Medical Physician's Name _____

Physician's Phone ( ) _____ Date of Last Visit _____

Emergency Information: Please lst the names and telephone numbers of two relatives (or friends) *not living with you* that we may contact in the case of an emergency.

Name _____ Relation _____ Name _____ Relation _____

Address _____ Address _____

Phone ( ) _____ Phone ( ) _____

MEDICAL/DENTAL HISTORY

YES	NO	HAVE YOU EVER HAD?
____	____	High Blood Pressure
____	____	Hepatitis or Liver Disease
____	____	Epilepsy, convulsions, or seizures
____	____	Cortisone-Steroid Treatment
____	____	Kidney or Bladder Disease
____	____	Diabetes
____	____	Tuberculosis or Emphysema
____	____	Asthma
____	____	Shortness of Breath
____	____	Swollen Ankles
____	____	Chest Pains
____	____	A Pacemaker
____	____	Artificial Heart Valve
____	____	Heart Murmur
____	____	Mitral Valve Prolapse
____	____	Rheumatic Fever
____	____	Artificial Joints
____	____	Stroke
____	____	Thyroid Trouble
____	____	Psychiatric Treatment
____	____	Arthritis or Rheumatism
____	____	Venereal Disease
____	____	Glaucoma
____	____	Chemotherapy
____	____	Radiation Therapy
____	____	Sinus Problems/Hayfever
____	____	Allergies
____	____	Eye Surgery
____	____	AIDS/HIV+
____	____	Blood Transfusion
		If You Are Female, Are You
____	____	Pregnant
____	____	Taking Birth Control Pills
____	____	Taking Hormone Medication

Main problem that brought you to office?

____

____

Are you presently under the care of a physician? ____ YES ____ NO

If yes, for what?

____

Are you presently taking any drugs or medication? ____ YES ____ NO

If yes, please list

____

____

____

Are you allergic to any medication, local anesthetic, materials or latex gloves? ____ YES ____ NO

If yes, what drugs or materials?

____

____

____

Have you ever had a bleeding problem? ____ YES ____ NO

Do you use tobacco procucts? ____ YES ____ NO

Do you have a history of fainting? ____ YES ____ NO

Have you ever been treated for osteoporosis? ____ YES ____ NO

Do you have any disease or condition not listed or anything about your health problem that we have not covered? ____ YES ____ NO

If yes, please list________________

____

____

____

	YES	NO	HISTORY UPDATED doctor initial	date
Date of last dental visit ________________				
Were x-rays taken at that time?	____	____		
Were your teeth cleaned?	____	____		
Do you have well water? (private)?	____	____		
Does you water have fluoride in it?	____	____		
Have you ever been treated for gum disease?	____	____		
Do you have bad breath?	____	____		
Do you clench or grind your teeth?	____	____		
Are your teeth sensitive?	____	____		
Does your jaw click or pop?	____	____		
Have you experienced any pain or soreness in the muscles of your face or around your ear?	____	____		

RELEASE:

I AUTHORIZE THE DENTIST TO PERFORM DIAGNOSTIC PROCEDURES AND TREATMENT AS MAY BE NECESSARY FOR PROPER DENTAL CARE. I AM RESPONSIBLE TO INFORM THIS OFFICE OF ANY CHANGE IN HEALTH HISTORY.

Signature ______________________ Date __________

FINANCIAL POLICY

We ask that all patients read and sign our Financial Policy as well as complete our Patient Information form prior to seeing the dentist. Payment of services are due at the time services are rendered. We accept cash, check, credit cards and approved financing.

We may accept assignment of insurance benefits. However, you must understand that:

1. Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract. Our relationship is with you, not your insurance company. We cannot be come involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurance, and "usual and customary" charges. Our involvement will be limited to supplying factual information to facilitate claim processing.
2. All charges are your responsibility whether your insurance company pays or does not pay. Not all services are covered benefit in all con tracts. Some insurance companies arbitrarily select certain services they will not cover.
3. Fees for the services, along with unpaid deductibles and co-payments are due at the time of treatment.
4. I understand that employees of Southaven Dental Care are NOT repre sentatives for my insurance company and the estimate I receive from them is not a guarantee of payment from my insurance company.
5. If your insurance company does not pay your claim within 30 days, it is your responsibility to contact your insurer to expedite payment. If your insurance does not pay, your are responsible for your payment.
6. If your insurance company does not pay in full within 45 days, we may require you to pay the balance.
7. There will be a fee charged for returned checks.
8. Balances older than 60 days may be subject to collection placement and fees.
9. I authorize payment from my insurance carrier be made directly to the dentist.
10. I authorize this office to release necessary medical or dental information about me to my insurance carrier.
11. There will be a charge for broken appointments.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems to us, so we may assist you in management of your account. We have a number of different financial arrangement options available.

FIXED OR REMOVAL PROSTHETICS, such as dentures, crowns, bridges or partial dentures, are understood to be a product that is uniquely suited to each particular patient. The full amount contracted for such services, is, therefore, considered to be due and payable when the initial impression is made. AS A COURTESY TO YOU, Southaven Dental Care will, if necessary, accept 50% of this amount at the time of impression. The balance must be paid at the time of permanent seating, or no more than 30 DAYS from date of impression, WHICHEVER comes first. We accept insurance for payment for the covered portion, however, you must pay your portion at the time services are rendered. PROSTHETICS, MUST BE SEATED IN A TIMELY MANNER TO INSURE YOUR COMFORT AND PROPER FIT. If you fail to have your prosthetics permanently seated within 60 days from date of impression, a second impression must be made and you will be charged an additional amount. ALL X-RAYS TAKEN ARE A PART OF OUR PERMANENT RECORDS. THERE IS A DUPLICATE CHARGE FOR ANY X-RAYS REMOVED FROM THIS OFFICE.

Again, thank you for choosing Southaven Dental Care as your dental care provider. We appreciate your trust in us and the opportunity to serve you.

Patient or Guardian Signature ______________________ Today's Date __________