



Welcome to our family! Here are a few of our policies we are kindly asking you to keep in mind:

Insurance and Financial Policy

At Southern Family Dental, we promise to do everything we can to provide you with the best possible care. We are honored that you chose us and plan to work together as a team to help you to have the best experience: from the beginning to the end. In order for us to be able to do so, we need your cooperation and understanding in regards to our payment policy.

We will work with you to come up with the best treatment plan to fit your dental needs. If you have dental insurance, we will file both and accept payments from both your primary and secondary insurance companies, in an effort to help you receive your maximum allowable benefits. Before any treatment is started, we will estimate your co-payment but please remember: ***this is only an estimate.***

Please note that we will make every effort to answer your insurance questions to the best of our ability. However, please remember that benefits vary and it would be best if you took the time to familiarize yourself with your insurance plan limitations, frequencies, waiting periods, and coverage amounts. You are responsible for your portion of the payment not covered by your insurance at the ***time of treatment.*** If your insurance does not make payment within 30 days, you will be billed for the unpaid balance. For a specific quote on your insurance benefit, we will be happy to file a "pre-treatment authorization" with your insurance company prior to treatment. Please note that this is not a guarantee of coverage, but will give you a more accurate idea of what out of pocket expenses you will be responsible for.

If you have any questions or concerns about the above information or any uncertainty regarding payment or insurance benefits, please don't hesitate to ask us. We are here to help!

I understand the above insurance and financial policy and authorize Southern Family Dental to submit and assign benefits on my behalf, and to release information relative to dental claims. I also authorize payment of my dental insurance benefits, otherwise payable to me, to Southern Family Dental

Patient's name: _____ Date: _____

Patient/Parent/Legal guardian signature: _____

No-show and Broken Appointment Policy

You are our number one priority and our goal is to provide you with the best and most timely dental care possible. When we make your appointment, we set aside time and space for you and your specific dental needs. Failure to keep your appointment without adequate notice adds to the overall cost of healthcare as trained professionals and dental facilities are not being used. We kindly ask that you provide us with at least a **2-business-day notice** if you are unable to make it to your appointment. You will be charged a broken appointment fee of **\$60/hour** if you fail to provide us with adequate notice. We reserve the right to reschedule your appointment if you arrive more than **10 minutes late.**

Patient's name: _____ Date: _____

Patient/Parent/Legal guardian signature: _____



Policies, continued.

Privacy and Disclosure Policy

At Southern Family Dental, we understand that your medical and dental information is personal and we are committed to protecting it. We create a record of the care and services you receive at our office. We need this record to provide you with quality dental care and to comply with certain legal requirements. This notice will tell you about the way we may use and share your Protected Health Information.

- ❖ Patient Rights: You have the right to request a copy of your health records and to request the type of format you want (paper or electronic). NOTE: there is a \$30 fee for transfer or release of records, including x-rays
- ❖ We have a legal duty to: Keep your personal health information private and also to notify you of any accidental disclosure of your private health information in a timely manner.
- ❖ We have the right to: change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
- ❖ Notice of change to privacy practices: before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

The following describes different ways that we are permitted to use and disclose your dental/ medical information. We will not use or disclose your dental/ medical information for any purpose not listed below without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

- ❖ For treatment: we may use your PHI to provide you with dental treatment or services. We may disclose dental/ medical information about you to healthcare providers who may be involved in your treatment both directly and indirectly.
- ❖ For payment: we may use and disclose your PHI for payment purposes. A bill may be sent to you or a third-party payer or a collection agency. The information on or accompanying the bill may include your dental/ medical information.
- ❖ For health care operations: we may use and disclose your PHI for our health care operations including quality assessments, evaluating the performance of employees and conducting training.
- ❖ Southern Family Dental may not sell or use your PHI for marketing or fundraising purposes without your signed authorization.
- ❖ If you pay for your dental treatment and request that we not disclose the procedure to your insurance company we must comply with your request as long as you pay in full for the procedure in a timely manner.

I have read and understand the above Privacy and Disclosure Policy

Patient's name: _____ Date: _____

Patient/Parent/Legal guardian signature: _____



Last name: _____ First name: _____ MI: _____

Patient is: (please circle one) Policy Holder or Responsible Party

Preferred name: _____

How did you hear about us? _____

Do you prefer to be contacted for appointment confirmation via email or phone? (please circle one)

Responsible party (if someone other than the patient):

Last name: _____ First name: _____ MI: _____

Address: _____

City, State, Zip: _____

Home Tel#: _____ Work Tel#: _____ Cell #: _____

Birth date: _____ SS#: _____ Driver's Lic# _____

Responsible party is (please circle one): policy holder for patient/primary ins holder/ secondary ins holder

Patient information:

Address: _____

City, State, Zip: _____

Home Tel#: _____ Work Tel#: _____ Cell #: _____

Birth date: _____ SS#: _____ Driver's Lic# _____

Email: _____

Sex: M F Marital status (please circle one): Married Divorced Single Separated Widowed

Primary Insurance information:

Name of insured: _____ Relationship to insured: _____

Insured SS# _____ Insured Birth Date: _____

Employer: _____

Insurance company name: _____

Insurance company phone: _____

Secondary Insurance information:

Name of insured: _____ Relationship to insured: _____

Insured SS# _____ Insured Birth Date: _____

Employer: _____

Insurance company name: _____

Insurance company phone: _____

I consent to the procedure decided upon to be necessary or advisable in the opinion of the dentist

Patient/ Legal guardian signature: _____ Date: _____



Patient Name: _____ Date of Birth: _____ Today's Date: _____

The answers you provide below are for our records only, and will be kept confidential in accordance with applicable laws. Your oral health is closely related to your overall health. Information regarding your medical history will allow us to provide the best, most customized dental care possible.

Medical History

Physician's name: _____ Date of last visit: _____

Physician's address: _____ Physician's Phone #: _____

Have you ever had a blood transfusion? Y N If yes, please describe: _____

Have you ever had any serious illnesses or operations? Y N

If yes, list operation(s) and date(s): _____

Pregnant? Y N If yes, what is your due date? _____

Please check if you currently have/ ever had:

- | | | | | | |
|----------------------------------|-----------------------|-------------------------|-----------------------|---------------------------------|-----------------------|
| Allergies, hay fever, sinusitis | ☐ | Heart problems | ☐ | Thyroid problems | ☐ |
| Anemia | ☐ | Hepatitis | ☐ | Tonsillitis | ☐ |
| Arthritis, rheumatism | ☐ | Herpes | ☐ | Tuberculosis | ☐ |
| Artificial heart valves | ☐ | High blood pressure | ☐ | Tumor or growth | ☐ |
| Asthma | ☐ | HIV/AIDS | ☐ | Ulcer | ☐ |
| Asthma: required hospitalization | ☐ | Jaundice | ☐ | Venereal disease | ☐ |
| Abnormal bleeding with surgery | ☐ | Kidney disease | ☐ | Weight loss, unexplained | ☐ |
| Blood disease/ clotting disorder | ☐ | Low blood pressure | ☐ | Do you wear contacts? | ☐ |
| Cancer | ☐ | Mitral valve prolapse | ☐ | Do you consume alcohol? | ☐ |
| Chemical dependency | ☐ | Osteopenia | ☐ | Are you allergic to latex? | ☐ |
| Chemotherapy | ☐ | Osteoporosis | ☐ | Are you allergic to penicillin, | |
| Circulatory problems | ☐ | Pacemaker | ☐ | aspirin, or any drugs? | ☐ |
| Cortisone Treatments | ☐ | Radiation treatments | ☐ | If yes, please specify: | |
| Cough: persistent or bloody | ☐ | Respiratory disease | ☐ | _____ | |
| Diabetes | ☐ | Rheumatic fever | ☐ | _____ | |
| Emphysema | ☐ | Scarlet fever | ☐ | Are you currently taking | |
| Epilepsy | ☐ | Shortness of breath | ☐ | any medications? | ☐ |
| Fainting | ☐ | Sinus trouble | ☐ | If yes, please list: | |
| Glaucoma | ☐ | Sickle cell anemia | ☐ | _____ | |
| Headaches | ☐ | Stroke | ☐ | _____ | |
| Heart Murmur | ☐ | Swelling of feet/ankles | ☐ | _____ | |

Dental History

Reason for today's visit: _____ Date of last dental visit: _____

Please check if you currently have/ ever had:

- | | | | | | |
|--------------------------------|-----------------------|----------------------------|-----------------------|----------------------------|-----------------------|
| Bad breath | ☐ | Swollen/ bleeding gums | ☐ | Have you ever had allergic | |
| Blisters on lips or mouth | ☐ | Head, neck, or jaw pain | ☐ | reactions to novocaine, or | |
| Burning sensation on tongue | ☐ | Loose teeth | ☐ | any anesthetics? | ☐ |
| Chew on one side of mouth | ☐ | Mouth breathing | ☐ | If yes, please explain: | |
| Cigarette, pipe, cigar smoking | ☐ | Orthodontic treatment | ☐ | _____ | |
| Smokeless tobacco | ☐ | Periodontal treatment | ☐ | Have you had trouble from | |
| Dry mouth | ☐ | Sensitivity to pressure | ☐ | previous dental care? | ☐ |
| Clenching/grinding of teeth | ☐ | Sensitivity to temp/sweets | ☐ | | |

I have read and answered the above questions to the best of my knowledge: Signed _____