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 ***24 hour notice*** if you are unable to make it to your appointment. You will be charged a broken appointment fee of $45 if you fail to provide us with adequate notice. We reserve the right to reschedule your appointment if you arrive more than 15 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 discloser 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 no 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

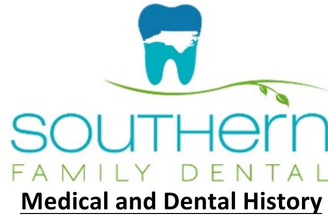
Patient information:
Address:____
City, State, Zip: ____
Home Tel#: _______________________ Work Tel#: _______________________ Cell #:______________________
Birth date: ________________________ SS#: _____________________________ Driver's Lic#_________________
Email: ___________________________________
Sex: M F Marital status (please circle): 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: ___________________



Medical and Dental History

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	Ostopenia	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 ____