SOUTHERN OAK DENTAL

Welcome

Patient Information Form

Thank you for allowing us to take care of all your dental needs and giving you the best care possible by completing the entire form in ink and legible. If you have questions or need help, just ask. We look forward to bring your dentist of choice!

Circle one : Dr /Mr / Mrs/ Ms / Miss First: _____ MI: _____ Last: _____ Jr/Sr: ____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Employer: _____ Work Phone: _____

Driver's License #: _____ Social Security #: _____ Date of Birth: _____ Is patient a Minor? Yes / No

Sex (circle) M F Email Address: _____ Preferred Contact Method:_____ Text Y / N

Circle One: Single / Married / Divorced / Separated / Widowed Spouse/Parent Name: _____

Social Security #: _____ Date of Birth: _____ Phone: _____

Employer: _____ Emergency Contact (if different): _____ Phone: _____

Is anyone in your family a patient at any Southern Oak Dental, If so, who?

_____

How did you hear about Southern Oak Dental?

☐ Newspaper ☐ Flyer ☐ TV ☐ Internet ☐ Referral ☐ Phone Book ☐ Other _____

Head of Household and /or Responsible Party for Payment: _____ Phone #: _____

Do you have Dental Insurance? (circle) Yes No **Please Complete all Fields**		Do you have **Secondary** Dental Insurance? (circle) Yes No	
Primary Insured, The Subscriber		**Secondary Insured**	
Primary Insurance		Secondary Insurance	
Subscriber Name		Subscriber Name	
Subscriber ID#		Subscriber ID #	
Date of Birth		Date of Birth	
Relationship to Subscriber	☐ Self ☐ Spouse ☐ Child ☐ Other	Relationship to Subscriber	☐ Self ☐ Spouse ☐ Child ☐ Other
Employer Name		Employer Name	
Employer Phone #		Employer Phone #	
Insurance Company		Insurance Company	
Insurance Group #		Insurance Group #	
Insurance Phone #		Insurance Phone #	

Please present Insurance Card to receptionist to be copied

Assignment of Benefits

I authorize payment directly to Southern Oak Dental for all Insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all service rendered on my behalf or my dependents. I authorize Southern Oak Dental to release the information required to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ Date _____

SOUTHERN OAK
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Medical History

Patient Name: _____ Date of Birth: _____

Physician's Name: _____ Physician's Phone: _____

Reason for today's visit? _____

If wearing dentures, age of dentures: _____ Are you interested in new dentures? (Circle) Yes No

Have you taken antibiotics prior to dental procedures in the past? (Circle) Yes No (If so why? _____)

Have you had an adverse reaction, are allergic, or become ill: Penicillin, Aspirin, Codeine, Local anesthetics, Latex, Metals, or any other medications? (Circle) Yes No Explain: _____

List Medications that you are currently taking:

_____

_____

Dental History

Do you have a history of:	**Y**	**N**		**Y**	**N**		**Y**	**N**
Bad Breath			Loose Teeth or Broken Fillings			Sensitivity to Sweets		
Bleeding Gums			Orthodontic Treatment			Sensitivity When Biting		
Blister on Lips or Mouth			Pain Around Ear			Frequent Headaches		
Finger Nail Biting			Periodontal Treatment			Jaw, Head or Neck Injuries		
Grinding Teeth			Sensitivity to Cold			Jaw Clicking or Pain		
Lip or Cheek Biting			Sensitivity to Heat			Tooth Pain		

Medical History

Do you have a history of:	**Y**	**N**		**Y**	**N**		**Y**	**N**		**Y**	**N**
Rheumatic Fever			**Asthma**			**Thyroid Disease**			Alcoholism		
Heart Murmur			**Allergies or Hives**			**Epilepsy or Seizures**			**Mouth sores/growth**		
Mitral Valve Prolapse			**Anemia**			**Fainting or Dizzy Spells**			**Teeth Grinding/Clenching**		
Diabetes			**Venereal Disease**			**Arthritis**			**Psychiatric treatment**		
Pace Maker/Heart Surgery			**Aspirin/Anticoagulant Therapy**			**Ulcers or Stomach Problems**			**Pain in Jaw (TMJ)**		
High Blood Pressure			**HIV Positive / Aids**			**Latex Allergy**			**Any type of Implant**		
Low Blood Pressure			**Blood Transfusion**			**Sinus Problem**			**Any type of transplant**		
Heart Problems			**Excessive Bleeding**			**Cancer (Type_____)**			**Any Artificial Joints**		
Stroke			**Hepatitis (Type_____)**			**Chemotherapy**			**Other Disease or Illness**		
Lung Disease			**Liver Disease**			**Radiation Treatment**					
Breathing Problems			**Kidney Disease**			**Use of Tobacco**					
Tuberculosis			**Dialysis**			**Drug Addiction**					

Women Only:

Are you Pregnant (circle) Yes No / Are you Nursing (circle) Yes No / Are you taking Birth Control (circle) Yes No

_____

I certify that I have read and understand the above questions and acknowledge that questions are answered to the best of my knowledge.

Patient Signature _____ Date _____

SOUTHERN OAK
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Payment Policy

Thank you for choosing our office as your primary dental care provider. We are committed to providing you with the quality dental care. Below are the payment policies for our offices. Please read, initial and sign in the spaces provided. If you have, any questions please feel free to ask. A copy can be provided upon request.

Please initial in the spaces provided below:

_____ 1. INSURANCE

We participate with most insurance plans. If you are insured by a plan in which we do not participate, payment in full is expected at each visit. Knowing you insurance benefits is your responsibility. Our office will only receive estimates thru your insurance company based on your benefits and is not a guarantee of payment. Please contact your insurance company with any questions you may have regarding your coverage.

_____2. COVERAGE CHANGES

If you insurance coverage changes, it is your responsibility to notify us before your next appointment so that we can make the appropriate changes to help you maximize your benefits.

_____ 3. CLAIM SUBMISSION

Your insurance benefit is a contract between you and your insurance company. As a courtesy to you, we will submit your claims for payment directly to us for services rendered. It is your responsibility to comply with any request for information that the insurance might need in order to pay the claim. Failure to do so will result in a transfer of the balance to your account.

_____ 4. CO-PAYMENTS AND DEDUCTIBLES

All co-pays and deductibles must be paid at the time of services. Your co-payment is only an estimate. Occasionally, insurance companies do not pay all that is expected. When this occurs, the remaining balance is your responsibility. This arrangement is part of your contract with your insurance company and not the dental office. Failure on our part to collect these fees can be considered fraud. Please help us by paying your co-payment at each visit.

_____ 5. NON-COVERED SERVICES

Please be aware that your insurance company may not cover some of the necessary services rendered. You will be responsible for these services in full on the day of treatment.

_____ 6. PROOF OF IDENTIFICTION

There have been increased cases of fraud. We require each patient to complete our patient information form. You will need to provide a copy of a valid driver's license or ID and your social security number, which is necessary to verify insurance.

_____ 7. NON-PAYMENT

If your account is over 30 days past due, you will receive a letter stating that you have 10 days to pay the balance in full. Partial payments will not be accepted unless arrangements have been made in writing with the manager. Please be aware that if a balance remains unpaid, your account will be turned over to a collection agency and a collection agency fee will be applied.

_____ 8. MISSED APPOINTMENTS

We reserve a time for you so that we can take care of your dental needs. As a courtesy to other patients who may need care during your scheduled time there is a fee of up to $75 for appointments cancelled without a 24-hour notice or failure to show at your scheduled visit.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns. I acknowledge that I have read and accept the payment policy of your office, I have an understanding of all the information that was written, and all of my questions have been answered to my satisfaction.

_____ _____

Patient or Guardian Signature Date

SOUTHERN OAK
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Privacy Is Important to Us

Acknowledgement of Receipt of Notice of Privacy Policies

I received a copy of the Notice of Privacy Practices of Southen Oak Dental. I hereby authorize, as indicated by my signature below, Dental Home to use and to disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent form.

_____ Print Name

_____ Signature

_____ Address

_____ Date

Please check your preferred means of communication:

□ You may contact me at my home telephone number: _____

□ You may contact me on my mobile telephone number: _____

□ You may contact me on my work telephone number: _____

□ You may send me an email at: _____

□ Other: _____

Please list authorized persons with whom we may discuss your Protected Health Information (PHI). Please notify us if you desire to remove a name from this list in the future.

1. _____Relationship: _____ Date ___/___/____ added/removed

2. _____ Relationship: _____ Date ___/___/____ added/removed

3. _____ Relationship: _____ Date ___/___/____ added/removed

****For Office Use Only****

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- □ Individual refused to sign
- □ Communication barriers prohibited obtaining the acknowledgement
- □ An emergency situation prevented us from obtaining the acknowledgement
- □ Other (Please Specify): _____ Staff initials:_____