New Patient Dental Intake Form

Patient Information

Name: _____ Birthdate: _____

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

Home phone: _____ Work phone: _____ Email: _____

Sex: ☐ M ☐ F Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Partnership ☐ Widowed

Employer or School: _____ Phone: _____

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

Spouse, partner or parent name: _____

Person to contact in case of an emergency: _____ Phone: _____

How did you learn about our practice or whom may we thank for referring you? _____

Who is responsible for your account and payment? (if different from previous listing): _____

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

Phone: _____ Email: _____ Birthdate: _____

Dental Insurance

Insurance company: _____ Phone # _____

Subscriber's Social Security # _____ Group # _____ ID # _____

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

How much is your deductible? _____ How much have you used? _____ What is your annual maximum benefit? _____

Whose name is this insurance under? _____

Employer offering this insurance? _____ Phone: _____

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

Secondary Dental Insurance

Insurance company: _____ Phone # _____

Subscriber's Social Security # _____ Group # _____ ID # _____

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

How much is your deductible? _____ How much have you used? _____ What is your annual maximum benefit? _____

Whose name is this insurance under? _____

Employer offering this insurance? _____ Phone: _____

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

Dental History

Reason for today's visit: _____

Date of last dental care visit: _____ Date of last dental x-rays: _____

Former dentist's name: _____ Phone: _____

Check if you have any problem with the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between certain teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to any of the following: cold, hot, sweets
- ☐ Sensitivity when biting
- ☐ Sores or growth in your mouth

How often do you floss? _____ How often do you brush? _____

Medical History

Your physician: _____ Date of last visit: _____

Have you ever taken any of the groups of drugs collectively referred to as "fen-phen"? ☐ Yes ☐ No

Have you had any serious illnesses or operations? ☐ Yes ☐ No

If yes, describe: _____

Have you ever had a blood transfusion? ☐ Yes ☐ No

If yes, give approximate dates: _____

Women: are you pregnant? ☐ Yes ☐ No

Are you nursing? ☐ Yes ☐ No

Are you taking birth control? ☐ Yes ☐ No

Check if you have or have had any of the following:

- ☐ Anemia
- ☐ Arthritis, rheumatism
- ☐ Artificial heart valves
- ☐ Artificial joints, pins, etc.
- ☐ Asthma
- ☐ Bleeding abnormally
- ☐ Blood disease
- ☐ Cancer
- ☐ Chemical dependency
- ☐ Chemotherapy
- ☐ Circulatory problems
- ☐ Congenital heart lesions
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart murmur
- ☐ Heart problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ HIV AIDS
- ☐ Jaw pain
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Mitral valve prolapse
- ☐ Pacemaker
- ☐ Radiation treatment
- ☐ Respiratory disease
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Sexually transmitted disease
- ☐ Stroke
- ☐ Swelling of feet or ankles
- ☐ Thyroid problems
- ☐ Tobacco use
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer

List medications you are currently taking and the correlating diagnosis:

Medication	Diagnosis

Please list any allergies you may have:

Allergy	Allergy

To the best of my knowledge, the above information is complete and correct.
I understand that it is my responsibility to inform my doctor if I or my minor child has a change in health.

_____ _____

Patient or Guardian Signature *Date*

HIPAA COMPLIANCE

Patient Consent to Receive Mail and/or Telephone Messages

Patient's Name: (*Please print*)

LAST NAME FIRST NAME MIDDLE

1. Do we have your permission to send recall/treatment appointment reminders to your home? Yes____ No ____

2. Do we have your permission to leave the following information on your home answering machine or voice mail?

Appointment Information	Yes ____	No ____
Billing Information	Yes ____	No ____
Dental/Medical Information	Yes ____	No ____

3. Do we have your permission to leave the following information on your work answering machine or voice mail?

Appointment Information	Yes ____	No ____
Billing Information	Yes ____	No ____
Dental/Medical Information	Yes ____	No ____

4. Do we have your permission to send the following information to your e-mail address provided to us on your patient registration form?

Appointment Information	Yes ____	No ____
Billing Information	Yes ____	No ____
Dental/Medical Information	Yes ____	No ____

5. Do we have your permission to send the following information to your cell phone number (including text messages) provided to us on your patient registration form?

Appointment Information	Yes ____	No ____
Billing Information	Yes ____	No ____
Dental/Medical Information	Yes ____	No ____

6. Do we have your permission to send the following information to your fax machine at the number provided to us on your patient registration form?

Appointment Information	Yes ____	No ____
Billing Information	Yes ____	No ____
Dental/Medical Information	Yes ____	No ____

7. I hereby give permission to share any information concerning me with the person(s) named below:

Name: _____ Name: _____

DATE: _____

SIGNED: _____ **WITNESS:** _____

Print Name: _____ Print Name: _____

Relationship to Patient: Self ____ Spouse ____ Parent ____ Child ____ Legal Guardian ____ Other: ____

TERMS AND CONDITIONS OF SERVICE

In consideration of all services provided by Southern Prosthodontics, LLC and their employees and contractors, or by Southern Prosthodontics, LLC, and their employees and contractors, the undersigned hereby acknowledges and agrees on behalf of himself or herself, and on behalf of his or her children, dependents, and other persons for whom he or she serves as guarantor (collectively, "Dependents"), with the following terms and conditions of service:

Medical Information. The undersigned hereby certifies that all information provided to the Southern Prosthodontics, LLC is true, correct and complete and agrees to promptly inform the Southern Prosthodontics, LLC of any changes in any information (including regarding any Dependent). Southern Prosthodontics, LLC is authorized to use and disclose to any insurance, billing, management or processing company, agency or organization any health care information and medical records relating to the undersigned or any Dependent to obtain payment for services, determine insurance benefits, or otherwise as required by law. Southern Prosthodontics, LLC is authorized to contact the undersigned at any telephone number provided above (unless otherwise revoked in writing) to discuss this form and any billing, treatment, or other matter related to any dental treatment (including for any Dependent).

Treatment: Informed Consent. The undersigned authorizes Southern Prosthodontics and any treating dentist, hygienist, and staff member to perform all treatment described in any treatment plan (and including all other services determined by such dentist to be necessary or appropriate in connection with such treatment plan) accepted by undersigned for himself or herself or any Dependent. Dentistry is a biological procedure and not an exact science; therefore, despite the highest standard of care, no guarantee is or can be given by Southern Prosthodontics or any dentist or any other person employed or contracted by Southern Prosthodontics regarding any treatment or the results that may be obtained. The patient must comply with all specified appointments, procedures, and continuing care, and failure to do so will adversely affect the patient's treatment often necessitating additional required treatment (or retreatment) with additional fees. Failure to show within 15 minutes of the scheduled time for, or provide at least 48 hours advance notice of cancellation of, any appointment for any reason will result in a broken appointment fee of $45. Southern Prosthodontics, LLC does not exercise control over the professional services of any of its treating dentists; therefore, the undersigned shall solely hold the treating dentist responsible for any treatment performed (including, without limitation, treatment provided under the treating dentist's supervision) and agrees to hold harmless Southern Prosthodontics and its interest holders, members, managers, officers, directors, owners, affiliates, employees, agents, contractors, and all other persons and entities under common control or ownership with the Southern Prosthodontics, LLC. Fees in treatment plans for non insurance/discount plan patients are only valid for 30 days; all insurance/discount plan fees are subject to change at any time based upon changes in plan fee schedules or to correct errors.

Financial Responsibility; Insurance. THE UNDERSIGNED PATIENT AND GUARANTOR ASSUME FULL RESPONSIBILITY FOR PAYMENT OF ALL FEES AND CHARGES FOR ALL SERVICES OF THE DENTAL GROUP, WHETHER OR NOT COVERED BY INSURANCE. THE PATIENT'S PORTION OF ALL FEES (INCLUDING ALL DEDUCTIBLES AND CO-PAYS) IS DUE AND PAYABLE IN FULL AT THE TIME SERVICES ARE PERFORMED. For treatment involving multiple appointments, such as a crown, root canal, denture, or implant, the entire patient portion is normally due when treatment is started. Any special financial arrangements must be made before treatment is started. All insurance, discount plans and discount coupons must be presented before treatment is started. The Dental Group submits insurance claims solely to primary dental insurance for patients' convenience and does not assume responsibility for the processing of such insurance or failure of insurance to pay for any reason. Dental insurance rarely covers all fees; estimated or preauthorized insurance benefits are not guaranteed. The undersigned agrees to pay promptly on demand any balance not paid by insurance within 60 days after the date of service. A service charge of 12% per month (18% per annum) is charged on all balances more than 30 days past due. Insurance balances are considered past due if not paid within 60 days of the date of service. The undersigned shall pay all costs incurred by Southern Prosthodontics, LLC relating to collection of any unpaid or delinquent balance (including, without limitation, attorneys and collection agency fees, court costs, paralegals) whether or not suit is filed. Southern Prosthodontics, LLC reserves the right to terminate or deny any treatment if the patient's account is delinquent.

Assignment of Benefits; Authorization and Release. The undersigned hereby certifies that all insurance coverage described above is current and valid and assigns directly to the Southern Prosthodontics, LLC all insurance benefits covering the undersigned or any Dependent for all services rendered. The undersigned hereby agrees that his or her signature below will be maintained "on file"; the Southern Prosthodontics, LLC is authorized to use such signature on all applicable insurance claims and submissions. If any insurance payment is made to the undersigned, he or she shall immediately remit such payment to the Southern Prosthodontics, LLC.

Notice of Privacy Practices. The undersigned has reviewed a copy of Southern Prosthodontics Notice of Privacy Practices effective June 1, 2019, as amended.

I have read the above terms and conditions of service by the Dental Group and understand and accept such terms:

Signature of Patient, Parent, Legal Guardian,Health Care Proxy or Surrogate, or Power of Attorney Date Signed:

Printed of Patient, Parent, Legal Guardian, Health Care Proxy or Surrogate, or Power of Attorney Date Signed:

Signature of Witness

Printed name of Witness