WELCOME

Patient Name: _____ Birth Date ___/____/____ SSN _____
Name patient wishes to be called: _____ Gender: ____ F ____ M

Address: _____ Home Phone: _____
City: _____ State: ____ Zip: _____ Mobile Phone: _____
E-mail: _____ Work Phone: _____
Whom may we thank for referring you? _____
Has any member of your immediate family been seen in our office? YES / NO If yes, who? _____

INSURANCE INFORMATION:
Policy Holder: _____ Policy Holder's Birth Date: ___/____/____
Policy Holder's SSN: _____ Subscriber ID #: _____
Employer: _____ Name of Insurance Company: _____

DENTAL HISTORY

How long since your last dental visit?
_____

What is your reason for this visit?
_____

Are you aware of any specific dental problems?
_____
_____

Are you currently in any pain? Y N

Are you happy with your smile? Y N If not, what would you change?
_____
_____
_____
_____

Southern Dental Associates ◆ Dedicated to Clinical Excellence

MEDICAL HISTORY

Please circle yes or no for each of the following that apply

Y N – Allergy to Latex
Y N – Anemia
Y N – Artificial Joints
Y N – Asthma
Y N – Blood Disease
Y N - Cancer
Y N – Currently Pregnant
Y N – Diabetes
Y N – Dizziness/Fainting
Y N – Epilepsy/ Seizures
Y N – Excessive Bleeding
Y N – Taking Blood Thinners
Y N – Glaucoma
Y N – Heart Disease
Y N – Heart Murmur
Y N – Hepatitis
Y N – High Blood Pressure
Y N – HIV/AIDS
Y N – Pacemaker
Y N – Radiation Treatment
Y N – Stroke
Y N – Sinus Problems
Y N – Tuberculosis
Y N – Venereal Disease

DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED?
_____
_____

ARE YOU ALLERGIC TO ANY MEDICATIONS? _____
_____

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING: _____
_____
_____

DO YOU HAVE ANY CONDITION THAT REQUIRES YOU TO BE PREMEDICATED WITH ANTIBIOTICS PRIOR TO DENTAL TREATMENT? YES OR NO _____

EMERGENCY CONTACT PERSON: _____ **PHONE:** _____

PATIENT/GUARDIAN SIGNATURE:_____ **DATE:** _____

Updated: _____ _____ _____ _____ _____ _____

Southern Dental Associates

Information posted at www.southerndentalnc.com

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____ have received a copy of this office's Notice of Privacy Practices.

Please Print Name: _____

_____ _____

Signature Date

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
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify) _____

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment, activities and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

_____ _____

Signature Date

Financial Policy

6570 Shallowford Rd.
Lewisville, NC 27023
336-945-5555

1690 River St.
Wilkesboro, NC 28697
336-838-9400

This is an agreement between Southern Dental Associates, as creditor, and the Patient/Debtor named on this form.

In this agreement the words "you," "your," and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we," "us," and "our" refer to Southern Dental Associates.

By executing this agreement, you are agreeing to pay for all services that are received.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the finance charge, if any, and any payments or credits applied to your account during the month.

Payment options:
We accept cash, checks, money orders, care credit and most major credit cards.

Payments: Unless we approve other arrangements in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the end of the month.

Charges to Account: We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service.

Patient's name: _____

Responsible party (If not the patient): _____

Signature: _____ Date: _____

Co-Signature: _____ Date: _____

Non-Contracted Insurance: Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company.

Finance Charge: A finance charge will be imposed on each item of your account, which has not been paid within ninety (90) days of the time the item was added to the account. The **FINANCE CHARGE** will be computed at the rate of 1.5% per month or an **ANNUAL PERCENTAGE RATE** of eighteen (18%).

Credit History: If your account becomes delinquent we have the option to report your account status to any credit reporting agency such as a credit bureau. Efforts will be made to collect the unpaid balance, before reporting to the credit bureau.

****CONTINUED ON BACK****

Required payments: Any co-payments required by an insurance company must be paid at the time of service.

Returned checks: There is a fee of $25.00 for any checks returned by the bank.

Missed appointments: Missed appointments are costly to our practice, thus we require 48 hours notice to cancel or reschedule an appointment. If your appointment is cancelled with less than 48 hours notice or you fail to show up for your appointment, it is considered a "broken appointment." After 2 broken appointments, it is up to doctor discretion if you are dismissed from our practice or if a non-refundable deposit at a minimum of $50.00 will be required to reserve any additional appointment times. The non-refundable deposit will be applied toward your treatment after it has been rendered and is only forfeited if you fail to present for your appointment or cancel with less than 48 hours notice.

Past due accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs, which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyers' fees that we incur plus all court costs. In case of suit, you agree the venue shall be in either Forsyth or Wilkes County, North Carolina.

Waiver of confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Transferring of Records: You will need to request in writing, and pay a reasonable copying fee if you want to have copies of your records sent to another doctor or organization. The amount of the fee is dependent on the number of pages we need to copy. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

Workers Compensation: We require all services be paid in full and once workers compensation pays they can pay directly to you.

Personal Injury: If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your health insurance. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility. We cannot bill your attorney for charges incurred due to a personal injury case. We reserve the right to handle payment of these treatment plans on a case-by-case basis.

Co-signature: If another person signs this or another Financial Policy, that co-signature remains in effect until canceled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Authorization for Use or Disclosure of Protected Health Information

I, _____, authorize Southern Dental Associates to use and disclose the protected health information described below to the following person(s):

_____

□ Appointment Reminders

□ Billing/Account Information

□ Treatment Needs

□ Insurance Information

□ All Personal Information

□ Other (please specify): _____

This authorization shall remain in effect unless other written notification is given.

I understand that I have the right to revoke this authorization, in writing, at any time.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____

Patient Date

_____

Patient, Parent/Legal Guardian Signature