Southern Family Dental

PATIENT REGISTRATION FORM

Southern Family Dental is committed to dental excellence. We provide quality and affordable dental care while upholding the professional standards of dentistry. All staff members are united in the effort of educating our patients and providing compassionate care. We will listen to your concerns, educate you on oral health, and help you decide the best dentistry plan for you and your family. Thank you for trusting us with your dental care!

Patient Information (Please Print)

CIRCLE ONE: DR/ MR/ MRS / MS / MISS

FIRST _____ MIDDLE_____ LAST _____

ADDRESS _____ CITY _____ STATE ____ ZIP CODE _____

PHONE (HOME)_____ (WORK) _____ (CELL)_____

EMAIL ADDRESS _____ MAY WE CONTACT YOU VIA EMAIL? YES NO

DATE OF BIRTH _____ AGE _____ GENDER (circle) MALE FEMALE

PATIENT SOCIAL SECURITY NUMBER _____

EMERENCY CONTACT _____ PHONE _____

HOW DID YOU HEAR ABOUT US? WEBSITE FACEBOOK FRIEND OTHER _____

INSURANCE INFORMATION

SUSCRIBER NAME _____ SUSCRIBER SSN_____

DATE OF BIRTH _____RELATIONSHIP TO SUSCRIBER: ◊ SELF ◊ SPOUSE ◊CHILD ◊ OTHER

EMPLOYER NAME _____EMPLOYER PHONE_____

INSURANCE COMPANY_____ INSURANCE POLICY NO_____

INSURANCE PHONE NUMBER _____

IF PATIENT IS UNDER 18 YEARS OF AGE, PLEASE REFER TO OUR POLICY BELOW:

Patients under the age of 18 must have a parent/guardian present in the waiting room and during the patient's appointment time. We cannot advise nor perform any treatment without a parent/guardian present.

PARENT/GUARDIAN NAME _____ PARENT/GUARDIAN PHONE _____

SECONDARY PARENT/GUARDIAN NAME _____ PHONE _____

HEALTH INFORMATION

PRIMARY PHYSICIAN NAME_____ PHONE _____

We take your oral health very seriously. Before we begin treatment, we need some brief information regarding medical history which may affect treatment. All information is confidential.

Reason for today's visit?

_____

Have you ever been hospitalized? (circle) YES NO
Explain_____

Height _____ Weight _____

Do you presently have or ever had a history of any of the following? Please check all that apply.

h	Y	N		Y	N
Abnormal Bleeding			Kidney Disease		
ADD/ADHD			Low blood pressure		
AIDS/HIV+			High blood pressure		
Anemia			Mental Disabilities		
Anxiety/nervous disorders			Mitral valve prolapse		
Arthritis			Mouth sores/growths		
Artificial Joints/Valves			Radiation treatment		
Autism			Respiratory disease		
Aspirin/anticoagulant therapy			Rheumatic fever		
Asthma			Scarlet fever		
Blood Transfusion			Shortness of breath		
Cancer (type:)			Sinus trouble		
Chemical Dependency			Skin Rash/allergies/hives		
Chemotherapy			Special diet/restrictions		
Crohn's Disease			Stroke		
Circulatory Problems			Thyroid disease		
Congenital Heart Defects			Tonsilitis		
Diabetes			Tuberculosis		
Emphysema			Tumor or growth (head/neck)		
Epilepsy/Seizure disorders			Ulcer		
Gastrointestinal Disorders			Venereal disease/STDs		
Glaucoma			Weight loss/Gain		
Grinding/teeth clenching			Other Disease or Illness:		
Headache/Migraines					
Heart Attack					
Heart Murmurs					
Hear Disease/Pacemaker					
Hepatitis Type ____					
Herpes Type _____					
Jaundice					
Jaw Pain					
Women patient's only:	Y	N		Y	N
Is there a possibilty of pregnancy			Are you nursing?		

Date of last dental visit _____Date of last dental x-rays _____ Date of last cleaning _____

Have you ever been treated for periodontal (gum) disease? (circle) YES NO

Have you Ever had Novacaine or other local anesthetic? (circle) YES NO

Are you interested in teeth whitening (price quote can be submitted, if interested)? (circle) YES NO

If wearing dentures, age of dentures _____ Are you interested in new dentures? (circle) YES NO

Are you taking or have taken any steroid/cortisone therapy in the last two years? (circle) YES NO

Are you taking or have taken Oral bisphosphonates? (e.g. FOSAMAX, ACTONEL, BONIVA, or IV Biphosphonates (e.g. ZOMETA, AREDIA) (circle) Yes No Taken for how long

_____

Have you taken antibiotics prior to dental procedures in the past? (circle) YES NO

PLEASE LIST ANY ALLERGIES TO THE FOLLOWING (please circle):

Aspirin Codeine Dental Anesthetics Latex Metals/Nickel

Penicillin Sulfa Erythromycin Tetracycline

Other: _____

Have you ever had an adverse reaction or become ill after taking penicillin, aspirin, codeine, local anesthetics, metals, or any other medication? (circle) YES NO

List any medications you are taking including non-prescription drugs and herbals/vitamins:

1. _____ 2. _____ 3. _____ 4. _____

In the space provided below, please provide any additional medical information.

_____

_____

_____

_____

I affirm that the information I have given is correct to the best of my knowledge. The information given will be for use in my (or my child's) treatment, billing and processing of insurance or Medicaid benefits to which I (or my child) am entitled. Information will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status (or my child's medical status). I authorize the dental staff to perform the necessary dental services that I (or my child) may need.

_____ _____ _____

Printed Name of Patient/Parent/Guardian Signature of Patient/Parent/Guardian Date

SOUTHERN FAMILY DENTAL

I, _____, consent to be a patient at the above named office and agree to a radiographic and clinical examination. **I also understand and consent to the following:**

1. During the course of treatment, I may undergo procedures in all phases of dentistry including periodontics (gum treatment and surgery), oral surgery, endodontics (root canals), fixed and removable prosthodontics (crowns, bridges, and dentures), restorative dentistry, temporomandibular disorder treatment, oral pathology, pediatric dentistry, and radiography.

2. I will provide a thorough and complete medical history, supply a full list of my medications with dosages, and consent to my dentist communicating with my other medical practitioners to inquire about any aspect of my health history.

3. No guarantees can be made about treatment outcomes, restoration longevity, or prognoses. I understand that any branch of medicine, including dentistry, can involve unanticipated results.

4. I will pay in full any cost of treatment or insurance copayments according to the office's financial policy. I understand that even if an insurance preestimate is given or a procedure has been preapproved, I am responsible for *any* costs that my insurance does not cover.

5. My treatment plan may change at any time and I will do my best to approach my dental care with optimism and open communication with my dentist, hygienist, and dental office staff.

6. I am welcome to ask questions about any aspects of my dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspects of my treatment that I am unsure about.

_____ _____

Patient or Guardian Name Date

_____ _____

Witness Date

Southern Family Dental

Notice of Privacy

As a provider of medical services we are required, under the Health Insurance Portability and Accountability Act, to inform you of your rights to protect your personal health information. As a covered entity, we must inform all patients of their rights regardless of insurance coverage.

OUR DUTY TO YOU

As your dental provider we will do everything within our control to maintain your records and information in a secure and private manner. We do reserve the right to change our policies, but you will be informed of any changes in advance. We will only release information, about you and your treatment, under specific circumstances. These include, but are not limited to the following:

Treatment: We may use your information during the course of treatment. This includes releasing information to other dentists, physicians, other health care providers, and our staff. Our staff includes full and part time employees, as well as, temporary personnel.

Payment: We may disclose personal information about you and your treatment to third party carriers and payment processing entities. This includes insurance carriers, claims clearinghouses, collection agencies, and third part administrators such as employee medical reimbursement accounts.

Operations: We may use your personal information in the course of operations of our office. This may include quality assurance/quality improvement reviews, credentialing, training, and certification and accreditation activities.

Miscellaneous Uses: At certain times we may be required to use your information for other purposes than as described above. Examples of these uses include: appointment reminders (cards, voice messages and letters), abuse/neglect, national security, family and friends (only to the extent for use in healthcare operations or payment), and in some cases to law enforcement and court ordered releases.

YOUR RIGHTS

Restrictions: You have the right to request restrictions or disclosure usage. We are not required to accept these restrictions, but we will make a note of the request and honor that request if applicable.

Access: You have the right to access your personal health information. A request for access must be made in writing. You may speak to our privacy officer to schedule an appointment to view your information. You may also request a copy of your personal health information. We will charge you a fee for the copies as set by Louisiana State Board of Dental Examiners.

Amendment: You have the right to request that we amend your personal health information. Your request must be in writing and explain what should be amended and the rationale for such request. We have the right to deny this request if we feel that it would render your information inaccurate. We will inform you of the decision to amend your information.

Disclosure: You have the right to request a list of the times and entities to whom we have disclosed your personal health information. These disclosures are only for instances other than treatment, payment or

operations. This disclosure will be given free on an annual basis if requested. We reserve the right to charge for this if requested more than once in a 12 month period.

Complaints: Please contact our privacy officer for any questions or complaints. If you feel that we have violated your privacy you can submit a written complaint to the U.S. Department of Health and Human Services. We can provide you with the address upon request.

Southern Family Dental

Acknowledgement of Receipt Notice of Privacy Practices

By signing below I acknowledge that I have received or reviewed the Notice of Privacy. I agree with the terms of this notice and understand my rights under this notice. By signing below I consent for the use of my personal health information for treatment, payment, and operations and other uses as described in the privacy notice. I also understand that I have the right not to sign this agreement.

Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

If we are unable to get your acknowledgement than our office will make a notation as to the reason why it was not obtained.

Reason why acknowledgement was not obtained:

_____

_____

_____

Staff Name: _____

Signature: _____

Date: _____

Southern
FAMILY DENTAL

Financial Policy (for all patients)

Thank you for choosing us as your dental care provider. The following describes our Financial Policy. Our office is committed to providing you with the best possible care. Your understanding of our financial policy is an essential element of your care and service. If you have any questions regarding any aspect of our policy, please feel free to present your question to any of our team members. Payment for services is due at the time services are rendered. We accept cash, debit card, and for your convenience Visa, MasterCard, American Express, Discover and 3rd party financing through Care Credit. Please be advised that we do accept check payments in the office. Our patients who have dental insurance are expected to pay the amount of their estimated co-pay and deductible at the time of service. Payment in advance may be required for certain treatment in order to reserve chair time and fund dental laboratory fees.

Deposit Policy:

Due to the extensive amount of time our staff and doctors devote to preparing and reserving uninterrupted time for appointments over 2 hours, we require a $40 deposit treatment fee to make your reservation. _____initials

Appointment Policy (for all patients):

We will work hard to accommodate appointments that fit your schedule and dental needs. We ask that you let us know about changes 24 hours in advance. We do understand that life happens, but any missed appointment without the 24 hour call may be subject to a $25 short/no notice fee, Habitual missed appointments are grounds for dismissal from the practice. _____initials

All minor patients must be accompanied by an adult (parent or legal guardian). The adult accompanying the minor is required to pay in accordance with our policies. We neither accept third party assignments nor do we recognize or enforce the terms of divorce or child support decrees. I have read and understand the Financial Policy and Appointment Policy for Southern Family Dental.

Southern
FAMILY DENTAL

I agree to abide by these policies.

Patient/Guardian Signature: _____

Printed Name: _____

Date: _____

Insurance Policy and Assignment of Benefits (for patients with dental insurance only)

As a courtesy, we will file the forms necessary to see that you receive the full benefits of your coverage. Because your insurance policy is a contract between you, your employer, and the insurance company, it is your responsibility to make sure we have accurate and up to date insurance carrier information, restrictions of your policy, and billing information. If your insurance company has not paid your claim in full within 60 days the remaining balance will automatically become patient responsibility. _____initials

I hereby authorize my primary and/or secondary insurance company to make payments directly to Southern Family Dental. Furthermore, I have read and understand the Insurance Policy for Southern Family Dental. I agree to abide by these policies.

Patient/Guardian
Signature:_____ Printed Name:
_____

Date:_____

Office Policies

Welcome to Southern Family Dental. We are pleased to have the opportunity to care for your dental needs. Our purpose, as a dental team, is to provide quality dental care to all our patients. We want to help our patients achieve excellent oral health, with the goal of a lifetime of smiles with natural teeth. In order for our office to provide you or your family with the best dentistry available to us, we have developed the following policies to help our practice run smoothly and truly help those who are the most willing to receive dental treatment.

Limited Space Policy

We cannot support extra visitors to our practice. We ask that you limit the people coming into our office to just the patient and one parent or guardian (if the patient is a child). We are aware of the difficulty of locating a Medicaid dentist in the Lafayette area. This creates a high number of people who want to become patients in our office. For this reason, we have created these policies.

_____ Initials

Missed Appointment Policy

If you fail to show up for your scheduled appointment, or fail to give a proper 24 hours in advance cancel notice, then it will be counted as a missed/broken appointment on your record. If a second appointment is missed, then you will be dismissed from our office and have to seek dental treatment elsewhere. We understand emergencies happen, but please be aware that this is time that could have been given to another patient.

_____ Initials

Late Arrival Policy

If you arrive 15 minutes late for your appointment, then you will be asked to reschedule. It is not fair to those scheduled after you if we have to delay the start of their treatment. If you arrive late, but less than 15 minutes from the scheduled start time, we will try to fit you in,but we cannot promise that we will be able to perform all the planned or necessary treatments. If you are late for three different appointments, then you will be dismissed from our office and have to seek dental treatment elsewhere. We understand that there are many reasons that could be responsible for your late arrival; therefore we ask that you leave your house with plenty enough time to accommodate traffic and any other unforeseen events.

_____ Initials

I have read and understand my participation requirements in the above office policies. I also understand that if I do not abide by the office policies, then the consequences could result in rescheduling or cancellation of my scheduled appointment or dismissal as a patient from the office.

_____ _____

Signature of Patient or Parent/Guardian Date