



Patient Information (confidential)

Today's Date _____

Patient Name _____ Birth Date _____

Home Phone _____ Cell Phone _____ Email _____

Address _____ City _____ State _____ Zip _____

Check Appropriate Box: Minor Single Married Widowed

Patient or Parent's Employer _____ Position _____ SS# _____

Business Address _____ City _____ State _____ Zip _____

Emergency Contact _____ Relationship _____ Phone _____

Responsible Party (if patient is a minor)

Name of person responsible for account _____ Relationship to patient _____

Address _____ City _____ State _____ Zip _____

Birth Date _____ SS# _____ Employer _____ Phone _____

Dental Insurance Information

Name of insured _____ Relationship to patient _____

Birth Date _____ SS# _____ Date effective _____

Name of Employer _____ Work Phone _____

Insurance Company _____ Group # _____

Insurance Co. Address _____ City _____ State _____ Zip _____

Please fill out if you know your policy benefits:

Percentage of: Preventative _____ Basic _____ Major _____ Insurance Fiscal Year Date _____

Limits on: Cleanings _____ Flouride Treatments _____ X-Rays _____

Amount of deductible: \$ _____ Maximum annual benefit: \$ _____ Amount remaining: \$ _____

Assignment and release: I, the undersigned, certify that I (or my dependent) have insurance coverage with the above insurance company and assign directly to Southwest Dental Associates all insurance benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Southwest Dental Associates to release all information necessary to secure the payment of benefits. I authorize the use of this signature for all insurance submissions.

Signed _____ Date _____

I understand the responsibility for payment for dental services provided in this office for me or my dependents is mine, due and payable at the time services are rendered. I further understand that 1½% finance charge per month (18% annually) will be added to any balance over 60 days. In the event of default, I/we promise to pay legal interest on the indebtedness, together with collection costs and attorney fees as may be required to effect collection on this note. I certify that the above information is true and correct and consent to a credit check based on that information. I agree to be, and hereby am, fully responsible for the total payment of the charges for procedures performed in this office, including any amounts not covered by any dental insurance or prepayment plan that I/my spouse may have.

Signed _____ Date _____



New Patient Medical History

Medical doctor _____ Office phone _____ Date of last physical exam _____

Are you under medical treatment now? _____ Have you been in the last 2 years? _____

Have you ever been hospitalized for any surgery or serious illness? _____

Do you have, or have you had any of the following conditions? Check all that apply:

- Heart attack/surgery, Heart murmur, Heart disease/Pacemaker, Chest pains, High blood pressure, Low blood pressure, Rheumatic fever, Stroke, Asthma/Respiratory problems, Hay fever/Allergies, Tuberculosis, Hepatitis/Jaundice, Kidney disease, Diabetes, Thyroid problems, Stomach problems, Leukemia/Anemia/other blood disorder, Cancer, Radiation/Chemotherapy, Full or partial joint replacement, Arthritis, Glaucoma, Fainting/Dizziness, Epilepsy/Convulsions, MS, HIV infection/AIDS, Frequent cold sores, Osteoporosis, Chemical dependency, Eating disorder, I have taken Fen-Phen, I wear contacts, None of the above, Other

Women only:

Pregnant? _____ Birth control? _____ Did you know antibiotics decrease the effect of birth control? _____

Medication

Please list any medications you are currently taking:
I'm not taking any medication
Pharmacy name: _____

Allergies

Have you ever had an allergic reaction to the following:
Aspirin/Ibuprofen, Codeine, Iodine, Latex, Local Anesthetic, No known drug allergies, Penicillin, Sedatives, Sulfa, Other

Patient Dental History

Date of last dental visit: _____ Why: _____ Previous Dentist: _____ Date of last x-rays: _____
Are you having pain or discomfort at this time?
Do your gums bleed when you brush?
Do you have a history of gum disease?
Have you had difficult extractions in the past?
Do you have any lumps in or near your mouth?
Have you had any head, neck, or jaw injuries?
Do you clench or grind your teeth?
Do you wear a denture, partial, or retainer?
Have you had a bad experience in a dental office?
Do you use any tobacco products?
Do you like your smile?

Signature I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information may be detrimental to my health.

Patient Parent or Guardian Date

For clinic use only: Blood Pressure _____ Pulse _____ Clinician Initials _____ Date _____



Southwest Dental Associates Financial Policy

Philosophy

It is our desire to provide you with quality dental care at an affordable price. In order to continue to do so, we must avoid unnecessary overhead expenses. This policy is written to assist our practice in serving our patients at the most affordable cost.

For those patients with insurance coverage, we will properly bill your insurance company as a courtesy. Please remember that your insurance contract is between you, your employer, and the insurance company. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. We do not dictate our standard of care based on what insurance companies will or will not cover. You and your oral health are our primary concern.

Procedure

We always request payment at the time of service, if you have insurance, your portion is expected. If this is not possible, we expect you to let our credit manager know ahead of time to make payment arrangements.

If your account has not had payment activity in 6 weeks, you will receive a letter and phone call. If no response to this letter, you will be finance charged and a second letter will be sent. If no response, you will receive a third and final letter as well as a courtesy phone call to make payment arrangements. Lack of response will force us to transfer your account to a third party credit bureau where your credit will be adversely affected. We understand that temporary financial problems may arise and effect the timely payment of your account. Should these problems arise, please contact our account manager ASAP and we will work out a new arrangement with you.

Returned checks will have a charge of a \$25 fee. Charges for broken or canceled appointments without 24-hours notice may apply. We are disclosing our policy to you so that we may avoid any misunderstanding in the future.

HIPAA

Our dental office is compliant with the HIPAA regulations. The HIPAA policy is available for review upon request. Thank you.

I have read and understand this policy and agree to comply with the above.

Patient Signature _____ Date _____