Southridge DENTAL

Welcomes You!

Thank you for selecting our dental health care team! We strive to provide you with the best possible dental care. To help us meet all your dental health care needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us, we will be happy to help.

PATIENT INFORMATION

Name _____ Birthdate _____ SS# _____ Date _____

If Child, Parents or Guardians _____ ❒ Minor ❒ Single ❒ Married ❒ Other

Home Address _____ City _____ State _____ Zip _____

Home Telephone _____ Patient's or Parent's Employer _____ Occupation _____

Work Telephone _____ Ext. _____ Pager/Other _____ How Long Employed? _____

Business Address _____ City _____ State _____ Zip _____

E-mail Address _____ Drivers License # _____

Emergency Contact: _____ Phone: _____

PLEASE CIRCLE: SPOUSE / PARENT INFORMATION

Their Name _____

Employer _____

Work Telephone _____ Ext. _____

Birth Date _____ SS# _____

HOW DID YOU FIND OUT ABOUT US?

Whom may we thank for referring you to Southridge Dental _____

What other ways have you heard about us?

❒ Sign/Location
❒ Telephone Directory
❒ Internet/Web Site
❒ Idaho Press Tribune
❒ Radio
❒ Coupons
❒ Business Cards

DENTAL INSURANCE

Primary Dental Insurance

Insurance Company Name _____

Insurance Co. Address _____

Insurance Co. Telephone _____

Group Number _____ Policy I.D.# _____

Insured's Name _____

SS# _____ D.O.B. _____

How much is your Deductible? _____

Secondary Dental Insurance

Insurance Company Name _____

Insurance Co. Address _____

Insurance Co. Telephone _____

Group Number _____ Policy I.D.# _____

Insured's Name _____

SS# _____ D.O.B. _____

How much is your Deductible? _____

MEDICAL HISTORY

Name of Physician _____

Telephone _____ Date of Last Visit _____

Are you under medical treatment now? ❒ Yes ❒ No

Your current health is: ❒ Good ❒ Fair ❒ Poor

Are you taking any prescription drugs? ❒ Yes ❒ No

Are you taking any non-prescription medications? ❒ Yes ❒ No

DENTAL HISTORY

How may we help today? _____

Are you currently in pain? _____

Your current dental health is: ❒ Good ❒ Fair ❒ Poor

Are you allergic to or have you had a reaction to any of the following?

Y	N	Penicillin/Antibiotics	Y	N	Dental Anesthetics
Y	N	Aspirin	Y	N	Codeine
Y	N	Erythromycin	Y	N	Latex
Y	N	Tetracycline	Y	N	Sulfa Drugs
Y	N	Iodine	Y	N	Metals (Mercury)

How do you feel about the appearance of your teeth? _____ Would you be interested in bleaching? _____

Previous dentist _____ Location _____

Date of last dental care _____ Last dental x-rays _____

Please check(✓) if you have had trouble with any of the following:

❒ Bad Breath	❒ Grinding Teeth	❒ Sensitivity to Heat
❒ Bleeding Gums	❒ Loose Teeth or Broken Fillings	❒ Sensitivity to Sweets
❒ Clicking or Popping Jaw	❒ Periodontal Treatment	❒ Sensitivity when Biting
❒ Food collection between teeth	❒ Sensitivity to Cold	❒ Sores or growths in your mouth

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

Have you ever experienced an adverse reaction during or in conjunction with a dental procedure? If yes, explain _____

Previous hospitalizations, illnesses, or operations (please describe, and give approximate date) _____

_____

Have you ever had a blood transfusion? ❒ Yes ❒ No If yes, please give approximate date _____

Women: Are you pregnant? ❒ Yes ❒ No Nursing? ❒ Yes ❒ No Taking birth control pills? ❒ Yes ❒ No

Please check (✓) if you have had any of the following:

❒ AIDS	❒ Cortisone Treatments	❒ Hepatitis	❒ Rheumatic Fever
❒ Anemia	❒ Cough, Persistent	❒ High Blood Pressure	❒ Scarlet Fever
❒ Arthritis, Rheumatism	❒ Cough up Blood	❒ HIV Positive	❒ Shortness of Breath
❒ Artificial Heart Valves	❒ Diabetes	❒ Jaw Pain	❒ Skin Rash
❒ Artificial Joints	❒ Epilepsy	❒ Kidney Disease	❒ Stroke
❒ Asthma	❒ Fainting	❒ Liver Disease	❒ Swelling of Feet or Ankles
❒ Back Problems	❒ Glaucoma	❒ Mitral Valve Prolapse	❒ Thyroid Problems
❒ Blood Disease	❒ Headaches	❒ Nervous Problems	❒ Tobacco Habit
❒ Cancer	❒ Heart Murmur	❒ Pacemaker	❒ Tonsillitis
❒ Chemical Dependency	❒ Heart Problems	❒ Psychiatric Care	❒ Tuberculosis
❒ Chemotherapy	Describe_____	❒ Radiation Treatment	❒ Ulcer
❒ Circulatory Problems	❒ Hemophilia	❒ Respiratory Disease	❒ Venereal Disease

Please list any medications, both prescription and non-prescription, you are currently taking _____

Please list any allergies _____

Signature _____ Date _____ Signature _____ Date _____

Signature _____ Date _____ Signature _____ Date _____

Signature _____ Date _____ Signature _____ Date _____

I have reviewed this questionnaire and answered its questions accurately, to the best of my knowledge. I understand that the answers I have provided will be used by the dentist to determine appropriate dental treatment, and I agree to notify the dentist if any change in my health status should occur.

I authorize the dentist to release all information necessary to secure payment of benefits. I authorize my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize use of this signature on all insurance submissions.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf. I understand that payment is due on the day of service unless other arrangements have been made. Any balance on account after 90 days will be assessed interest. The interest rate is 1.75% per month or 21% annually. I realize that failure to keep this account current may result in you being unable to provide additional services except for emergencies or prepayment of services. In the case of default on payment of this account, I agree to pay all collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any further outstanding account balances.

Signature _____ Date _____

SOUTHRIDGE DENTAL
Our Financial Policy

We are committed to providing you with the best possible care. If you have dual insurance, we are always available to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your responsibility.

Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance. Minors MUST be accompanied by an adult for all treatment.

We accept CASH, CHECKS, VISA, and MASTERCARD. Financing is also available upon request, prior to treatment.

In most instances we accept assignment of insurance benefits, in which case, your portion of each service is due at the time services are rendered. Those who have dual coverage should discuss their payment plans with the receptionist. If your insurance company pays more than the balance due, we will send a refund check too you immediately.

We will gladly discuss your proposed treatment and answer any questions regarding your insurance.

YOU MUST REALIZE, HOWEVER, THAT:

1. YOUR insurance is a contract between you, your employer and the insurance company.
2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore, are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50% or 80%) or "UCR" is defined as Usual, Customary and Reasonable fees fro this region, thus, our fees are considered Usual, Customary and Reasonable by most insurance companies. However, this statement does not apply to companies who reimburse based on arbitrary "schedule" of fees, which bears no relationship to the current standard cost of care in this area.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
4. Should your insurance take longer than 60 days to pay, we would ask that you take care of the balance due and then be reimbursed if and when we receive the insurance payment.

Retuned checks are subject to an **additional fee**. Charges may be incurred for **broken appointments** and **appointments cancelled** without 24 hours notice.

We must emphasize that as dental care providers, our relation is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the day the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE don't hesitate to ask us. WE **ARE HERE TO HELP YOU**!

RESPONISBLE PARTY
SIGNATURE:_____DATE:_____

SOUTHRIDGE DENTAL
HEALTH INFORMATION PRIVACY POLICIES & PROCEDURES

These Health Information Privacy Policies and procedures implement our obligations to protect the privacy of individually identifiable health information that we create, receive, or maintain as a healthcare provider.

We implement these Health Information Privacy Policies and Procedures as a matter of sound business practice; to protect the interests of our patients; and to fulfill our legal obligations under the health Insurance Portability an Accountability Act of 1996 ("IIPAA"), its implementing regulations at 45 CFR Parts 160 and 164 (Dec. 28, 29000) ("Privacy Rules"), as amended (67 Fed. Reg. 53182 [Aug. 14, 2002]), and state law that provides greater protection or rights to patients than the Privacy Rules.

As a member of our workforce or as our Business Associate, you are obligated to follow these Health Information Privacy Policies and Procedures faithfully. Failure to do so can result in disciplinary action, including termination of your employment or affiliation with us.

These Policies and Procedures address the basics of HIPAA and the Privacy Rules that apply in our dental practice. They do not attempt to cover everything in the Privacy Rules. The Policies and Procedures sometimes refer to forms we use to help implement the policies and to the Privacy Rules themselves when added detail may be needed.

Please note that while the Privacy Rules speak in terms of "individual" rights and actions, these Policies and Procedures sue the more familiar word, "patient" instead; "patient" should be read broadly to include prospective patients, patients of record, former patients, their authorized representatives, and any other "individuals" contemplated in the Privacy Rules.

If you have questions or doubts about any use or disclosure of individually identifiable health information or about your other obligations under these Health Information Privacy Policies and Procedures, the Privacy Rules or other federal or state law, consult before you act.

Dr. Roarke J. Miller

_____ _____

Please sign and date above.