# Southern Dental Fort Smith

In an effort to provide you the best service possible, we ask you to fill out this form completely and review our office policies.

## Patient Information

Patient Name_____ M F Preferred Name_____
Date of Birth_____/____/____ Age_____ Social _____-_____-_____ Circle One: Married Single Other
P.O. Box_____ Street Address:_____
City _____ State_____ Zip Code_____
E-mail address_____
Home Phone (_____)_____ Work Phone (_____)_____ (if allowed)
Mobile Phone (_____)_____
Employer_____ Position_____
Who may we thank for referring you?_____
Or circle one: Google Facebook Website Insurance Provider Yellow Pages Other(please specify)_____

Do you have dental insurance? Yes No If yes, please request our insurance form at the front desk
Is patient under the age of 18? If yes, please request our guardian form at the front desk

## Dental History

1. Purpose of this visit_____
2. How long since last dental visit?_____ Date of last dental x-rays?_____
3. Have you had any allergic reaction to dental treatment?_____ Explain_____
4. Do you clench or grind your teeth?_____ When?_____
5. Have you experienced problems with your jaw?_____ Clicking Popping Pain_____
6. Have you experienced any soreness or lumps in your face/mouth?_____ Where?_____
7. Does food get caught in your teeth?_____ Where?_____
8. Are you sensitive to: Hot Cold Sweets Chewing Pressure
9. Do your gums bleed or hurt?_____ When?_____
10. How often do you brush?_____ Floss?_____
11. Have you had gum surgery?_____ When?_____
12. Are your teeth: Loose Shifted Chipped Cracked Discolored
13. Do you snore or have difficulty sleeping?_____ Explain_____
14. Do you play high contact sports?_____ If yes, do you wear a mouthguard?_____
15. Are you unhappy with past dental treatment?_____ Explain_____
16. Are there old fillings or dental work that you don't like?_____ Explain_____
17. Are you unhappy with the appearance of your smile? _____ Why?_____
18. What would you like to change most about your smile? _____

Are you interested in having someone talk to you about: (please check all that apply)

○ Botox ○ Zoom! Whitening ○ Veneers/Lumineers ○ Invisalign

# Medical History

These questions are for your benefit and assure that treatment will take into consideration your past and present health status. Some questions may seem unrelated to your dental condition, but they are all associated with proper oral health care. Please answer each question, or circle YES or NO where applicable.

1. Are you in good dental health? YES NO
2. Are you under the care of a physician? YES NO If so, what is the condition being treated? _____
   _____
   Physician's name_____ Phone #_____
3. Have you ever had a serious illness or operation? YES NO
   If so, please explain_____
4. Have you ever been hospitalized? YES NO
   If so, please explain _____
5. Are you taking any medications? YES NO
   If so, please list _____
6. Are you taking any recreational drugs (marijuana, cocaine, etc.)? YES NO
   (Please note that some recreational drugs taken within 24 hours of dental treatment could be fatal.)

Are you allergic to any of the following:

□ Penicillin □ Sulfa Drugs

□ Aspirin □ Codeine

□ Other, _____

Do you require Pre-Medication (with antibiotics) for your dental treatment for heart murmur, MVP, artificial joint or other health concerns not listed?

YES NO

Are you taking any medications for osteoporosis? YES NO If so, what? _____

Please check if you have or have had any of the following:

| | | | |
|---|---|---|---|
| □ AIDS/HIV | □ Congenital Heart problem | □ Heart Murmur | □ Recent Weight Loss |
| □ Anemia | □ Cortisone Medication | □ Hemophilia | □ Respiratory Disease |
| □ Angina/Chest Pain | □ Diabetes | □ Hepatitis/Jaundice | □ Rheumatic Fever |
| □ Arthritis | □ Drug Addiction | □ High Blood Pressure | □ Rheumatism |
| □ Artificial Prosthesis | □ Epilepsy/Seizure | □ Joint Replacement | □ Scarlet Fever |
| □ Asthma | □ Emphysema | □ Kidney Disease | □ Sinus Trouble |
| □ Blood Disease | □ Excess Bleeding | □ Latex Allergy | □ Tobacco Use |
| □ Blood Transfusion | □ Fainting Spells | □ Liver Disease | □ Thyroid Disease |
| □ Cerebral Palsy | □ Hay Fever | □ Mental Disorder | □ Tuberculosis |
| □ Chemotherapy | □ Head Injuries | □ Nervous Disorder | □ Ulcers |
| □ Cancer | □ Heart Attack | □ PhenFen/Redux | □ Venereal Disease |
| □ Cold Sore | □ Heart Failure | □ Radiation Treatment | □ Other |

Do you wear a cardiac pacemaker or have you had heart surgery? YES NO
Do you have any health conditions or problems not listed? _____ If yes, please explain _____
_____

Women, are you pregnant or is there a possibility that you could be pregnant? YES NO

Nursing? YES NO Taking Birth Control? YES NO

I certify that the above information is complete and accurate. If any changes occur to my health, I will advise the office immediately. I understand that I am responsible for full payment of each procedure at, or prior to, the time of treatment. I agree to give 24 hour notice if I change an appointment. I grant permission for Southern Dental Group to take any necessary x-rays, administer anesthetics, and to employ such operative and technical procedures as necessary or advisable for the diagnosis and treatment of the above patient. All records, including photographs, are the property of the office.

Print Name_____

Signed_____Date_____

(If under 18, signature of parent/legal guardian)

**Southern Dental Group Office Policy**

## Time Commitment

A scheduled appointment is a commitment of time between you and our doctor/hygienist. When an appointment is missed or cancelled on short notice that time is lost instead of being used by another patient. Our office usually confirms appointments 24 hours in advance. Please advise the office if you need to change your appointment at that time. We reserve the right to charge an office visit fee for appointments missed or cancelled without a 24 hours prior notice. Multiple missed appointments can result in dismissal from the practice.

## Dental Insurance

We are happy to bill your dental insurance carriers, on your behalf at no charge. The benefits that are actually paid by insurance carriers vary widely from carrier to carrier and group to group, and depend primarily on the benefits negotiated and paid for by your employer, union, or other group with the insurance carrier. We can provide you with an approximate **estimate** of your coverage prior to treatment. However, we cannot guarantee the insurance payment as estimated.

Hence, **any treatment rendered to you will be your financial responsibility irrespective of what your insurance pays.** With your signature (below) you accept our policy and authorize Southern Dental Group to 1) Bill your insurance carriers on your behalf; 2) release any information regarding treatment at this office to your insurance carrier(s); 3) authorize payment directly to Southern Dental Group, any insurance benefits due to services rendered.

******Please inform the dental assistant if you have had x-rays taken at another dental office in the past five years. Insurance may not cover certain procedures if they have been done in another office. Southern Dental Group is not responsible for any balances left by insurance due to treatment performed in another dental office, or otherwise.

### Payment Options

For your convenience, we accept cash, check, and all major credit cards (Visa, MasterCard, American Express, and Discover). Furthermore, our office offers applications for easy to use financing programs, the most popular being CareCredit, which offers up to 18 months interest free** financing with no penalty for early payoff. **Financing is subject to application approval**.**

### Non-payment of services/Collection Policies

By signing below, I understand that any amounts not paid by insurance for any reason are my responsibility to pay. Any past due accounts turned over to a collection agency will be subject to additional collection fees, which are a percentage of my balance due, up to 40%.

By signing below, I agree that any collection or servicing agency or agencies retained to collect any money due Southern Dental Group may contact me by telephone or text message at any number given by me or associated with my account, including but not limited to cellular/wireless numbers which may result in my incurring fees for the call or text message. I understand, acknowledge and agree that the collectors may contact me by autodialing devices and through pre-recorded messages, artificial voice message or voice mail messages. I further agree that the collectors may contact me using e-mail at any e-mail address I provide or is otherwise associated with my account.

### Notice of Privacy Practices

Our office obeys federal and state law regarding the privacy of your health information. With your signature below you acknowledge the receipt of our office's Notice of Privacy Practices as well as the policies listed above.

Print Patient's Name_____
Patient or Parent/Guardian
Signature_____Date_____

**I would like the following people to be given any access to my health information, including but not limited to health history, appointments and diagnoses.**

Name_____Relationship_____
Name_____Relationship_____
Name_____Relationship_____



## Insurance Information page and Legal Guardian/Spouse Page.

**You may skip this page if you are over 18 and do not have any insurance coverage.**

## Spouse Information (if on their Insurance) or Legal Guardian Information (if patient under 18)

First Name_____ Middle_____ Last Name_____
Date of birth _____/____/_____ Social _____-_____-_____ P. O. Box _____
Street Address:_____
City_____ State_____ Zip Code_____
Home Phone(_____)_____ Work Phone(_____)_____ (if allowed)
Mobile Phone (_____)_____ May we text you? Y N
Employer_____ Position_____

## Insurance Information

**Primary Dental Insurance**

Policy Owner's Name_____ Relationship to patient_____
Date of Birth ____/____/____ Social _____-_____-_____ Policy ID #_____
Employer_____ Insurance Company's Name_____
Insurance Company Address_____
City_____ State_____ Zip Code_____
Insurance Company Phone Number_____ Group #_____

**Secondary Dental Insurance (if applicable)**

Policy Owner's Name_____ Relationship to patient_____
Date of birth _____/_____/_____ Social _____-_____-_____ Policy ID #_____
Employer name_____ Insurance Company_____
Insurance company address_____
City_____ State_____ Zip Code_____
Insurance Company Phone Number_____ Group #_____