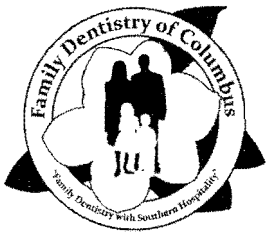

"Family Dentistry with Southern Hospitality"

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us.

Welcome!

Patient _____

SS # _____

Date _____

PATIENT INFORMATION

Name _____ Birthdate _____ Home Phone (____) _____

Address _____ City _____ State _____ Zip _____

Sex ☐ M ☐ F ☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for ____ years

E-mail _____ Cell Phone #1 (____) _____ Cell Phone #2 (____) _____

Employer/School _____ Employer/School Phone (____) _____

Employer/School Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone (____) _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone (____) _____

RESPONSIBLE PARTY

Name of Person

Responsible for this Account _____ Relation to Patient _____

Address _____ Home Phone (____) _____

Driver's License # _____ Birthdate _____ Bank _____

Employer _____ Work Phone (____) _____

Currently a patient in our office? ☐ Yes ☐ No E-mail _____ Cell Phone (____) _____

INSURANCE INFORMATION

Name of insured _____ Relation to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Employer _____ Work Phone (____) _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Active Duty, Pay Rank _____

Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max Annual Benefit _____

ADDITIONAL INSURANCE

Name of insured _____ Relation to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Employer _____ Work Phone (____) _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Active Duty, Pay Rank _____

Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max Annual Benefit _____

DENTAL HISTORY

Reason for today's visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental X-rays _____

Address _____

Physician's Name_____ Date of last visit_____

Please check Yes or No to indicate if you have had any of the following:

AIDS	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Type:_____		Scarlet Fever	☐ Yes ☐ No
Arthritis, Rheumatism	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No
Artificial Heart Valves	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Artificial Joints	☐ Yes ☐ No	Meds:_____		Skin Rash	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	HIV Positive	☐ Yes ☐ No	Special Diet	☐ Yes ☐ No
Back Problems	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Bleeding abnormally		Jaw Pain	☐ Yes ☐ No	Swelling of Feet or Ankles	☐ Yes ☐ No
(with extractions or surgery)	☐ Yes ☐ No	Joint Replacement	☐ Yes ☐ No	Swollen Neck Glands	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No	Tumor or Growth on	
Circulatory Problems	☐ Yes ☐ No	Nervous Problems	☐ Yes ☐ No	Head or Neck	☐ Yes ☐ No
Congenital Heart Lesions	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Ulcer	☐ Yes ☐ No
Cortisone Treatments	☐ Yes ☐ No	Women:		Venereal Disease	☐ Yes ☐ No
Cough, Persistent or Bloody	☐ Yes ☐ No	Are you pregnant?	☐ Yes ☐ No	Weight Loss, Unexplained	☐ Yes ☐ No
Do you wear Contact Lenses	☐ Yes ☐ No	Due date:_____		Any Hospital Stays	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Are you nursing?	☐ Yes ☐ No	Explain_____	
Diabetes	☐ Yes ☐ No	Are you taking birth		_____	
Epilepsy	☐ Yes ☐ No	control pills?	☐ Yes ☐ No	_____	
Fainting or Dizziness	☐ Yes ☐ No	Have you ever been told you need to take		Dental Treatment	☐ Yes ☐ No
Glaucoma	☐ Yes ☐ No	pre-medication before?	☐ Yes ☐ No	If Yes for what reason_____	
Headaches	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	_____	
Heart Murmur	☐ Yes ☐ No	Radiation Treatment	☐ Yes ☐ No	_____	
Heart Problems	☐ Yes ☐ No	Respiratory Disease	☐ Yes ☐ No		

MEDICATIONS

Please list medications you are currently taking:

_____

_____

_____

_____

ALLERGIES

☐ Aspirin
☐ Barbiturates (sleeping pills)
☐ Codeine
☐ Iodine
☐ Latex
☐ Local Anesthetic
☐ Penicillin
☐ Sulfa
☐ Other _____

Pharmacy Name_____ Phone _____

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance at the time of service.

IN ORDER TO CONTROL YOUR COST OF BILLINGS, WE REQUEST THAT ALL CHARGES NOT COVERED BY YOUR INSURANCE CARRIER BE PAID AT EACH VISIT.

If this account is assigned to an attorney or collection agency for collection and/or suit, the practice shall be entitled to reasonable attorney's fees and cost of collection.

I authorize the release of any information necessary to determining liability for payment and to obtain reimbursement for any claim.

I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled including private insurance and other health plans to the practice named on this form.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance.

I understand that I may be charged 1.5% finance charge per month (18% annually) if my balance goes beyond 90 days.

I give permission for my dentist and clinical team to take any necessary radiographs, study models, and photographs to make a complete diagnosis of my dental needs.

I authorize the refund of overpaid insurance benefits in accordance with my insurance policy conditions where my coverages are subject to coordination of benefits clause. It is further agreed that any credit balance resulting from payment of the insurance or other sources, which is not subject to coordination of benefits clause, may be applied to any other account owed by myself or my family.

PERSON BRINGING PATIENT FOR TREATMENT IS RESPONSIBLE FOR PAYMENT OF ACCOUNT

THANK YOU FOR YOUR COOPERATION

(I have read, agree to, and understand the statements listed above) **YOU SHOULD READ THOSE TERMS CAREFULLY.**

X_____(L.S.) DATE _____
SIGNED (Patient, or parent if under 18 years of age.)