Patient Information

Full Name: _____ Preferred Name: _____

Address: _____City:_____ State:_____ Zip Code:_____

Home#: _____ Work#: _____ Cell#: _____

Sex: _____ Male _____Female Marital Status: _____ Married _____Single _____Other

Date of Birth: _____ SSN: _____ Driver's License: _____

Email: _____ Employment: ____Full-Time ____Part-Time ____Retired

Employer Name/City & State: _____

Student: ____ Full-Time ____Part-Time ___Non School Name/City & State: _____

Emergency Contact Name & Phone Number:

_____#_____

How did you hear about our dental practice? _____

Responsible Party (if other than patient)

Full Name: _____ Relationship to Patient: _____

Address: _____

Home#: _____ Work#: _____ Cell#: _____

Sex: _____ Male _____Female Marital Status: _____ Married _____Single

Date of Birth: _____ SSN: _____ Driver's License: _____

Primary Dental Insurance Information

Insurance Name: _____ Policy # _____

Member ID #_____Group#: _____ Plan: _____

Policy Holder's Name: _____ Policy Holder's SSN: _____

Relationship to Patient: _____Self _____ Spouse _____Parent Policy Holder's DOB: _____

Employer (if employer sponsored): _____

Secondary Dental Insurance Information

Insurance Name: _____ Policy # _____

Member ID #_____Group#: _____ Plan: _____

Policy Holder's Name: _____ Policy Holder's SSN: _____

Relationship to Patient: _____Self _____Spouse _____Parent Policy Holder's DOB: _____

Employer (if employer sponsored): _____

MEDICAL HISTORY **Name: _____**

Are you under a physician's care now? ( ) Yes ( ) No
If yes, name & number_____

Have you ever been hospitalized or had a major operation? ( ) Yes ( ) No
If yes, please list_____

Have you ever taken Fosamax, Boniva, Actonel or any medications containing bisphosphonates? ( ) Yes ( ) No
If yes, please list_____

Do you use tobacco or Vape? ( ) Yes ( ) No If yes, please answer the following:
Type_____ Packs per day_____ Years of use_____ Quit date_____

Are you allergic to any of the following? ( ) Yes ( ) No
( ) Aspirin ( ) Penicillin ( ) Metal ( ) Latex ( ) Adhesives ( ) Sulfa ( )Codeine
If other, please list_____

Do you use any controlled substances? ( ) Yes ( ) No
If yes, please list_____

Women only: Please check if you are any of the following:
( ) Pregnant/Trying to get pregnant ( ) Nursing ( ) Taking oral contraceptives

Do you have, or have you had, any of the following? (If yes, please check.)

( ) Alzheimer's Disease	**( ) Diabetes**	**( ) Hemophilia**
( ) Anaphylaxis	**( ) Drug Addiction**	**( ) Hepatitis A, B or C**
( ) Anemia	**( ) Emphysema**	**( ) Herpes**
( ) Angina/Chest Pains	**( ) Epilepsy/Seizures**	**( ) HIV Positive/AIDS**
( ) Arthritis/Gout	**( ) Excessive Bleeding**	**( ) High Blood Pressure**
( ) Artificial Heart Valve	**( ) Excessive Thirst**	**( ) High Cholesterol**
( ) Artificial Joint	**( ) Fainting Spells/Dizziness**	**( ) Hives/Rash**
( ) Asthma	**( ) Frequent Cough**	**( ) Irregular Heart Beat**
( ) Blood Disease	**( ) Frequent Diarrhea**	**( ) Kidney Problems**
( ) Breathing Problems	**( ) Frequent Headaches**	**( ) Leukemia**
( ) Bruise Easily	**( ) Glaucoma**	**( ) Liver Disease**
( ) Cancer	**( ) Hay Fever/Allergies**	**( ) Low Blood Pressure**
( ) COPD/Winded Easily	**( ) Heart Attack/Failure**	**( ) Lung Disease**
( ) Chemotherapy	**( ) Hypoglycemia**	**( ) PRE-MEDICATION**
( ) Cold Sores/Fever Blisters	**( ) Heart Murmur**	**( ) Mitral Valve Prolapse**
( ) Congenital Heart Disorder	**( ) Heart Pace Make**	**( ) Osteoporosis**
( ) Convulsions	**( ) Heart Disease**	**( ) Hernia Repair**
( ) Pain in jaw joints	**( ) Parathyroid Disease**	**( ) Psychiatric Disorder**
( ) Radiation Treatments	**( ) Recent weight loss/gain**	**( ) Renal Dialysis**
( ) Rheumatic Fever	**( ) Rheumatism**	**( ) Sexually Transmitted Disease**
( ) Shingles	**( ) Sickle Cell Disease**	**( ) Sinus Trouble**
( ) Spina Bifida	**( ) Stomach/Intestinal Disease**	**( ) Stroke**
( ) Swelling of limbs	**( ) Thyroid Disease**	**( ) Tonsillitis**
( ) Tuberculosis	**( ) Tumors or Growths**	**( ) Ulcers**
( ) Sleep Apnea/Snoring	**( ) Tobacco use or Vaping**	**( ) Other _____**

MEDICAL HISTORY (cont.) **Name: _____**

Are you currently taking any blood thinners (Aspirin, Coumadin, Warfarin, Plavix, etc)?
( ) Yes ( ) No If yes, please list_____

Please list all MEDICATIONS you are currently taking including dietary supplements, herbal medicines and natural products:

	NAME	DOSAGE	FREQUENCY
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

DENTAL HISTORY

Reason for seeking dental care _____

Date of last dental visit _____ Date of last X-rays_____

How often do you: Brush _____times per _____ Floss _____ times per _____

How do you feel about dental treatment? Relaxed A little uneasy Tense Anxious Very Anxious

Do you have or have you ever had any of the following?

____Aching/sensitive teeth	____Broken/missing filling	____Areas of food traps
____Persistent bleeding gums	____Loose teeth	____Difficulty opening wide
____Broken/missing/loose teeth	____Bad breath	____Clicking or popping jaw
____Grinding or clenching	____Dry mouth	____Jaw pain or tiredness
____Swelling/lumps in mouth	____Injuries to teeth/jaw	____Gum infection
____Growths/lesions in mouth	____Cold sores	____Unfavorable dental experience
____Orthodontic treatment	____Other_____	

If you could change your smile, what would you change?

____Remove unsightly fillings	____Straighten teeth	____Change shape of teeth
____Close gaps between teeth	____Replace missing teeth	____Whitening

____Other_____

Consents, Authorizations & Releases

I hereby certify that all information submitted is true and accurate to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health and that it is my responsibility to inform Southern Oaks Dental of any changes in my medical status.

I hereby agree to allow Southern Oaks Dental, it's Dentists and staff to take radiographs, study models, photographs or any other diagnostic aid he/she deems appropriate to make a thorough diagnosis of my dental needs and to perform any and all forms of dental treatment I have agreed upon.

I hereby authorize the release of information, including but not limited to, the diagnosis, radiographs and records of any treatments or examinations rendered by Southern Oaks Dental to my insurance company, insurance claims processing companies and consulting professionals associated with my treatment.

I hereby acknowledge that I am personally responsible for payment of all fees for dental services provided in this office for me and/or my dependents regardless of insurance coverage. I am aware that it is my responsibility to understand my own dental insurance policy including benefits, limitations and exclusions. I understand that the filing of insurance dental claims is provided as a courtesy and that any dental coverage is an agreement between my insurance company and myself. I understand that full payment or an estimated portion according to expected insurance coverage is due at time of service. This estimated portion may not be disclosed nor guaranteed by my insurance company, and I understand my portion may be more if my insurance company does not pay the anticipated estimated amount. I also understand that services are treatment planned and rendered independent of insurance coverage. Breach of this responsibility carries the penalty of compensating the practice for any related collection fees accrued.

I, the undersigned, understand that Southern Oaks Dental sets aside a dedicated chair and time slot for each patient scheduled. Cancelled/missed appointments prevent other patients needing services from being seen during that time. I understand and agree to the following appointment cancellation policies.

Please Initial each below:

_____Appointments scheduled with any Dentist or hygienist must be cancelled/rescheduled at least 24 hours in advance to avoid the possible loss of the reservation deposit and/or a $50 cancelation fee.

_____No-show appointments with any Dentist or hygienist will result in an automatic loss of the reservation deposit and/or a $75 cancelation fee.

_____Repeated cancelled/missed appointments will result in loss of future appointment privileges.

I hereby acknowledge that by signing this consent I agree to adhere to the above policies.

X

Patient/Authorized Party Signature **Printed Name** **Relationship** **Date**

Acknowledgement of Receipt of Notice of Privacy Practices

Name: _____ **DOB:** _____

Address: _____

Best # to reach you during the day: (____)_____ **or** (____)_____

Email Address: _____

I give my permission for Southern Oaks Dental to discuss the selected items with the following offices/persons below:

Name(s) & Number(s) of those we may speak with (such as family members or friends)

Name_____**#**_____

Relationship _____

CIRCLE ONE FOR EACH BELOW:

Confirming Appointments/Treatment – Yes No

Financial – Yes No

Medical/Dental History – Yes No

I have received a copy of the Notice of Privacy Practices for Marcus Brian Ward, DMD, PA dba Southern Oaks Dental.

x _____

Signature **Relationship** **Date**