

South Main Dental

PATIENT INFORMATION

ABOUT YOU:

Patient Name: Last First MI Preferred Name

Birthdate: Gender: ☐ Male ☐ Female

Family Status: ☐ Married ☐ Single ☐ Child ☐ Other

SS#: DL #:

Email: DL-State:

Address: Apt #:

City: State: Zip:

Home#: Cell#:

Work#: Referred by:

Employer: Occupation:

Employer Address:

ABOUT SPOUSE:

Spouse Name: Last First MI Preferred Name

Birth Date: SS#:

Cell#: Work#:

Employer:

RESPONSIBLE PARTY (IF PATIENT IS A MINOR)

Name: Last First MI Preferred Name

Birthdate: Gender: ☐ Male ☐ Female

Family Status: ☐ Married ☐ Single ☐ Child ☐ Other

SS# DL #:

Email: DL-State:

Address:

City: State: Zip:

Home#: Cell#:

Work#: Occupation:

Employer:

Employer Address:

PRIMARY INSURANCE COVERAGE

Dental Coverage: ☐ Yes ☐ No

Insurance Plan Name:

Subscriber ID # Group#

Subscriber Name: Last First MI Preferred Na

Subscriber relationship to patient:

***If Subscriber is other than patient, complete the following:

SS#: DL #:

Email: DL-State:

Address: Apt #:

City: State: Zip:

Home#: Cell#:

Work#: Occupation:

Employer:

Employer Address:

SECONDARY INSURANCE COVERAGE

Dental Coverage: ☐ Yes ☐ No

Insurance Plan Name:

Subscriber ID # Group#

Subscriber Name: Last First MI Preferred N

Subscriber relationship to patient:

***If Subscriber is other than patient, complete the following:

SS#: DL #:

Email: DL-State:

Address: Apt #:

City: State: Zip:

Home#: Cell#:

Work#: Occupation:

Employer:

Employer Address:

South Main Dental

HEALTH HISTORY (CHECK ALL THAT APPLY)

- | | | | |
|---|---|---|---|
| ☐ None of the following | ☐ Diabetes | ☐ HIV/AIDS | ☐ Radiation Treatment |
| ☐ Abdominal Aneurysm | ☐ Difficulty Breathing | ☐ Irritable Bowel Syndrome | ☐ Respiratory Problems |
| ☐ Abnormal Bleeding | ☐ Dizziness | ☐ Jaundice | ☐ Rheumatic Fever |
| ☐ Acid Reflux/GERD | ☐ Emphysema | ☐ Joint Replacements | ☐ Rheumatism |
| ☐ A-Fib | ☐ Epilepsy | ☐ Kidney Disease | ☐ Scarlet Fever |
| ☐ Alcohol/Drug Abuse | ☐ Excessive Bleeding | ☐ Kidney Problems | ☐ Seasonal Allergies |
| ☐ Anemia | ☐ Fainting | ☐ Liver Disease | ☐ Seizures |
| ☐ Anxiety/Depression | ☐ Fever Blisters | ☐ Low Blood Pressure | ☐ Shingles |
| ☐ Arthritis | ☐ Fibromyalgia | ☐ Lupus | ☐ Sickle Cell/Traits |
| ☐ Artificial Joints | ☐ Frequent Headaches | ☐ Macular Degeneration | ☐ Sinus Problems |
| ☐ Artificial Valves | ☐ Glaucoma | ☐ Mental Disorders | ☐ Sjogren's Syndrome |
| ☐ Asperger's Syndrome | ☐ Gout | ☐ Mitral Valve Prolapse | ☐ Sleep Apnea |
| ☐ Asthma | ☐ Head Injuries | ☐ Multiple Sclerosis | ☐ Stomach Problems |
| ☐ Autism | ☐ Heart Attack | ☐ Nervous Disorders | ☐ Stroke |
| ☐ Bell's Palsy | ☐ Heart Disease | ☐ Osteoporosis | ☐ Thyroid |
| ☐ Blood Disease | ☐ Heart Murmur/MVP | ☐ Other* | ☐ Tobacco User |
| ☐ Blood Transfusion | ☐ Heart Problems | ☐ Pacemaker | ☐ Tremors |
| ☐ Cancer | ☐ Heart Stent | ☐ Parkinson's | ☐ Tuberculosis |
| ☐ Chemotherapy | ☐ Heart Surgery | ☐ Peripheral Neuropathy | ☐ Tumors |
| ☐ Colitis | ☐ Hepatitis | ☐ Pneumothorax | ☐ Ulcers |
| ☐ Congenital Heart Defects | ☐ High Blood Pressure | ☐ Pregnancy | ☐ Veneral Disease |
| ☐ COPD (lung disease) | ☐ High Cholesterol | ☐ Psoriasis | |
| ☐ Dementia | | | |

***OTHER CONDITIONS - Please list.**

Have you previously been hospitalized?

- ☐ Yes: If yes, explain _____
☐ No

Are you taking any medications?

- ☐ No ☐ Yes*

*** If Yes, please list all medications you are currently taking including prescription, over-the-counter and herbal supplements.**

Do you suffer from any allergic reaction?

- ☐ No ☐ Yes*

*** If yes, please list any allergies to medications or other materials.**

South Main Dental

Who should we contact in case of emergency?

Name

Phone #

Relationship

Who is your regular physician or clinic?

Who is your preferred pharmacy? Location?

Do you have artificial joints (such as hip, knee or shoulder replacements) or a heart condition that require antibiotics prior to dental treatment (commonly known as PRE-MEDS)? ☐ Yes ☐ No

Do you take blood thinners (including aspirin)? ☐ Yes ☐ No

CONSENT

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Payment is due at the time of service unless prior arrangements have been made. I understand that I am responsible for payment of services rendered and also responsible for any copay and/or deductibles that my insurance does not cover.

Signature _____

Date _____

SOUTH MAIN DENTAL PATIENT CONSENT & OFFICE POLICIES

1. COMMUNICATIONS POLICY

I understand and agree that **South Main Dental** may contact me by text message (SMS) for purposes including, but not limited to:

- Appointment reminders and confirmations
- Scheduling changes or updates
- Treatment follow-up messages
- General communication related to my care or account
- Billing statements
- Review requests
- Secure, encrypted text-to-pay links to review and pay my balance

I understand that:

- Standard messaging rates may apply based on my mobile carrier.
 - I may opt out of text messages at any time by replying **“STOP.”**
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2. FINANCIAL POLICY

I understand and agree that:

- I am financially responsible for all charges related to my dental care.
 - As a courtesy, South Main Dental may file my dental insurance; however, insurance estimates are not guarantees of payment and South Main Dental is a non-contracted provider and not in network with any insurance companies.
 - Any balance not paid by my insurance company, including deductibles, copayments, non-covered services, and denied claims, is my responsibility. Payment is due at the time services are rendered unless other arrangements are made in advance.
 - I agree to provide accurate insurance information and notify the office of any changes.
 - I understand that this assignment of benefits allows South Main Dental to bill my insurance company on my behalf and request that all insurance proceeds be payable to South Main Dental.
 - I understand that while South Main Dental will submit claims to my insurance company as a courtesy, it is my responsibility to follow up on any unpaid or delayed claims.
 - Any balance not paid by my insurance company within **30 days from the date of service** is my responsibility.
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3. APPOINTMENT SCHEDULING POLICY

- Upon scheduling an appointment, I will receive a **“Save the Date”** text so that I can reference my scheduled appointment date and time.
 - I will also receive a **two-week reminder text**, which requires no action.
 - **Two days before** my scheduled appointment, I will receive a confirmation text that **requires a response**. South Main Dental reserves the right to automatically cancel any **unconfirmed appointments**.
 - We understand that unplanned issues can arise and that you may need to cancel or reschedule an appointment. If this occurs, we respectfully ask for **48 hours' advance notice**.
 - A **\$50.00 deposit** will be required to reschedule a missed appointment when 48 hours' advance notice was not provided.
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4. HIPPA ACKNOWLEDGEMENT

I acknowledge that I have been given the opportunity to review South Main Dental's Notice of Privacy Practices. I understand that the Health Insurance Portability and Accountability Act (HIPAA) protects the privacy and security of my personal and health information including information about my dental care, treatment and payment history.

I understand my protected health information may be used and disclosed by South Main Dental for purposes of treatment, payment and healthcare operations and that this information will not be shared for other purposes without my permission unless required by law.

I understand that I have the right to request restrictions on how my information is used or disclosed and to revoke this consent in writing at any time. I also understand that I may request and receive a copy of this consent form.

5. AUTHORIZED CONTACT

I authorize the person(s) listed below to communicate with South Main Dental regarding my **dental treatment, appointments, account, billing, insurance, and financial information**.

Authorized Contact Name: _____

Relationship to Patient: _____

Phone Number: _____

6. CONSENT & ACKNOWLEDGMENT

- I have read, understand, and agree to the above Consents and Policies.
 - I consent to treatment as recommended by my provider.
 - This consent remains in effect until revoked.

PATIENT / RESPONSIBLE PARTY (PARENT/LEGAL GUARDIAN IF APPLICABLE)

Printed Name: _____

Signature: _____

Relationship (if other than patient): _____

Date: _____
