SOUTHRIDGE DENTAL PATIENT REGISTRATION

(Please Print)

PATIENT INFORMATION

Name_____ Birth date _____Sex _____M_____F

Address_____ City _____ State_____ Zip_____

Home Phone (_____)_____Cell (_____)_____Social Security _____

Email: _____

_____Minor _____Single _____Married _____Divorced _____Widowed _____Separated

FOR CHILD OR TEEN

Nickname (if any) _____ School_____ Grade_____

Father's Full Name _____Employer _____Work Phone (____)_____

Mother's Full Name _____ Employer _____ Work Phone (____)_____

Other Children in Family
Name and Age_____

FOR ADULT

Employer_____ Position_____ Work Phone _____

Spouse's Name _____

Spouse's Employer _____ Position_____ Work Phone _____

Whom May We Thank for Referring you?_____

Person to Contact in Case of Emergency _____ Phone_____

INSURANCE INFORMATION

Name of Insured_____ Social Security # _____ Relationship to Patient _____

Address_____ Home Phone (____)_____

Birth date_____ Employer _____ Work Phone (____)_____

Insurance Company_____ Group #_____

(OVER)

SECONDARY INSURANCE

Name of Insured_____ Relationship to Patient _____

Birth date_____ Social Security #_____

Employer_____ Work Phone (_____)_____

Insurance Company_____ Group #_____

Please Initial and Sign Below

____I hereby authorize the administration of such medications and performance of such diagnostic and therapeutic procedures as may be necessary for proper dental care.

____ I assign all insurance benefits directly to **Dillon Dental Care, P.A.** I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of the signature on all insurance submissions whether manual or electronic.

____I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents/guardians are responsible for all fees and services rendered for treat of a minor/child. I accept full financial responsibility for all charges.

Date Signature (parent or guardian if a minor)

Southridge Dental
10/17

Southridge Dental Health Record

1320 Mendota Road East, Inver Grove Heights, MN 55077/ (651)451-1884
Information about your general health is important for us to know in planning your dental treatment.
This information is of course, confidential.

Name	Date of Birth	File Number

Dental History

Name, phone, address of former dentist		
When was your last Check-up?	Have you had a complete series of x-rays taken?	When?
Are you aware of a dental problem? If yes, explain.		
What do you feel is the present condition of your mouth?		
Are you interested in preventing dental problems by having regular dental exams and care?		

Please circle any of the following that apply to you (now or in the past):

Gums bleed	Jaw joint noise	Wisdom teeth removed	Other:
Gum disease	Locked jaw	Teeth sensitive to sweets	
Collects food	Unpleasant taste	Teeth sensitive to cold	
Grinding or clenching	Mouth sores	Teeth sensitive to heat	
Smoker	Bite is off	Teeth sensitive to pressure	

How often do you brush your teeth?	How often do you floss your teeth?

Medical History

Name, phone, address of physician		
Are you now under the care of a physician? If yes, for what reason?		
Have you ever had any serious illness or accident? If yes, please explain.		
List all medications or drugs you are taking and their dosages.		
1.)	2.)	3.)
4.)	5.)	6.)
(Women) Are you pregnant?	If yes, how far along?	

Southridge Dental Care **(over, please)**

Medical History (continued)

Please circle any of the following that apply to you (now **or in the past):**

Heart Disease	Epilepsy, convulsions	Sinus problem
Heart murmur	Anemia	Tumors
Mitral valve prolapse	Thyroid problem	Stroke
Rheumatic fever	Chemical dependency	Arthritis
Congenital heart defect	IV drug abuse	Radiation therapy
Abnormal blood pressure	Abnormal bleeding	Mental health care
Ulcers	Fainting spells	Prosthetic implant/pacemaker
Tuberculosis, lung disease	Hepatitis	Artificial hip/knee
Diabetes	HIV positive/AIDS	Venereal disease
Excessive urination, thirst	Jaundice	Tobacco use
Eating disorders	Asthma, hay fever	Oral contraceptives

Are you allergic to: (please circle) Penicillin Local Anesthetic Codeine Other:_____

Patient Signature _____ **Date** _____

Recorded by _____ **D.D.S. Signature** _____

Medical updates

Date:	Date:	Date:
No change	No change	No change
See notes	See notes	See notes

Notes

FINANCIAL POLICY

1. Payment is expected in full by cash, check or Master Card/Visa/Discover at the time of service for non-insured patients.

2. Insured patients are expected to pay their deductible and estimate co-payments at the time of service.

3. A **5%** Savings can be realized when paying in **CASH OR CHECK** only at the time of service.

4. Any patient participating in CAPS Plan will be entitled to a savings when payment is made at the time of service.

6. Seniors will be offered a **10%** Savings when paying at the time of service by cash or check not credit card. A senior is classified as retired or 62 years of age. If Seniors participate in any insurance plan, CAPS, or any other discounted plan, no additional savings will be given.

7. In cases of extensive treatment, special arrangements can be made with our office at your request. If arrangements are not made, payment in full will be expected at the time of service completion.

8. A service charge of **1.5%** will be placed on any account balance over 90 days with the exception of ortho accounts.

9. In the event your account is turned over to our collection agency for non-payment you would be responsible for any collection agency fees charged.

Patient Signature_____

Date_____

Rev 10/17

Address: 1320 Mendota Road East, Inver Grove Heights, MN 55077/ **Phone**: 651-451-1884 **Fax**: 651-306-9709/ **Email:** fd@southridgedentalmn.com/ **Website:** www.southridgedentalmn.com

Southridge Dental

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number: _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Cris

Telephone: 651-451-1884 Fax: 651-306-9709

Address: 1386 Mendota Rd. E. Inver Grove Hts., MN 55077

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

Authorization to Release Health Information

I, _____, give permission to Southridge Dental providers to disclose and release my
(Patient Name)
protected health information to the entities listed below:

Release to Name (s):	Relationship to Patient:
_____	_____
_____	_____
_____	_____

Health Information to be disclosed (Check all that apply):

_____ My complete health record (including but not limited to diagnosis, lab tests, prognosis, treatment and billing for all conditions) OR

_____ My complete health records, as above, with the exception of the following information:
_____

- The following information would require consent by law and is not standard record in a dental practice: Mental Health Psychotherapy notes and Chemical Dependency Program

This health information may be used to enable the persons I authorize to know and understand my condition and my treatment, treatment options, for treatment consultation, for claims payment purposes, or related reasons.

This authorization shall be effective for one year unless otherwise indicated: (check one)

_____ All past, present, and future periods, OR

_____ Date or event: _____ unless I revoke it. You may revoke this authorization in writing at any time by notifying us in writing.

_____
Patient Name (Printed)

_____ _____
Patient or Guardian Signature Date

Address: 1320 Mendota Road East, Inver Grove Heights, MN 55077/ **Phone**: 651-451-1884/ **Fax**: 651-306-9709
Email: fd@southridgedentalmn.com/ **Website**: southridgedentalmn.com

Authorization to Release Health Information

I, _____, give permission to Southridge Dental providers to disclose and release my
(Patient Name)
Protected to disclose and release my protected health information described below:

Release to Name (s):	Relationship to Patient:
_____	_____
_____	_____
_____	_____

Health Information to be disclosed (Check all that apply):

_____ My complete health record (including but not limited to diagnosis, lab tests, prognosis, treatment and billing for all conditions) OR

_____ My complete health records, as above, with the exception of the following information:
_____

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_____
Patient Name (Printed)

_____ _____
Patient or Guardian Signature Date

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Records Release to Southridge Dental

Please release any current x-rays for:

Name_____

Address_____

_____

Phone _____

Birth date_____

Date of last exam and cleaning_____

Patient Signature_____

Date_____

Send to:

Southridge Dental
1320 Mendota Rd. E
Inver Grove Hts, MN 55077
Ph: 651-451-1884
F: 651-306-9706
fd@southridgedentalmn.com