



## 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(s) and Age(s) \_\_\_\_\_

### 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 \_\_\_\_\_




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**INSURANCE INFORMATION**

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Name of Insured \_\_\_\_\_ Social Security # \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Address \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_

Birth date \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_

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**SECONDARY INSURANCE**

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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 **Southridge Dental, 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.

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Date \_\_\_\_\_ Signature (parent or guardian if a minor)

# 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 confidential.

Name	Date of Birth	
<b>Dental History</b>		
Name, phone, address of former dentist		
When was your last Check-up?	Have you had a complete series of x-rays taken? Yes / No	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
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?	

<b>Medical History</b>		
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?





## **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 12/18



## Patient Consent for Use of Electronic Communication (Text and Email)

Text and e-mail communication provides a fast and easy way to communicate with your healthcare provider for those issues that are non-emergent, non-urgent or non-critical. It is not a replacement for the interpersonal contact that is the very basis of the patient-healthcare provider relationship; rather it can support and strengthen an already established relationship.

The following summarizes the information you need to determine whether you wish to supplement your dental experience at our practice by electronically communicating with staff members.

### General Considerations

- Text and e-mail communication will be considered and treated with the same degree of privacy and confidentiality as written medical records.
- Any email we send to you will be secure because it goes through our encrypted server. Standard e-mail services such as Gmail, AOL, Yahoo, and Hotmail, are not secure. This means if you don't have an encrypted email service and you respond to our email it can be intercepted and read by unauthorized individuals. If you want your reply to remain secure, please consider calling us. However, any email of text message we send you to CONFIRM or REMIND you about appointments scheduled or appointments needed is secure. Please feel free to reply to those messages.
- Your cell phone number and or email address will not be used for external marketing purposes without your permission. You may receive a group mailing from the practice, however, the recipients e-mail addresses will be hidden.

### Provider Responsibilities

- The provider will attempt to electronically confirm your e-mail address or phone number by requesting a return response to our initial e-mail or text message.
- Your provider may route your messages to other members of the staff for informational purposes or for expediting a response.
- Designated staff may receive and read your responses.
- The provider will make every attempt to respond to your message within 2 business days. If you do not receive a response within 2 business days, please contact the office at (651)451-1884.
- Copies of e-mails sent and received from and to you will be incorporated into your medical record. You are advised to retain all electronic correspondence for your own files.

### Patient Responsibilities

- Text and e-mail messages should not be used for emergencies or time sensitive situations. In the event of a medical emergency, you should contact 911. For emergent or time sensitive situations, you should contact your dental provider through the office.
- Please acknowledge that you received the practice's appointment reminders by sending a response confirming your appointment.

AUTHORIZATION: I have read and understood the above description of the risks and responsibilities associated with electronic communication with my dental provider. I acknowledge that commonly used e-mail services are not secure and fall outside of the security requirements set forth by the Health Information Portability and Accountability Act for the transmission of protected health information. I have been given the opportunity to discuss electronic communication as supplement to in-person office visits with my provider; I hereby consent to electronic communication via text and non-secure e-mail services. I understand that I may revoke my consent to communicate electronically at any time by notifying Southridge Dental in writing, but if I do, the revocation will not have any effect on actions my dental provider has already taken in reliance on my consent. I agree to release my provider and the practice from any and all liability that may occur due to electronic communication over a non-secure network. I further agree to be held accountable for the patient responsibilities as outlines above.

Please mark all forms of communication you give consent for:  Cell phone (text message)  Home Phone (voicemail)  Email  Postcard

Cell Number: \_\_\_\_\_ Home Number: \_\_\_\_\_ E-mail: \_\_\_\_\_

**\*\*Interested in Patient Connect?\*\*\***You can request appointments, customize your communication preferences, and even pay you bill online. Email required.

I agree and offer no objection to the verbal release of health information to the person(s) listed below.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

**Address:** 1320 Mendota Road East, Inver Grove Heights, MN 55077  
**Phone:** (651) 451-1884 / **Fax:** (651) 306-9709 / **Email:** [FD@southridgedentalmn.com](mailto:FD@southridgedentalmn.com)  
**Website:** [www.southridgedentalmn.com](http://www.southridgedentalmn.com)



## 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 \_\_\_\_\_

Previous Dentist or Practice Name: \_\_\_\_\_

Previous Provider Phone Number: \_\_\_\_\_

Send Records to:

Southridge Dental

1320 Mendota Rd. E

Inver Grove Hts, MN 55077

Phone: 651-451-1884

Fax: 651-306-9709

Email: fd@southridgedentalmn.com



# CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

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## SECTION A: PATIENT GIVING CONSENT

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ E-mail: \_\_\_\_\_

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 Hays

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

Address: 1320 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 health 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.**

## REVOCAION 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: \_\_\_\_\_

**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



## **Appointment Cancellation Policy Agreement**

Southridge Dental is committed to providing exceptional dental care. We understand that unplanned issues can come up and you may need to cancel or reschedule an appointment. Our doctor and hygienists want to be available for your needs as well as the needs of all of our patients. When a patient does not show up for a scheduled appointment, another patient loses an opportunity to be seen.

**As of January 1<sup>st</sup>, 2019 please call us at (651) 451-1884 by 2:00 p.m. two days prior to your scheduled appointment to notify us of any changes or cancellations. To cancel a Monday appointment, please call our office by 2:00 p.m. on Wednesday of the week prior.** If prior notification is not given, you will be charged \$50 for each hour of the missed appointment.

Thank you for being a valued patient and for your understanding and cooperation as we institute this policy. This will enable us to open otherwise unused appointments to better serve the needs of all our patients.

The Staff of Southridge Dental

Please sign below to consent to these terms.

\_\_\_\_\_  
Signature (Parent/Guardian if under 18)

\_\_\_\_\_  
Date