PATIENT REGISTRATION

(Please Print)

PATIENT INFORMATION

Name____ Birth date _____________

Address____ City ___________________ State_____ Zip_______

Home Phone (_____) ________________Cell (______) _________________Social Security _____________

Email: ____

______Minor _____Single ______Married _____Divorced _____Widowed _____ Separated

Current Gender Identity:________ Sex Assigned at Birth:________ Preferred Pronouns:_________

FOR CHILD OR TEEN

Preferred Name or 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

Preferred Name or Nickname (if any) ___________________

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_________________________________ Subscriber #_______________ Relationship to Patient ___________

Address____ Home Phone (____) __________

Birth date__________________ Employer ________________________________ Work Phone (____) __________

Insurance Company____ Group #________________

SECONDARY INSURANCE

Name of Insured____ Relationship to Patient ________________

Birth date__________________ Subscriber #_____________________

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.

*** We recognize that the identities you carry may differ from the legal and insurance identification. In order to ensure that there are no errors, what gender does your insurance company have on record? ________________
What is the name on your insurance card? ____

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	

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
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?

Medical History (continued)
Please check any of the following that apply to you (now or in the past):

☐ Alzheimer's Disease	☐ Artificial Heart Valve	☐ Cortisone Medication
☐ Blood Thinning Medication	☐ Cancer	☐ Cold Sores / Fever Blisters
☐ Congenital Heart Defect	☐ High Blood Pressure	☐ Low Blood Pressure
☐ Ulcers	☐ Tuberculosis	☐ COPD
☐ Hay Fever / Seasonal Allergies	☐ Diabetes, Type 1	☐ Diabetes, Type 2
☐ Excessive Urination	☐ Excessive Thirst	☐ Eating Disorder
☐ Intermittent Asthma	☐ Severe Asthma (daily medication)	☐ Epilepsy, Convulsions
☐ Anemia	☐ Chemical Dependency	☐ IV Drug Use
☐ Abnormal Bleeding	☐ Fainting Spells	☐ HIV Positive / AIDS
☐ Hepatitis A	☐ Hepatitis B	☐ Hepatitis C
☐ Sinus Problems	☐ Tumors	☐ Pacemaker
☐ Arthritis	☐ Stroke	☐ Radiation Therapy
☐ Prosthetic Implant	☐ Artificial Knee	☐ Artificial Hip
☐ Mental Health Care	☐ Venereal Disease	☐ Oral Contraceptives
☐ Cigarettes, eCigarettes	☐ Chewing Tobacco	☐ Nicotine Gum
☐ Heart Disease	☐Thyroid Problem	☐ Marijuana Use

Are you allergic to: Penicillin / Amoxicillin Plastics Local Anesthetic Metals Latex

(please Circle) Codeine Sulfa 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** if payment is made on the same day of service.

4. 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.

5. In certain cases, as determined by Southridge Dental, a service charge of **1.5%** may be placed on any account balance over 90 days with the exception of ortho accounts.

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

7. Appointment changes/cancellations/tardiness: 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. An appointment is considered missed if you are 15 minutes late. This allows us time to fill your reserved slot with another patient in need. Thank you for your consideration!

Signature______________________________ Date___________________

Relationship to Patient: ____

Rev 02/23

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: ___________________________

Previous Provider Fax 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

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 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: ____________________

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.

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. An appointment is considered missed if you are 15 minutes late. This allows us time to fill your reserved slot with another patient in need.

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 Whole Team of Southridge Dental

Please sign below to consent to these terms.

Sign: ________________________________ Date:_______________________

Relationship to Patient: __________________________

Rev 03/23

Payment Options

Southridge Dental is working toward the goal of becoming a paperless practice and is now offering more electronic billing services! This allows greater flexibility for patients to pay their portion for services provided by our office. As a new patient or established patient, you have multiple options available for financing your visit. We can send you a paper bill, an electronic payment request via text, or we can keep your card on file. Please review the options below and let us know which you prefer.

PAPER STATEMENTS

After paying your estimated patient portion at the time of service, we will be happy to bill your insurance. Once insurance pays their portion, a billing statement will be sent via mail if any patient portion remains. Be sure to update us on any insurance changes to ensure timely processing. If this is the method you would prefer, please sign below.

Patient signature ____ Date______________

ELECTRONIC BILLING

We can now send electronic payment requests via text. You will then be able to follow the link to make a payment online. If you would prefer these services, please sign under the desired option below:

a. I authorize Southridge Dental to send me **TEXT** messages for billing purposes or for balance of charges not paid by insurance, if applicable.

   Patient signature ____ Date_____________

CARD ON FILE

If preferred, we can also store your card on file for any balances not paid by your insurance carrier. We will notify you prior to charging your card and it will not exceed a maximum amount that you set forth. We are also able to set up financial arrangements via an in-house payment plan if you need additional assistance financing your treatment. If this is the method you would prefer, please sign below.

Patient signature____Date______________

If you have any other questions regarding how we can assist with financing your care, please see the front desk and we would be happy to help!

All the best,

The Southridge Dental Team

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