FINANCIAL POLICY FOR SOUTHRIDGE DENTAL

We offer two different options in which your dental treatment can be paid. Please choose one of the following options.

OPTION ONE

You may pay in full at the time of service, after which we will submit your dental claim on your behalf and have the insurance company issue the cheque directly to you.

OPTION TWO

Direct billing from Southridge Dental - Assignment of Benefits from your insurance company will require a valid credit card number to be left on file. Your credit card will only be charged if, after receiving final payment from the dental insurance, there is a balance and we are unable to contact you. **Our office will not allow any balance to extend past 45 days from date of service.**

All dental procedures in our practice are treatment based on the dental needs of the individual patient; not limited to the benefits extended to the patient by their insurance providers.

CREDIT CARD AUTHORIZATION

I authorize Southridge Dental to keep my signature on file and to charge my Visa/MC account for:

- Balance of charges not paid by my insurance immediately after receiving payment from insurance company.
- All outstanding balances on my family account if not paid within 45 days by my insurance.
- Charges accrued as a result of broken appointments or short notice cancellations.

Patient Name(s): ______________________________

____

____

Cardholder Name: ______________________________

Cardholder Address: ______________________________

____

____

Phone Number: (H) ____________ (W) ____________ (C) ____________

Card Number: ______________________ Exp. Date: ____________

Verification Code: ________ (last 3 digits on back of card)

Cardholder Signature: ______________________________

INSURANCE AUTHORIZATION

I hereby authorize payment directly to Southridge Dental for services rendered, otherwise payable to me. I authorize the release of any information relating to my dental claims through this office.

Authorized Signature ______________________ **Date** ____________

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CHART NO.

MEDICAL ALERT

PATIENT INFORMATION (Please Print)

Gender: ☐M ☐F ☐Other

Preferred Pronoun: ____________

Patient's Name: ☐Dr. ☐Mr. ☐Ms. ☐Mrs. ☐Miss ______________________________ Birthdate ____/____/____
LAST FIRST MIDDLE MO. DAY YR.

Home Address ______________________________ Cell Phone ____________

______________________________ Home Phone ____________
CITY POSTAL CODE

Employer ______________________________ Work Phone ____________

Email Address ______________________________

SPOUSE/COMMON LAW INFORMATION (if applicable)

Name ______________________________ Birthdate ____/____/____
MO. DAY YR.

Employer ______________________________ Bus. Phone ____________

IF PATIENT IS A MINOR

Father ____________ Employer ____________ Bus. Phone ____________

Mother ____________ Employer ____________ Bus. Phone ____________

PARENT'S CONSENT *I hereby authorize necessary dental services for* ______________________

Emergency Contact ______________________________

*Whom may we thank for referring you to our office? ______________________________

How would you prefer to be reminded of your appointments; Email ☐ Text Message ☐ Call ☐

Person Responsible for Account: ☐ Self ☐ Spouse ☐ Other ____________

- I acknowledge full responsibility for the payment of all dental services and agree to pay for them in full at the time of service unless other financial arrangements have been made.

Signature ______________________________

Cancellation Policy: We require 2 business days notice to change or cancel an appointment to avoid a short notice cancellation fee. Short notice cancellations within 24 hours are subject to a $50 fee for every 30 minutes of reserved time.

To assist in proper diagnosis and treatment

MEDICAL HISTORY

Name of physician ______

Date of last physician visit ______

Reason ______

Yes	No	
☐	☐	Do you have any general health problems? ______
☐	☐	Do you routinely take any medication? (please list on next page) ______
☐	☐	Are you presently under the care of a physician? ______
☐	☐	Have you been treated in hospital within the last two years for any reason? ______

Have you ever had one of the following:

Any unusual reactions to:

- ☐ a. Penicillin ______
- ☐ b. Aspirin ______
- ☐ c. Codeine ______
- ☐ d. Any other ______

Yes	No	
☐	☐	Allergies to any medication (please list on next page) ______
☐	☐	Allergies to any anesthetics ______
☐	☐	Other Allergies ______
☐	☐	Are you pregnant ______

Trimester ______

CIRCLE ANY CONDITIONS YOU HAVE BEEN TREATED FOR:

Tuberculosis or lung disease
Joint replacement
Prolonged bleeding from a minor cut
Diabetes or glaucoma
Heart murmur
Hepatitis or liver trouble
Ulcer or stomach problems
Heart problems or stroke
Asthma or sinus problems
Kidney or thyroid problems
X-ray radiation therapy
Hepatitis ☐A ☐B ☐C ☐D
High or low blood pressure
Rheumatic fever or rheumatic heart
Arthritis or rheumatism
Nervous problems or epilepsy
Tested positive to HIV Virus
Osteoporosis

DENTAL HISTORY (If Yes explain)

Name of last dentist ______

Date of last dental examination ______

Date of last dental x-ray ______

Yes	No	
☐	☐	Do you use dental floss regularly ______
☐	☐	Have you had professional instruction on home care ______
☐	☐	Are you presently having dental pain ______
☐	☐	Are you aware of any decayed teeth ______
☐	☐	Do you have rough or broken fillings ______

Are your teeth sensitive to:

- ☐ heat/cold ______
- ☐ sweets ______
- ☐ bite pressure ______

Yes	No	
☐	☐	Does food catch between any teeth ______
☐	☐	Do your gums bleed when you brush ______
☐	☐	Are you ever aware of bad breath ______
☐	☐	Do you clench or grind your teeth ______
☐	☐	Do you want to improve the appearance of your teeth ______

SIGNATURE ______ DATE ______

ATTITUDES TOWARDS DENTISTRY

Yes	No	
☐	☐	Do you experience anxiety about dental treatment ______
☐	☐	Has anxiety postponed needed dental treatments ______
☐	☐	Do you expect to be able to keep your remaining teeth ______
☐	☐	How would you rate the quality of your past dental treatment ______
☐	☐	Would you like to know about the techniques available to reduce dental anxiety (including sedation)? ______

FOR PATIENTS WITH DENTURES/PARTIALS

How long have you worn dentures ______

Yes	No	
		How old is this set ______
☐	☐	Has your denture been relined ______
☐	☐	Is your denture comfortable ______
☐	☐	Do you use denture adhesive ______
☐	☐	Are you satisfied with the appearance of your dentures ______
☐	☐	Do your dentures cause sore spots ______

FOR THE CHILD PATIENT

Yes	No	
☐	☐	Does your child brush regularly ______
☐	☐	Has your child had many cavities ______
☐	☐	Have your child's teeth been treated with fluoride ______
☐	☐	Is your child apprehensive about dental visits ______

ALLERGIES TO MEDICATIONS

______

______

______

______

MEDICATIONS

Medication	Dose/Frequency	Condition Medication Was Prescribed For

Have you ever been treated for cancer or osteoporosis with oral or IV Bisphosphonates (some brands include Actonel, Fosamax, Boniva, Reclast, Aredia, Didronel) **YES** ☐ **NO** ☐

If yes, when and for how long? ______