Southern Smiles Dentistry

PATIENT REGISTRATION FORM

Today's Date: _____ Whom May we thank for your referral: _____

Patient Information

Last Name: _____ First Name: _____ M.I _____

Birth Date: ___/____/____ Social Security number: _____-_____-_____

Sex: _____ Marital Status: _____ Name of spouse/Parent: _____

Address: _____ Apt# _____

City: _____ State: _____ Zip Code: _____

Home Phone #: _____ Cell Phone #: _____

Email: _____

Best way to reach you: _____

Patient or Parent's employer: _____

Spouse's Information:

Last Name: _____ First Name: _____

Spouse Phone #: Cell: _____ Home: _____

Spouse Email: _____ DOB: ____/___/____

Dental Insurance

Name of Subscriber: _____ Subscriber ID #_____

Insurance Company: _____ Group # _____

Insurance Company Billing Address and Phone Number:

_____

Southern Smiles
Dentistry

Dental History **Patient Name (please print):** _____

(Please check any of the following that apply to you)

- ❑ Sensitivity (hot, cold, sweets, pressure)
- ❑ Discomfort when chewing
- ❑ Headaches, earaches, neck pain
- ❑ Jaw joint pain
- ❑ Teeth or fillings breaking
- ❑ Bad breath/bad taste in mouth
- ❑ Bleeding, swollen or irritated gums
- ❑ Loose, chipped or shifting your mouth
- ❑ Grinding or clenching teeth

What would you like to do to improve your smile?

- ❑ Whiten
- ❑ Straighten
- ❑ Close spaces
- ❑ Replace silver fillings with tooth colored fillings
- ❑ Repair chipped teeth
- ❑ Replace missing teeth
- ❑ Replace old crowns that don't match other teeth

Do you have or have you ever had any of the following?

❑ Dentures ❑ Partial Dentures
❑ Braces ❑ Periodontal (gum) treatments

How long has it been since your last cleaning?

❑ Less than 1 yr ❑ 1-2 yrs ❑ 3-5 yrs ❑ over 5 yrs

What is most important about your visit today? _____

_____ _____ _____

Name of previous dentist Phone number City & State

Why did you leave your previous dentist? _____

_____

Previous dental experiences: _____

On a scale of 1 to 10 with 10 being the highest:

How important is your dental health to you? 1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health? 1 2 3 4 5 6 7 8 9 10

Sleep History

Have you ever had a sleep study or do you currently use a CPAP? ❑Yes ❑No
Does your partner say that you snore? ❑Yes ❑No
Do you take frequent naps during the day, or often feel tired? ❑Yes ❑No
Other: _____

Medical History

Have you been under the care of a medical doctor during the past two years? ❑Yes ❑No
If yes, for what? _____

Physician's name: _____ Last visit to Physician: _____

Do you have high blood pressure? ❑Yes ❑No What is your normal blood pressure? _____

Emergency Contact: _____ **Phone Number:** _____

Are you allergic or have you had a reaction to the following:

Local Anesthetic	❑Yes ❑No
Penicillin or other antibiotics	❑Yes ❑No
Aspirin, Ibuprofen or Tylenol	❑Yes ❑No
Codeine, Valium or other sedatives	❑Yes ❑No
Latex or metals	❑Yes ❑No

Updates:

Initials_____ Date _____
Initials_____ Date _____
Initials_____ Date _____
Initials_____ Date _____

Patient Signature: _____ **Date:** _____
Doctor Signature: _____ **Date:** _____

Have you ever had an allergic or adverse reaction to any medication or substance (including foods)? ❑Yes ❑No

If yes, please list: _____

_____

Are you currently taking any medications, drugs or pills? ❑Yes ❑No

If yes, please list name and dosage: _____

_____

_____

_____

Do you use tobacco? ❑Chew ❑smoke How often?_____How long? _____

Do you consume alcohol? ❑Yes ❑No How many beverages per week? _____

Do you use any mood altering drugs other than those previously listed? ❑Yes ❑No

Have you had or now have the following conditions or treatments:

AIDS	❑Yes ❑No	Heart condition	❑Yes ❑No
Alcoholism	❑Yes ❑No	Heart murmur	❑Yes ❑No
Allergies or hives	❑Yes ❑No	Heart pacemaker	❑Yes ❑No
Asthma	❑Yes ❑No	Heart surgery	❑Yes ❑No
Arthritis/Rheumatism	❑Yes ❑No	Hemophilia	❑Yes ❑No
Artificial heart valve	❑Yes ❑No	Hepatitis type _____	❑Yes ❑No
Artificial joints-type _____	❑Yes ❑No	High blood pressure	❑Yes ❑No
Bleeding/Blood disorder	❑Yes ❑No	HIV positive	❑Yes ❑No
Blood thinners/Aspirin	❑Yes ❑No	HPV	❑Yes ❑No
Bone disease or bone cancer	❑Yes ❑No	Kidney trouble	❑Yes ❑No
Bruise easily	❑Yes ❑No	Latex sensitivity	❑Yes ❑No
Cancer	❑Yes ❑No	Liver disease	❑Yes ❑No
Chemotherapy	❑Yes ❑No	Milk/Casein allergy	❑Yes ❑No
Chest pain (Angina)	❑Yes ❑No	Mitral valve prolapse	❑Yes ❑No
Chronic cough	❑Yes ❑No	Neurological disorders	❑Yes ❑No
Cold sores/Fever blisters	❑Yes ❑No	Nervous/Anxious	❑Yes ❑No
Congenital heart disease	❑Yes ❑No	Osteoporosis	❑Yes ❑No
Contact lenses	❑Yes ❑No	Psychiatric/Psychological care	❑Yes ❑No
Cortisone medicine	❑Yes ❑No	Radiation therapy	❑Yes ❑No
Diabetes: Type _____	❑Yes ❑No	Rheumatic fever	❑Yes ❑No
Drug addiction	❑Yes ❑No	Sinus trouble	❑Yes ❑No
Emphysema	❑Yes ❑No	Sleep apnea/Snoring	❑Yes ❑No
Epilepsy or seizures	❑Yes ❑No	Stroke	❑Yes ❑No
Fainting or dizzy spells	❑Yes ❑No	Thyroid problems	❑Yes ❑No
Family history of diabetes	❑Yes ❑No	Tuberculosis (T.B.)	❑ Yes ❑No
Glaucoma	❑Yes ❑No	Tumors	❑Yes ❑No
Heart attack	❑Yes ❑No	Ulcers/Reflux	❑Yes ❑No

Premedication Required: ❑**Yes** ❑**No** _____

Any disease, condition or problem not listed: _____

Women

Are you pregnant or planning a pregnancy? ❑Yes ❑No

If yes, due date:_____

Are you a nursing mother? ❑Yes ❑No

Are you taking birth control pills? ❑Yes ❑No

Patient Name (Please Print) _____

Patient/Parent signature _____ **Date** _____

Doctor Signature _____ **Date** _____

NOTICE PRIVACY PRACTICE ACKNOWLEDGEMENT

James R. Canham, DDS

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

SOUTHERN SMILES DENTISTRY

James R. Canham, DDS

15 Lafayette Place, Ste. E Hilton Head, SC 29926

Telephone: 843-686-5526

Fax: 843-432-3210

Financial Responsibility

• This agreement is to inform you of your financial obligation to our practice. We are committed to providing you with the highest quality dental care using only the best material and technology available in the market today. We are also committed to providing you with up- to-date information and educational tools so that you may fully participate in maintaining optimum oral health. This financial agreement is intended to facilitate our ability to provide excellent service to you while minimizing our administrative costs. While we do understand that emergencies do arise, we require a 48 hour notice to reschedule an appointment to prevent from being charged a fee.

• All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and the insurance company. Our office is not a party to that contract.

• As a courtesy to you we will help you process all your insurance claims. You may direct your insurance company to pay your benefits directly to our office by signing the authorization on the Assignment of Benefits Agreement at the end of this document. In order for our office to file your insurance claim, you must bring a completed dental insurance form or proof of insurance at each appointment.

• Our office will accept an assignment of benefits from your insurance company with the provisions listed below. It is important to understand, though, that the agreement regarding your dental benefits is between you, your employer, and your insurance company. The obligation you have with our practice is to pay for treatment, regardless of the amount that may or may not be reimbursed by your insurance company. The following provisions identify our policies governing insurance claims.

• Although we are willing to complete insurance information forms and submit a claim on your behalf, we do not accept responsibility for the outcome of the transaction. Completing insurance forms is a courtesy we extend to you in an effort save you time and to facilitate payment to you from your insurance company. By having our office process your insurance forms, it is important that you understand that this does not eliminate your financial obligation for your treatment.

• Our office will not enter into a dispute with your insurance company over any claim, although we will provide necessary documentation your insurance company requests to sort out any confusion or questions that may arise. We will cooperate fully with the regulations and requests of your insurance

company. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company.

• A non-refundable deposit is required for any appointment over 1 hour and 30 minutes. The deposit amount shall be estimated for that particular visit. Any cancellation less than 2 business days will deem the deposit non- refundable.

- ALL X-Rays, photos and records taken at Southern Smiles Dentistry are property of SSD. If a copy of records is required there is a duplication fee and a records release form to be filled out prior to receiving records. The fee for 3-D Cone Beam X-ray (on a disk) is $150.00. The fee for any other type of X-Ray is $50.00

• Please do not hesitate to ask if you have any questions regarding this financial agreement. We are committed to providing you with the most positive experience in dental care.

I HAVE READ AND ACCEPT TERMS AND CONDITIONS OF THIS FINANCIAL AGREEMENT. I UNDERSTAND PAYMENT FOR SERVICES IS TO BE PAID IN FULL AT THE TIME OF SERVICE. I AUTHORIZE SOUTHERN SMILES DENTISTRY TO CHARGE MY CREDIT CARD FOR CANCELLATIONS MADE LESS THAN 2 BUSINESS DAYS PRIOR TO RESERVED TIME.

Credit Card: Visa Mastercard Discover Credit Card #: _____

Expiration: _____ CVC: _____

Patient or Guardian Printed Name: _____

Patient or Guardian Signature:_____ Date: _____

Informed Consent Photographs

I understand that photographs, X-Rays, and other records may be made during the course of my examination, treatment and follow up care. I give permission for such items to be used for purposes of research, education or publication in professional journals.

Patient Signature: _____ Date: _____