Welcome to South 40 Dental! – Tell Us About Yourself

Name: _____
Last First MI Title

Preferred Name:_____ ❑ Male ❑ Female

Parent/Guardian Name if Under 18 Years Old: _____

Address: _____City _____Prov. _____Postal Code_____

Date of Birth (Day)_____ (Month)_____ (Year)_____

Home Phone: _____ Work Phone: _____

Cell Phone:_____ E-mail Address: _____

Employer:_____ Occupation: _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Domestic Partner

How did you hear about our office?_____

Do you prefer to be contacted for appointment confirmation via: E-mail or phone or Text? (Please circle preference)

■ Insurance – Primary ■

Subscriber Name: _____ Relationship to Patient: _____Subscriber DOB: _____

Subscriber Employer: _____ Insurance Company Name: _____

Group Number: _____ Subscriber ID: _____

■ Insurance – Secondary ■

Subscriber Name: _____ Relationship to Patient:_____ Subscriber DOB:_____

Subscriber Employer: _____

Insurance Company Name: _____

Group Number: _____ Subscriber ID: _____

■ Assignment and Release (For Direct Billing)

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to South 40 Dental all insurance benefits, if any, otherwise payable to me for services rendered. 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 payments of benefits. I authorize the use of this signature on all insurance submissions.

Policy Holders Signature: _____

Relationship to plan member: ❑ Self ❑ Spouse ❑ Child Date: _____

CONSENT: I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

Patient or Parent/Guardian Signature:_____

MEDICAL HISTORY

Do you have a personal physician? ❑ Yes ❑ No

Physician's Name:_____

Physician's Phone: _____ Date of last Visit:_____

Your current physical health is: ❑ Good ❑ Fair ❑ Poor

Are you currently under the care of a physician? ❑ Yes ❑ No

Please explain: _____

Do you use tobacco in any form? ❑ Yes ❑ No

Have you had any metal rods, pins or implants placed? ❑ Yes ❑ No

Are you taking any medications? ❑ Yes ❑No

Please list each one: _____

Have you ever had any surgical procedures? ❑ Yes ❑ No

Please list each one: _____

Yes	No	Conditions
❑	❑	Abnormal Bleeding
❑	❑	Alcohol Abuse
❑	❑	Allergies
❑	❑	Anemia
❑	❑	Angina Pectoris
❑	❑	Arthritis
❑	❑	Artificial Heart Valve
❑	❑	Asthma
❑	❑	Cancer
❑	❑	Chemotherapy
❑	❑	Congenital Heart Defect
❑	❑	Diabetes
❑	❑	Difficulty Breathing
❑	❑	Drug Abuse
❑	❑	Emphysema
❑	❑	Epilepsy
❑	❑	Facial Surgery
❑	❑	Fainting Spells
❑	❑	Frequent Headaches

Yes	No	Conditions
❑	❑	Glaucoma
❑	❑	HIV+ AIDS
❑	❑	Heart Attack
❑	❑	Heart Murmur
❑	❑	Heart Surgery
❑	❑	Hemophilia
❑	❑	Hepatitis A, B or C
❑	❑	High Blood Pressure
❑	❑	Joint Replacement
❑	❑	Kidney Problems
❑	❑	Liver Disease
❑	❑	Low Blood Pressure
❑	❑	Mitral Valve Prolapse
❑	❑	Pace Maker
❑	❑	Psychiatric Problems
❑	❑	Radiation Therapy
❑	❑	Seizures
❑	❑	Shingles

Yes	No	Conditions
❑	❑	Sickle Cell Disease
❑	❑	Sinus Problems
❑	❑	Stroke
❑	❑	Thyroid Problems
❑	❑	Tuberculosis
❑	❑	Ulcers

Yes	No	Allergies
❑	❑	Aspirin
❑	❑	Codeine
❑	❑	Dental Anesthetics
❑	❑	Erythromycin
❑	❑	Jewelry
❑	❑	Latex
❑	❑	Metals
❑	❑	Penicillin
❑	❑	Tetracycline

Yes	No	If Female, Please Answer
❑	❑	Are you taking Birth Control Pills?
❑	❑	Are you pregnant? If so, # of Weeks _____
❑	❑	Are you nursing?

Any other medical issues? (Please list) _____

Nearest relative not living with you:

Name:_____Phone: _____

Relationship_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature:_____Date: _____

DENTAL HISTORY

How may we help you today? _____

Please rate your CURRENT dental health : ❑ Good ❑ Fair ❑ Poor

Do you REQUIRE ANTIBIOTICS before dental treatment? ❑ Yes ❑ No

Are you having PAIN, SWELLING or SORE SPOTS at this time? ❑ Yes ❑ No

Have you ever had GUM TREATMENT/SURGERY? ❑ Yes ❑ No

Do you now or have you had any pain/discomfort in your jaw joint? (TMJ) ❑ Yes ❑ No

Are you MISSING any teeth? ❑ Yes ❑ No

On a scale of 1 to 10, how would you rate your SMILE? (1 being lowest, 10 highest) 1 2 3 4 5 6 7 8 9 10

Do your GUMS BLEED? ❑ Yes ❑ No

If you SNORE, would you like an oral device to help you stop snoring? ❑ Yes ❑ No

How often do you: FLOSS_____ BRUSH?_____

Are your teeth SENSITIVE to heat, cold or anything else? ❑ Yes ❑No

Have you ever had any COMPLICATIONS with any previous dental work? ❑ Yes ❑ No

Do you have a FEAR of the Dentist? ❑ Yes ❑ No If yes, please check: ❑mild ❑moderate ❑severe

Have you ever had any unfavorable dental EXPERIENCE? ❑ Yes ❑ No

When was your last dental CLEANING?_____ When was your last dental VISIT?_____

Why did you leave your previous dentist?_____

How can we ACCOMODATE you better during your dental visit? _____

Here at South 40 Dental, we offer a wide variety of services to enhance and keep your smile beautiful.
Please circle any services below you would like our friendly staff to discuss with you during your visit.

Dental Implants	Veneers/Lumineers (Cosmetics)	Invisalign
Six Month Adult Cosmetic Braces	Smile Makeover	Tooth Coloured Fillings(Composite)
Sedation Dentistry	Crown and Bridge	Wisdom Teeth Extractions
Partials and Complete Dentures	Night/Sport Guards	Teeth Whitening

FINANCIAL AGREEMENT

Payment options

We offer the following payment options: Cash, Debit, Visa, MasterCard, Money order, E-Transfer, and Dental Card Financing. Payment plans *may* be an option - ***please ensure it is arranged in advance of your treatment.***

Dental Insurance Benefits

We want you to get the most out of your dental plan benefits, so we offer direct billing and electronic claim filing (whenever permitted by your dental insurance plan). Our team will work with you to maximize your yearly limits and submit pre authorizations for major restorative work. Please remember that when we provide you with an estimate for your treatment, it is only an *estimate*- dental plan estimates/limits are subject to change and we base the estimates on the information provided to us by your plan.

If your plan accepts assignment of benefits and electronic claims, you will only be responsible for the portion of your treatment that your plan did not cover. Dental plan limits and coverage vary from plan to plan- the range of benefits cover as little as 30% and up to 100%. Most plans fall into the 50-80% range. **Some plans base the amount eligible on a fee schedule determined by insurance companies, so you may receive a lower percentage than the reimbursement level indicated in your dental plan. For example, if your plan states that it will pay 90% of the cost of a procedure, it means 90% of the fee determined by the insurance company, not the actual fee charged by our clinic.**

Some dental policies will not pay us directly, therefore we will submit the claims on your behalf, but you will be responsible for 100% of the fees *at the time of treatment*, and will receive reimbursement from your plan based on your dental plan fee schedule. If at any time your dental plan/benefits change, please notify us immediately.

We require you to pay your estimated portion at each visit. If you would like to discuss financial arrangements/financing options, please speak with one of our team members in advance of your treatment.

It is your responsibility to ensure all information provided to us and your insurance company is correct and up to date. We will be unable to submit or collect on your behalf if the information on file is not correct.

I have read, and understand and agree to all terms as above. I agree to pay all service charges that may be incurred should any balances remain unpaid after treatment.

X_____ Date_____

(Signature of responsible party)

Print Name:_____