**SONG DENTAL NEW PATEINT FORMS**

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| Patient Information |

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI: \_\_\_\_\_\_\_\_\_

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

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: ❑ Male ❑ Female

Marital Status: ❑Single ❑ Married ❑Child ❑Separated ❑Divorced ❑Widowed

Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

How did you hear about our office? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| Responsible Party Information  |

Name of Person Responsible for this Account: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Current Patient: ❑ Yes ❑ No

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| Insurance Information  |

Insurance Plan Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder’s DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder’s SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder’s Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Policy Holder: ❑ Self ❑ Spouse ❑Child ❑Other

Insurance Company’s Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| Medical History - CHECK ALL THAT APPLY |

❑Abnormal bleeding

❑Allergies

❑Anemia

❑Anesthetic reaction

❑Antibiotic Reaction

❑AIDS or HIV

❑Arthritis

❑Artificial Joints

❑Asthma

❑Aspirin Allergy

❑Blood Transfusions

❑Blood Disease

❑Circulatory disorder

❑Chemotherapy

❑Codeine Allergy

❑Cancer

❑Digestive Problems

❑Diabetes

❑Dizziness

❑Erythromycin Allergy

❑Epilepsy/Seizures

❑Excessive bleeding

❑Eating Disorder

❑Fainting

❑Glaucoma

❑Hay Fever

❑Head Injuries

❑Headaches

❑Heart Disease

❑Heart Murmur

❑Heart Trouble

❑High Cholesterol

❑High Blood Pressure

❑Hypoglycemia

❑Hepatitis

❑Ibuprofen Allergy

❑Jaundice

❑Kidney Disease

❑Latex Allergy

❑Liver Disease

❑Mental Disorders

❑Migraines

❑MVP

❑Nervous Disorders

❑Pacemaker

❑Pregnancy

❑Penicillin Allergy

❑Premed Required

❑Radiation

❑Respiratory Problems

❑Rheumatic Fever

❑Sinus Problems

❑Stomach Problems

❑Stroke

❑Tuberculosis

❑Tumors

❑Venereal Disease

❑Ulcers

**❑NONE OF THE ABOVE**

Please list any other **medical conditions**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently taking any **medications**? ❑No ❑Yes

If “**Yes**”, please list medications:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been told to take a **pre-medication** prior to dental treatment? ❑No ❑Yes

If “Yes”, please list medications \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**To the best of my knowledge, all of the proceeding answers and information provided are true and correct. I understand that providing incorrect information can be dangerous to my (or patient’s) health. It is my responsibility to inform the dental office of any changes in medical status**.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Patient, Parent, or Guardian**  **Date**

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| Your Future Appointments |

We realize that illness, emergencies, and changes in work or school schedules occasionally occur. Please understand that when we schedule your appointment, we are reserving time for your particular needs. Your commitment to yourself is to **KEEP YOUR SCHEDULED APPOINTMENT**. We will always make every effort to accommodate your scheduling needs and keep our schedule “on time.” If you are unable to keep your scheduled appointment, we require a **48-hour** notice (2 full days) so that we may accommodate the dental needs of another patient.

* As a courtesy to you, we will make every effort to confirm your reserved appointment. However, do not consider it our responsibility to do so. If we are unsuccessful, it is still your responsibility to keep your reserved appointment or contact us 48 hours in advance to change or cancel the reserved time.
* Being late decreases our ability to provide you with the best quality work possible. If you arrive more than 15 minutes late, your appointment may be rescheduled in order to meet the needs of those who are on time for their pre-reserved appointment. If this happens, it will be considered a missed appointment.
* All patients will receive the opportunity to miss one scheduled appointment at no charge. A missed appointment fee of $50 per hour of appointment reserved will be charged. Please note that a missed appointment fee is NOT covered by any insurance plans and is your responsibility to pay.

Thank you very much for your cooperation and understanding. We appreciate your mutual respect of everyone’s time. Song Dental takes pride in providing every patient the best care that they deserve and we thank you again for choosing us as your dental home.

**Initial \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| Financial Information |

As a courtesy, this Song Dental will help prepare and submit your insurance forms, however I understand that any fees not covered by insurance are my final responsibility. By signing this form I authorize this office to submit insurance claims and to contact my insurance company on my behalf. I understand that any fee estimate provided by this office is NOT a guarantee of payment. In consideration for the professional services rendered to me or at my request, I agree to pay for all services regardless of insurance coverage.

**Initial \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| Consent  |

I authorize Song Dental to take radiographs, study models, photographs, or any diagnostic aids deem appropriate by Doctor to make a thorough diagnosis of my dental needs. I authorize Doctor to perform any and all forms of medication, and therapy that may be indicated and agreed upon. I further authorize the release of any information, including the diagnosis and the records of any treatments or examinations rendered, to my insurance company or consulting professionals. The release to the insurance company is solely for the purpose of facilitating the billing and reimbursement directly to the dentist of insurance benefits under which I am entitled.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Patient, Parent, or Guardian** **Date**

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| Authorization for Release of Patient Information & HIPAA |

By signing and dating this authorization for release of my patient information, I allow the person(s) listed below to request and receive patient information. This authorization to release is valid for 5 years from today. I understand that at any time between the time of signing and the expiration date, I have the right to revoke this authorization.

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**In Case of Emergency Contact:**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that I have certain rights to privacy regarding your protected health information. These rights are given to me under the Health Insurance Portability & Accountability Act (HIPAA). Your name on this sheet indicates that you have been given the opportunity to review & request a copy of the Notice of Privacy Practices for Song Dental on the date indicated. If you have any questions regarding the information in the Notice of Privacy Practices, please do not hesitate to contact our Privacy Practice Officer.

**Initial \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| Dental History  |

Date of Last Dental Visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason for last visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Last Dental Cleaning\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Have you ever had a “deep cleaning? ❑Yes ❑No

Have you ever had an upsetting dental experience? ❑Yes ❑No

If **yes**, please describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| Oral Health Evaluation |

Do you feel pain in any of your teeth? ❑No ❑Yes

Do you consume tobacco? ❑No ❑Yes

Are you happy with your smile? ❑No ❑Yes

Are you interested in replacing missing teeth? ❑No ❑Yes

Are you interested in whitening your teeth? ❑No ❑Yes

What is holding you back from your perfect smile? ❑Fear ❑Time ❑Cost ❑Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_