WELCOME

SOUTH TOWNE DENTAL

Our office is HIPAA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA

Personal Info

First: _____ Last: _____ M.I.: _____
Birthday: _____/ _____/ _____ Age: _____ SSN: _____ - _____ - _____
Address: _____ Apt.: _____
City: _____ State: _____ Zip: _____
Email: _____
Mobile#: ( ) _____ - _____
Home#: ( ) _____ - _____ Work:#:( ) _____ - _____

Whom may we thank for referring?
Name: _____ Relation: _____

Other family members seen here:
_____

EMERGENCY CONTACT: _____ **PHONE#:** _____

Physician's name: _____
Phone: ( ) _____ - _____
Are you currently under the physician's care: _____ Y _____ N
Explain:_____

INSURANCE

Person Responsible for insurance:
Name: _____
Birthday: _____/ _____/ _____
SSN: _____ - _____ - _____
Relationship to Patient: _____
Insurance Company Name: _____

Please Initial:

_____ Appointments
The office requires 24hr notice for any changes or cancellations. You may be charged a fee.

_____ Insurance
The design of your unique plan will determine how benefits are paid. The patient is responsible for any balance remaining.

_____ Payment
The patient portion is due at the time of service.

500 Bellsworth Drive | St. Louis, MO 63125 Tel: 314-487-8844
www.SouthTowneDental.com Fax: 314-487-8529

Medications: Please list all over the counter, prescription, herbal supplements:

_____

_____

Have you been hospitalized in the last 2 years?
___Y ___N Explain: _____

_____

Have you ever had joint replacement/valve replacement: ___Y ___N
If YES: Date:_____ Explain: _____

_____

Have You ever had any of the following diseases or medical problems? (*circle all that apply*)

YES NO | Abnormal Bleeding
YES NO | Acid Reflux
YES NO | AIDS/HIV
YES NO | Alcohol/Drug Abuse
YES NO | Anemia
YES NO | Arthritis
YES NO | **Artificial Bones/Joints/Valves**
YES NO | Asthma
YES NO | Blood Transfusions
YES NO | **Cancer/Chemotherapy**
YES NO | Cold Sores/Fever Blisters
YES NO | Colitis
YES NO | Congenital Heart Defect
YES NO | COPD
YES NO | **Diabetes**
YES NO | Difficulty Breathing
YES NO | Emphysema
YES NO | Fainting Spells
YES NO | Frequent Headaches
YES NO | Glaucoma
YES NO | Hay Fever
YES NO | Heart Attack
YES NO | Heart Murmur
YES NO | **Heart Surgery**
YES NO | Hemophilia
YES NO | Hepatitis A
YES NO | Hepatitis B or C
YES NO | **High Blood Pressure**
YES NO | Hospitalized (any reason)
YES NO | Hypoglycemia
YES NO | Kidney Problems
YES NO | Liver Disease
YES NO | Low Blood Pressure
YES NO | Lupus
YES NO | Mitral Valve Prolapse
YES NO | Pacemaker
YES NO | Psychiatric Problems
YES NO | **Radiation Treatments**
YES NO | Rheumatic/Scarlet Fever
YES NO | Seizures
YES NO | Shingles
YES NO | Sickle Cell Disease
YES NO | Sinus Problems
YES NO | Sleep Apnea
YES NO | Stroke
YES NO | Thyroid Problems
YES NO | Tuberculosis (TB)
YES NO | Ulcers
YES NO | Veneral Disease

ALLERGIES

Are you allergic to any of the following?
(circle all that apply)

YES NO | Aspirin
YES NO | Codeine
YES NO | Penicillin
YES NO | Tetracycline
YES NO | Erythromycin
YES NO | Jewelry/Metals
YES NO | Latex

Please list any other drugs/materials that you are allergic to:

_____

_____

Please list any other medical conditions that you have had:

_____

_____

FOR WOMEN ONLY

Are you taking birth control medications?
YES :_____ NO_____
Are you pregnant?
YES NO Week#: _____
Are you trying to get pregnant?
YES NO
Are you nursing?
YES NO

What is the most important thing about your dental visit today?

_____

_____

_____

SIGN: _____ DATE: _____

OFFICE USE ONLY

I verbally reviewed the medical/dentist information above with the patient names herein. Initials _____ Date _____

Doctor's Comments: _____

_____

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NOTICE OF PRIVACY PRACTICES

NOTICE OF PRIVACY PRACTICES: By signing this form, I acknowledge that I have access to the Notice of Privacy Practices for SouthTowne Dental via the office or website at www.southtownedental.com. By signing this form, I also consent to SouthTowne Dental's use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations.

RIGHT TO REVOKE: You have the right to revoke consent at any time by giving us written notice of your revocation submitted to the Contact Person listed on the Notice of Privacy Practices. Please understand that revocation of this Consent will not affect any action we took reliance on this Consent before we received your revocation, but that we may decline to treat you or continue treating you if you revoked this Consent.

SIGNATURE: I, _____, have had a 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 for your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations. I also give consent for any photos taken during my visit to be used on SoutheTowne Dental's website and/or Facebook™ page for marketing and/or promotional purposes.

_____ _____/ _____/ _____

Signature of Patient Date

If this acknowledgement and Consent is signed by a parent/legal guardian/personal representative on the behalf of the patient, please comment the following:

Parent/Legal Guardian/Representative's Name: _____

Signature of Parent/Legal Guardian/Representative: _____

Relationship to client: _____

Date: _____/ _____/ _____

REVOCATION OF CONSENT

I revoke my Consesnt for your use and disclosure of my protected health information for treatment, payment, activities, and healthcare operations. I understand that revocation of this 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 continue to treat me after I have revoked my Consent.

SIGNATURE: _____ Date: _____/ _____/ _____

**You are entitled to a copy of this consent after you sign it. This form will be retained in your dental record.

DISCLAIMER – Consent to treat

To the best of my knowledge, the questions in this form have been answered accurately. I understand that providing incorrect or incomplete information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in medical status. The undersigned hereby authorizes the Doctor, in order to make a thorough diagnosis of the patient's dental needs, to take X-rays, study models, photographs or any other diagnostic aids deemed appropriate by the Doctor. I understand the Doctor will advise me of any and all forms of treatment, medication, and therapy that may be indicated in connection with _____(name of patient). I also understand that the Doctor may choose to employ such assistance as deemed fit. I further understand that use of anesthetic agents embodies certain risk. I understand that payment for dental services provided in this office for myself or my dependents is my responsibility, due and payable at the time that services are rendered, unless finiancial agreements have been previously made. A 1.5% monthly finance charge will be applied to all accounts over 90 days past due. There will be a $35 service charge on all returned checks. I understand that the Doctor's office requires a 24 hour notice for appointment cancellations, and that I may be charged for each appointment cancelled less than 24 hours in advance. In the event of default, I (we) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees, as may be required to effect collection of this note. Please sign your name here, verifying that all information provided is true and complete.

Insurance

Our Policy Regarding Dental Insurance

You are fortunate to have dental insurance, whether you have purchased it or your employer has provided it for you. Though your dental insurance is your responsibility we can help! We will go the extra mile to help you maximize your benefits. As a courtesy, we will help by filing your insurance forms, which will save you considerable time and trouble. We accept payments from most insurance companies, which reduces your immediate out-of-pocket expense.

Please remember, however, the financial obligation for dental treatment is between you and this office, and is not between this office and your insurance company.

Regardless of what we may calculate your insurance company to pay, it is only an estimate. Our estimate is based on limited information obtained from your insurance company. You must understand, we cannot forecast what they will pay.

We must stress that you are responsible for the total treatment fee. Your dental insurance is not designed to pay the entire cost of your treatment, but it is intended to help cover a certain portion of the cost. Better terms for dental insurance may be "dental assistance" or "dental benefits." In order for us to obtain your insurance information for submitting your claim and/or discuss your situation directly with your insurance, please complete the "Insurance Information" portion on the front page of the new patient packet.

_____ _____

Sign ***Date***

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