Offices of Heather Bond Southard, DDS

Patient Information

Date: _____

Circle One: (Mr.) (Mrs.) (Ms.) (Dr.)

Name: _____
Last **First** **MI** **Nickname**

Mailing Address: _____
City **State** **Zip**

Home Phone: _____ Mobile Phone: _____

Date of Birth: _____ SS # _____

Email Address: _____ DL # _____

Circle One: Married Single Divorced Separated Widowed
Sex: _____Male _____ Female
Employed: _____YES _____NO
Student Status: _____Full Time _____ Part Time

Employer Name: _____ Work #: _____

Whom may we thank for referring you to our office? _____

Reason for today's visit: _____

Primary Care Provider: _____

Primary Dentist: (for TMJ patients only) _____

Parent/Guardian Information (if minor)

Circle One: (Mr.) (Mrs.) (Ms.) (Dr.)

Name: _____
Last **First** **MI** **Nickname**

Mailing Address: _____
City **State** **Zip**

Home Phone: _____ Mobile Phone: _____

Date of Birth: _____ SS # _____

Email Address: _____ DL # _____

Circle One: Married Single Divorced Separated Widowed
Sex: _____Male _____ Female
Employed: _____YES _____NO
Student Status: _____Full Time _____ Part Time

Emergency Contact

Name: _____ Relation: _____

Phone Number 1: _____ Phone Number 2: _____

_____
Signature of patient /parent or guardian

SOUTHARD FAMILY DENTISTRY

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations,

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations; of the uses and disclosures we may make of your protected health information; and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health Information that we maintain,

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above, Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had 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 to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations,

Signature: _____ Date: _____

If tnis Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my 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 to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

Offices of Heather Bond Southard, DDS

Please list the names of the persons to whom we may disclose the patient's private health information and relationship to the patient:

Emergency Contact Name/Relationship: _____

Emergency Contact Phone #: (_____) _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Please list names of the organization(s) to which we may send notifications verifying appointments (for work or school excuses, etc):

School: _____

Work: _____

Other: _____

HIPAA POLICY

I understand that, under the Health Insurance Portability Act (HIPAA), I have certain rights to privacy regarding my protected information. I understand that this information may be used to:

- Conduct, plan, and direct my treatment and follow-up among multiple healthcare providers who may be involved in my treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations

I understand that, upon request, I have the right to receive a complete copy of your Notices of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand the practice has the right to change its Notices of Privacy Practices if necessary and that I may contact this office at any time to obtain a current copy.

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 that you are not required to agree to my requested restrictions, but if you agree to them then you are bound to abide by such restrictions.

_____ _____

Signature of patient/parent or guardian Date

Offices of Heather Bond Southard, DDS

PATIENT FINANCIAL RESPONSIBILITY

1. **INDIVIDUAL'S FINANCIAL RESPONSIBILITY**
    - I understand that I am financially responsible for my health insurance deductible, coinsurance or non-covered services.
    - Co-payments are due at the time of services.
    - Patient outstanding balances are due when you check in for your appointment.
    - If my plan **requires a referral,** I must obtain it prior to my visit.
    - In the event that my health plan determines a services to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided.
    - If I am uninsured, I agree to pay for the medical services rendered to me at the time of services, including all surgeries.
2. **SELF-PAY ACCOUNTS**

    Our office designates accounts, Self-Pay, under the following circumstances:

    1. A patient is covered by an insurance plan that our providers do not participate in.
    2. A patient does not have a current, valid insurance on file.
    3. A patient does not have a valid insurance referral on file.
    4. A patient does not have insurance coverage.
3. **PRIMARY CARE PHYSICIAN AND REFERRALS**

    If you are a TMJ patient and your insurance plan has a designated primary care physician and you are required to obtain a written referral from that doctor, you must provide our office with that referral at the time of check in. If you do not have a current, valid referral, we may ask you to reschedule your appointment.
4. **AUTHORIZATION TO RELEASE RECORDS**

    I herby authorize the **Offices of Heather Bond Southard, DDS** to release to my insurer, governmental agencies, or any other entity financially responsible for my dental/medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such dental/medical services as well as information required for precertification, authorization or referral to other dental/medical providers.

_____ _____

Patient Name (Please Print) Date of Birth

_____ _____

Signature of Patient or Responsible Party Date

Offices of Heather Bond Southard, DDS

Medical Information:

Name: _____ Date: _____

- Have you ever had an operation or serious illness? _____YES _____NO

If yes, please explain _____

- Have you ever had an allergic or adverse reaction to any drug or medications? _____YES _____NO

If yes, please explain _____

- Do you smoke? _____YES _____NO if yes, how much? _____
- Do you drink? _____YES _____No if yes, how much? _____

Is there anything about your general health that we should know about?
_____

Allergens

☐ No known allergens	☐ Iodine	☐ Plastic
☐ Antibiotics	☐ Latex	☐ Sedatives
☐ Aspirin	☐ Local anesthetics	☐ Sleeping pills
☐ Barbiturates	☐ Metals	☐ Sulfa drugs
☐ Codeine	☐ Penicillin	

PLEASE LIST ALL MEDICATIONS YOU ARE TAKING

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

DO YOU NOW OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?
If YES, please circle

Heart Murmur	Fainting or Dizzy Spells	Cold Sores
Congenital Heart Lesions	AIDS/HIV	Pain in Jaw Joint
Angina Pectoris	Thyroid Trouble	Radiation Therapy
Heart Pacemaker	Rheumatic Fever	Mouth Ulcers
Stroke	Heart Disease	Epilepsy
Anemia	Heart Attack	Seizures
Hepatitis	Artificial Heart Valves	Mononucleosis
Asthma	Heart Surgery	Stomach Ulcers
Chronic Cough	High Blood Pressure	Pregnancy
Tumors	Low Blood Pressure	Breastfeeding
Liver or Kidney Trouble	Diabetes	
Chemotherapy	Emphysema	
Sinus Trouble	Tuberculosis	
Bruise Easily	Arthritis	

Do you take blood thinners? YES NO

Have you ever been told you need a pre med before dental work? YES NO

Have you ever taken Bisphosphonates (bone builders)? YES NO

_____ _____

Signature of patient/parent of guardian Date

Offices for Heather Bond Southard, DDS

Primary Insurance Information

Insurance Company: _____

Insured ID: _____Group Number: _____

Insured Party Information:

Name: _____
Last **First** **MI**

Relationship to Patient: _____ Email: _____

Mailing Address: _____
City **State** **Zip**

Home Phone: _____ Work Phone: _____ Cell: _____

SS# _____ Date of Birth: _____

Secondary Insurance Information

Insurance Company: _____

Insured ID: _____Group Number: _____

Insured Party Information:

Name: _____
Last **First** **MI**

Relationship to Patient: _____ Email: _____

Mailing Address: _____
City **State** **Zip**

Home Phone: _____ Work Phone: _____ Cell: _____

SS# _____ Date of Birth: _____

INSURANCE AGREEMENT

As a courtesy to our patients with insurance, we will take care of all necessary paperwork associated with filling your claim. We will do everything that we can to maximize your insurance. I understand that my insurance is a contract between my insurance company, and me, the total balance for any necessary treatment is my responsibility.

I understand that it is my responsibility to know the limits of my insurance coverage. We do our best to forewarn you if a procedure will likely not be covered by your insurance.

_____ _____

Signature of patient/parent or guardian Date

Offices of Heather Bond Southard, DDS

OFFICE POLICY

We are delighted to welcome you to our practice and are pleased that you chose us to serve your needs. We are serious about providing superior care at reasonable prices and proud of our dedication to our patients. Our goal is to help you feel and look your best through excellent care. We look forward to seeing you on a regular basis.

If you are ever unable to make an appointment you have scheduled with us, please notify us at least 24 hours in advance, as this time has been set aside ESPECIALLY FOR YOU. Failure to keep your scheduled appointment more than once may lead to a $50.00 fee or removing you from our practice. Also we ask you to be at our office at the appointed time, as we are on schedule almost 100% of the time. In the meantime, we look forward to seeing you again and serving your needs.

FINANCES

I understand that I am financially responsible for the services rendered to me by this office. I understand that any accounts that are over 90 days past due may be turned over to collections. I understand that if any accounts are turned over accounts have to be paid in full before any other appointments will be scheduled. I also agree to pay a service charge for any returned checks.

PHOTO, SLIDE, AND VIDEO CONSENT

I do hereby authorize the Offices of Heather Bond Southard, DDS to take photographs, slides and/or videos of my face, jaw, and the hard and soft tissues in my mouth. I understand that these photographs, slides, and/or videos will be a part of my permanent dental records. I also understand that these photographs, slides, and/or videos may be used for educational purposes in lectures, demonstrations and professional publications and I hereby authorize said use.

GUARANTEE

In the unlikely event that a prosthetic was to fail, it will be replaced at no charge for up to five years from the day the procedure was completed. The guarantee will be reduced or withdrawn; in the case of missing routine hygiene visits, in the case of neglected oral hygiene, in the case of not following the directions of the doctor, in the case of natural degradation of the teeth, gum tissue or jaw-bone, in the case of existence of general illness or conditions which has a detrimental effect on the masticators.

I understand that by failing to come in for my hygiene visits, twice a year with and exam and x-rays, I am therefore considering the guarantee stated above to be null and void.

_____ _____

Signature of patient/parent or guardian Date