SoutheastSmiles
compassion. quality care. convenience.

General Information

First Name: _____ Last Name: _____ Middle Initial _____

Preferred Name: _____ DOB: _____ SS# _____-_____-_____

Address: _____ City: _____ State: _____ Zip: _____

Primary Phone: _____ Secondary Phone: _____

Email: _____

Preferred method of contact: ---Select One
Marital Status: ---Select One-
Employment Status: ---Select One-

Policy Holder, Parent/Guardian Information (For all minors or dependent's)

Insurance Company: _____ Phone: _____

Policy Holder/Responsible Party: _____ Relation to Patient: _____

DOB: _____ SS# _____-_____-_____ ID#_____

Address: _____ City: _____ State: _____ Zip: _____

Primary Phone: _____ Secondary Phone: _____
o Responsible party is also the Primary Insurance Policy Holder: ---Select One-

In Case of Emergency

Emergency Contact_____ Phone: _____

Medical Doctor: _____ Phone: _____

Date of your last dental cleaning: _____
What is the primary concern that you would like us to address first? _____ _____
Have you ever had serious complications associated with previous dental treatment? ---Select One- If so, please explain:
_____
_

Do you snore frequently? ---Select One-
Have you completed a sleep study? ---Select One-
If so, when _____ Where _____ With Dr. _____
Do you have a CPAP? ---Select One-
If so, how many nights a week do you wear your CPAP? ---Select One

Medical History

Your oral health is connected to the health of your entire body. It's important for us to know your medical history because

health problems that you may have, or medication that you may be taking, could have an important interrelationship with any dental treatment you may receive.

Are you under a physician's care now? ○Yes ○ No
If yes, please explain:

_____

Have you ever had a serious illness or had a major surgery? ○Yes ○ No
If yes, please explain:

_____

Have you ever had a blood transfusion? ○Yes ○ No
If so, approximately when:

_____

Are you taking any medication, pills or drugs? ○Yes ○ No
Are you taking any blood thinner medication? ○Yes ○ No
If yes, please explain:

_____

Please list any and all medications and supplements you are currently taking:
(Present pre-printed list to the Front Desk staff)

_____ _____ _____
_____ _____ _____
_____ _____ _____

Office Use only: Pre-Printed RX list in patient chart

Do you use controlled substances? If yes, please explain:

_____

Do you use tobacco of any kind? ○Yes ○ No

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

☐Aspirin ☐ Tylenol ☐ Codeine ☐ Acrylic ☐ Penicillin ☐ Amoxicillin ☐ALL Cillin's
☐ Metal -- type(s)? _____
☐ Latex
☐ Sulfa Drugs
☐ Other: _____

Are any of your teeth loose? ○Yes ○ No
Do you have missing teeth? ○Yes ○ No
If so, have they been replaced? ○Yes ○ No
Are you happy with the result? ○Yes ○ No
Do you currently have pain in any of your teeth? ○Yes ○ No
Have you had your wisdom teeth removed? ○Yes ○ No
How many times per day do you brush your teeth?
Do your gums bleed or become sensitive while brushing or flossing? ○Yes ○ No
Have you ever been treated for periodontal (gum) disease? ○Yes ○ No
Do you have sensitivity to any of (Select all that apply)? ☐ Cold ☐ Hot ☐ Air ☐ Sweets ☐ Biting

Female patients, are you...(Select all that apply.)

☐ Pregnant or Trying to Get Pregnant ☐ Taking Oral Contraceptives ☐ Nursing

---

Do you have, or have you had, any of the following? Please select all those that apply.

☐ AIDS
☐ ARTHRITIS
☐ ARTIFICIAL HEART VALVES
☐ DIABETES
☐ EPILEPSY/SEIZURES
☐ HEART CONDITION
☐ KIDNEY DISEASE / DIALYSIS
☐ MITRAL VALVE PROLAPSE
☐ OSTEOPOROSIS

SoutheastSmiles
compassion. quality care. convenience.

- ☐ ARTIFICIAL JOINTS
- ☐ ASTHMA
- ☐ ANXIETY/PANIC ATTACKS
- ☐ BACK PROBLEMS
- ☐ CANCER
- ☐ CHEMICAL DEPENDENCY
- ☐ CONGESTIVE HEART FAILURE
- ☐ HEART MURMUR
- ☐ HEADACHES
- ☐ HEPATITIS: Type _____
- ☐ HIGH BLOOD PRESSURE
- ☐ HIV POSITIVE
- ☐ IMPLANTED DEFIBRILLATOR
- ☐ JAW PAIN
- ☐ PACEMAKER
- ☐ RESPIRATORY DISEASE
- ☐ SHORTNESS OF BREATH
- ☐ SICKLE CELL DISEASE/ TRAIT STROKE
- ☐ TUBERCULOSIS
- ☐ VENEREAL DISEASE

Other not listed: _____

Patient Consent to Treat

1. To the best of my knowledge, all of the proceeding answers and information I have provided are true and correct. If I ever have a change in my health, I will inform Southeast Smiles at my next appointment. If I have any changes/updates to my insurance coverage, I will inform Southeast Smiles prior to the next appointment to ensure verification can be completed. I grant Southeast Smiles permission to provide dental treatment as deemed necessary. I authorize Southeast Smiles to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis of the patient's dental needs. I also authorize the dentist to perform any and all forms of necessary treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk.

2. (If signing as the responsible party) I acknowledge that the above information is correct and grant Southeast Smiles permission to provide my child's/dependent's dental treatment as deemed necessary. If my child/dependent ever has a change in his/her health or his/her medications, I will inform Southeast Smiles at the next appointment. I will be responsible for the cost of their dental care.

3. I authorize and request the performance of dental services by Southeast Smiles and the staff, as designated. I understand that Southeast Smiles and the staff will use digital radiographs, diagnostic and patient management techniques that are reasonable, necessary, and advisable. I authorize Southeast Smiles and their staff to perform my dental care as deemed necessary. I verify that I have read and understand the above policy.

Signature of Patient or Responsible Party: _____ Date: _____

Photographic Image Usage

☐ I hereby give permission to Southeast Smiles to use my intra-oral photographs for the purpose of educational training, our website, or any other lawful purpose. I understand I may change or withdraw this release/consent at any time

☐ I **DECLINE** permission to Southeast Smiles to use my intra-oral photographs for the purpose of educational training, our website, or any other lawful purpose. I understand I may change or withdraw this release/consent at any time.

Signature of Patient or Responsible Party: _____ Date: _____

Acknowledgement of Receipt of Notice of Privacy Practice

I have received a copy of the Notice of Privacy Practices (located in the back pocket of clipboard or on website) for Southeast Smiles 910 S. College Road Wilmington, NC 28403. I understand that I am not required to sign this acknowledgment in order to receive treatment.

Signature of Patient or Responsible Party: _____ Date: _____

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- An emergency existed & a signature was not possible at the time.

- The individual refused to sign.
- A copy was mailed with a request for a signature by return mail.
- Unable to communicate with the patient for the following reason: _____
- Other:_____

Prepared By: _____

Signature _____ Date _____

Authorization for Release of Information – Compound Release

Patient Name_____ Date of Birth _____

Southeast Smiles is authorized to release protected health information about the above-named patient in the following manner and to identify persons.

Please select your preferred method of communication for receiving the following information: **(Select all that apply.)**

• Results of lab tests/ x-rays?	☐ Voicemail	☐ Text	☐ Email
• Appointment reminder?	☐ Voicemail	☐ Text	☐ Email
• Scheduling changes?	☐ Voicemail	☐ Text	☐ Email
• Account Financials?	☐ Voicemail	☐ Text	☐ Email
• Security Breach Notification?	☐ Voicemail	☐ Text	☐ Email

Whom do you authorize us to share patient medical and financial information with? Please specify information type:

☐ **FINANCIAL** ☐ **MEDICAL**

Name: _____ Name: _____

Patient Rights:

• I have the right to revoke this authorization at any time.
• I understand this authorization will remain in effect until revoked by the authorizing patient.
• I may inspect or copy the protected health information (HIPAA) to be disclosed as described in this document.
• Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
• Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
• I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

By Initialing I acknowledge email and/or text communication, may not be sent in an encrypted manner.

(Initials) _____

Consent of Transmission of Protected Health Information by Email and Text Message

I consent to the transmission the following protected health information related to my health records, insurance billing and healthcare treatment - Information related to the scheduling of meetings or other appointments, information related to billing and payment, completed forms, including forms that may contain sensitive confidential information, information of clinical nature, including discussion of personal material relevant to my treatment, my health record, in part or in whole, or summaries of material from my health record. I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I also understand that I may terminate this authorization at any time in writing. I verify that I have read and understand the above policy.

Signature of Patient or Responsible Party: _____ Date: _____

Patient Financial & Appointment Policy and Agreement

This financial policy is an agreement between Southeast Smiles and you, the patient. By signing below, you are acknowledging that you understand the following policy and agree to pay for all services that are received.

All estimated treatment plan portions and deductibles must be paid at the time of service. These payments are part of your contract agreement with your dental insurance plan and it is our responsibility to collect payments of these amounts when services are rendered. Additionally, full payment is due at time of service for all patients who do not have insurance.
Your dental insurance policy is a contract between you and the insurance company. You must provide us with a current insurance card and billing information prior to each visit. Ensuring that we have the correct insurance information will help prevent claim problems and potential collection issues.

We will bill your insurance company and make every effort to ensure claims are promptly and correctly submitted. Occasionally, because of factors beyond our control, your insurance company may not reimburse us promptly. If payment is not received from your insurance company within 90 days, we will request payment in full from you. Any additional payments received from your insurance company after you have paid will be promptly refunded. If you are unable to keep your appointment, please let us know immediately so that we can offer the appointment to another patient. A fee of $50 will be assessed for standard appointments and $75 for operative appointments cancelled less than 48 hours of the scheduled time or failure to show at all for your scheduled appointment.

Patients with poor payment histories may have care terminated by Southeast Smiles or will be required to pay in full at the time of future visits whether they have insurance or not. We accept Visa, MasterCard, Discover, American Express, Care Credit, personal checks, money orders, as well as cash payments. If a check is returned for nonsufficient funds, a returned check fee of $30 will be added to your account.

Credit & Finance Charge Agreement: I understand that I am financially responsible for all charges regardless of third-party agreement. I agree to pay any deductible, coinsurance, co-pay or any service deemed a “non-covered benefit” by my insurance carrier at the time service is rendered. I understand that failure to pay outstanding balances in full within 90 days of the initial notification of the amount due will result incurred finance charges, submission to an outside collection agency, possible small claims court, as well as my dismissal as a patient from Southeast Smiles.
I have read this Patient Financial Policy and I understand and agree to its provisions:

Print Patients Name: _____

Signature of Patient or Responsible Party: _____ Date: _____