We are pleased to welcome you to our practice. Please take a few minutes to fill out these forms as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Date ____________ Home Phone (___)____________ Cell Phone (___) ____________

Name ______________________________ Preferred Name ____________
Last Name First Name Middle Initial

Address ____________ Soc. Sec. # ____________

City ____________ State ____________ Zip ____________

Sex ☐ M ☐ F Age______ Birthdate ____________ ☐ Married ☐ Widowed ☐ Single ☐ Minor ☐ Separated ☐ Divorced ☐ Partnered

Patient Employer/School ____________ Occupation ____________

Employer/School Address ____________ Employer/School Phone (___)____________

In case of emergency who should be notified? ____________ Phone (___) ____________

Whom may we thank for referring you? ____________

Primary Insurance

Person Responsible for Account ______________________________
Last Name First Name Middle Initial

Relation to Patient ____________ Birthdate____________ Soc. Sec. # ____________

Address (If different from patient's) ____________ Phone (___) ____________

City ____________ State ____________ Zip ____________

Person Responsible Employed By ____________ Occupation ____________

Business Address ____________ Business Phone (___)____________

Insurance Company ____________ Insurance Company's Phone #____________

Names of other dependents covered under this plan ____________

Additional Insurance

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name ____________ Relation to Patient ____________ Birthdate ____________

Address (If different from patient's) ____________ Phone (___) ____________

City ____________ State ____________ Zip ____________

Person Responsible Employed By ____________ Occupation ____________

Business Address ____________ Business Phone (___)____________

Insurance Company ____________ Insurance Company's Phone #____________

Names of other dependents covered under this plan ____________

Dental & Medical History

Reason for Today's Visit ______________________ Date of last dental care ______________________

Former Dentist ______________________ Date of last dental X-rays ______________________

Check (✓) if you have had problems with any of the following:

- ☐ Clicking or popping jaw
- ☐ Food collection between teeth
- ☐ Loose teeth or broken fillings
- ☐ Sores or growths in your mouth
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Grinding teeth

How often do you floss? ______________________ How often do you brush? ______________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Question			
Are you under a physician's care now?	☐Yes	☐No	If yes, describe: ______________
Have you had any serious illnesses/operations?	☐Yes	☐No	If yes, describe: ______________
Have you ever had a serious head/neck injury?	☐Yes	☐No	If yes, describe: ______________
Are you taking any medications?	☐Yes	☐No	If yes, describe: ______________
Have you taken Phen-Fen or Redux?	☐Yes	☐No	______________
Are you on a special diet?	☐Yes	☐No	______________
Do you use tobacco?	☐Yes	☐No	
Do you use controlled substances?	☐Yes	☐No	

Women: Are you

Pregnant/Trying to get pregnant? ☐Yes ☐No

Taking oral contraceptives? ☐Yes ☐No Nursing? ☐Yes ☐No

Are you allergic to any of the following?

Aspirin ☐Yes ☐No Penicillin ☐Yes ☐No Codeine ☐Yes ☐No Acrylic ☐Yes ☐No Metal ☐Yes ☐No

Latex ☐Yes ☐No Local Anesthetics ☐Yes ☐No ☐ Other (Please describe): ______________

Do you have, or have had, any of the following?

Condition		Condition		Condition	
AIDS/HIV Positive	☐Yes ☐No	Excessive Bleeding	☐Yes ☐No	Lung Disease	☐Yes ☐No
Alzheimer's Disease	☐Yes ☐No	Excessive Thirst	☐Yes ☐No	Mitral Valve Prolapse	☐Yes ☐No
Anaphylaxis	☐Yes ☐No	Fainting Spells / Dizziness	☐Yes ☐No	Pain in Jaw Joints	☐Yes ☐No
Anemia	☐Yes ☐No	Frequent Cough	☐Yes ☐No	Parathyroid Disease	☐Yes ☐No
Angina	☐Yes ☐No	Frequent Diarrhea	☐Yes ☐No	Psychiatric Care	☐Yes ☐No
Arthritis / Gout	☐Yes ☐No	Frequent Headaches	☐Yes ☐No	Radiation Treatments	☐Yes ☐No
Artificial Heart Valve	☐Yes ☐No	Genital Herpes	☐Yes ☐No	Recent Weight Loss	☐Yes ☐No
Artificial Joint	☐Yes ☐No	Glaucoma	☐Yes ☐No	Renal Dialysis	☐Yes ☐No
Asthma	☐Yes ☐No	Hay Fever	☐Yes ☐No	Rheumatic Fever	☐Yes ☐No
Blood Disease	☐Yes ☐No	Heart Attack / Failure	☐Yes ☐No	Rheumatism	☐Yes ☐No
Blood Transfusion	☐Yes ☐No	Heart Murmur	☐Yes ☐No	Scarlet Fever	☐Yes ☐No
Breathing Problem	☐Yes ☐No	Heart Pace Maker	☐Yes ☐No	Shingles	☐Yes ☐No
Bruise Easily	☐Yes ☐No	Heart Trouble / Disease	☐Yes ☐No	Sickle Cell Disease	☐Yes ☐No
Cancer	☐Yes ☐No	Hemophilia	☐Yes ☐No	Sinus Trouble	☐Yes ☐No
Chemotherapy	☐Yes ☐No	Hepatitis A	☐Yes ☐No	Spina Bifida	☐Yes ☐No
Chest Pains	☐Yes ☐No	Hepatitis B or C	☐Yes ☐No	Stomach / Intestinal Disease	☐Yes ☐No
Cold Sores / Fever Blisters	☐Yes ☐No	Herpes	☐Yes ☐No	Stroke	☐Yes ☐No
Congenital Heart Disorder	☐Yes ☐No	High Blood Pressure	☐Yes ☐No	Swelling Limbs	☐Yes ☐No
Convulsions	☐Yes ☐No	Hives or Rash	☐Yes ☐No	Thyroid Disease	☐Yes ☐No
Cortisone Medicine	☐Yes ☐No	Hypoglycemia	☐Yes ☐No	Tonsillitis	☐Yes ☐No
Diabetes	☐Yes ☐No	Irregular Heartbeat	☐Yes ☐No	Tuberculosis	☐Yes ☐No
Drug Addiction	☐Yes ☐No	Kidney Problems	☐Yes ☐No	Tumors or Growths	☐Yes ☐No
Easily Winded	☐Yes ☐No	Leukemia	☐Yes ☐No	Ulcers	☐Yes ☐No
Emphysema	☐Yes ☐No	Liver Disease	☐Yes ☐No	Venereal Disease	☐Yes ☐No
Epilepsy or Seizures	☐Yes ☐No	Low Blood Pressure	☐Yes ☐No	Yellow Jaundice	☐Yes ☐No

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes, please describe: ______________

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or my 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 ____________

FOR OFFICE USE ONLY REVIEWED BY: DATE:

LOUIS B. DANG, D.D.S.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse To Sign This Acknowledgement****

I, ____ have received a copy of this office's "Notice of Privacy Practices" and "Dental Materials Fact Sheet".

____
Signature (Parent/Guardian)

____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please specify)

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Southport Dentistry

Louis B. Dang, D.D.S.

Financial Policy

It is our office policy that all accounts are paid in full at the time services are rendered. As a courtesy to you, we will bill your insurance carrier. **We require that your estimated portion for treatment be paid at the time that the treatment is rendered.** Please keep in mind that you are responsible for your total obligation should your insurance benefits result in less coverage than anticipated. If your insurance carrier does not remit payment within 60 days, the balance will be due in full by you. We will continue to follow up with your insurance carrier and help you in any way possible to collect from them.

Any returned personal checks will be assessed a $25 fee in addition to any bank charges that we incur.

A billing charge of $2.00 will be charged to your monthly balance for accounts that are 60 days past due. Accounts that are past due after repeated attempts for collection may be pursued by a collection agency.

Cancellations/Failed Appointments: Appointment time is reserved solely for you. If you are unable to keep your appointment, we request that you give us the courtesy of a minimum of 24 hours notice so that we may offer this time to another patient. If you fail to keep an appointment, a $25 fee may be charged to your account.

I fully understand and agree to the terms of this financial policy. By signing below, I am authorizing the use of my signature on all insurance submissions (if applicable).

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Signature (Parent/Guardian if patient is a minor) Date