SOUTHDALE DENTAL ASSOCIATES

ABOUT YOU

Name:_____Nickname:_____ Female Male

Address:_____

City:_____State:_____Zip:_____

Cell:_____Work:_____Home:_____

Birth Date:_____/_____/_____Marital Status: Single Married Widowed Partnered Divorced Separated

Email Address:_____

Name of Spouse:_____

Names of Children:_____

Who may we thank for referring you?_____

How do you enjoy spending your free time?_____

EMERGENCY INFORMATION

Person to contact:_____Relationship:_____

Phone:_____ I give permission for Southdale Dental Associates to release my protected health information to the above person.

DENTAL INSURANCE INFORMATION

Primary Insurance Company:_____
Address:_____
Phone:_____
Name of Policy Holder:_____
Relation to Policy Holder:_____
Policy Holder DOB:_____/_____/_____
Policy Holder's Employer:_____
Subscriber ID Number:_____
Group Number:_____

Secondary Insurance Company:_____
Address:_____
Phone:_____
Name of Policy Holder:_____
Relation to Policy Holder:_____
Policy Holder DOB:_____/_____/_____
Policy Holder's Employer:_____
Subscriber ID Number:_____
Group Number:_____

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SOUTHDALE DENTAL ASSOCIATES

MEDICAL HISTORY

Are you under a physician's care now? Yes No If yes:_____

Have you ever been hospitalized or had a major operation? Yes No If yes:_____

Have you ever had a serious head or neck injury? Yes No If yes:_____

Please list all medications you are currently taking:_____

Have you been instructed to take premedication prior to dental procedures? Yes No If yes:_____

Have you ever taken Fosamax, Boniva, Actonel, or any bisphosphonates? Yes No If yes:_____

Do you use tobacco, e-cigarettes, or vaping products? Yes No Do you use controlled substances? Yes No

Women: Are you.... Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex
Sulfa Drugs Local Anesthetics Other?_____

Do you snore loudly (louder than talking or loud enough to be heard through closed doors)? Yes No

Do you often feel tired, fatigued, or sleepy during daytime? Yes No

Has anyone observed you stop breathing during your sleep? Yes No

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

AIDS/HIV Positive. . . . . Yes No	Cortisone Medicine. . . . . Yes No	Heart Trouble/Disease. Yes No	Renal Dialysis. . . . . Yes No
Alzheimer's Disease. . . . . Yes No	Diabetes Type_____ Yes No	Hemophilia. . . . . Yes No	Rheumatic Fever. . . . . Yes No
Anaphylaxis/Hives/Rash. . Yes No	Drug Addiction. . . . . Yes No	Hepatitis A. . . . . Yes No	Rheumatoid Arthritis . . . . . Yes No
Anemia. . . . . Yes No	Emphysema. . . . . Yes No	Hepatitis B or C. . . . . Yes No	Scarlet Fever. . . . . Yes No
Angina. . . . . Yes No	Epilepsy or Seizures. . . . . Yes No	High Blood Pressure. . Yes No	Shingles. . . . . Yes No
Arthritis/Gout. . . . . Yes No	Excessive Bleeding/Bruising. . . . . Yes No	High Cholesterol. . . . . Yes No	Sickle Cell Disease. . . . . Yes No
Artificial Heart Valve. . . . . Yes No	Excessive Thirst. . . . . Yes No	Hypoglycemia. . . . . Yes No	Sinus Trouble. . . . . Yes No
Artificial Joint. . . . . Yes No	Fainting/Dizziness. . . . . Yes No	Irregular Heartbeat. . Yes No	Sleep Apnea. . . . . Yes No
Asthma. . . . . Yes No	Frequent Cough. . . . . Yes No	Kidney Problems. . . . . Yes No	Spina Bifida. . . . . Yes No
Blood Disease. . . . . Yes No	Frequent Diarrhea. . . . . Yes No	Leukemia. . . . . Yes No	STD/HPV. . . . . Yes No
Blood Transfusion. . . . . Yes No	Frequent Headaches. . . . . Yes No	Liver Disease. . . . . Yes No	Stomach/Intestinal Disease. . Yes No
Breathing Problems. . . . . Yes No	Glaucoma. . . . . Yes No	Low Blood Pressure. . Yes No	Stroke. . . . . Yes No
Cancer. . . . . Yes No	Hay Fever. . . . . Yes No	Lung Disease. . . . . Yes No	Swelling of Limbs. . . . . Yes No
Chemotherapy. . . . . Yes No	Heart Attack/Failure. . . . . Yes No	Osteoporosis. . . . . Yes No	Thyroid Disease. . . . . Yes No
Chest Pains. . . . . Yes No	Heart Murmur/Mitral Valve Prolapse . . . . . Yes No	Pain in Jaw Joints. . . . Yes No	Tonsillitis. . . . . Yes No
Cold Sores/Fever Blisters. Yes No	Heart Pacemaker. . . . . Yes No	Psychiatric Care. . . . . Yes No	Tuberculosis. . . . . Yes No
Congenital Heart Disorder Yes No		Radiation Treatments. Yes No	Tumors or Growths. . . . . Yes No
		Recent Weight Loss. . . . Yes No	Ulcers. . . . . Yes No

Have you ever had a serious illness not listed above? Yes No If yes:_____

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 patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Patient Signature:_____ Date:_____

SOUTHDALE DENTAL ASSOCIATES

Patient Name:_____

DENTAL HISTORY

On a scale of 1 to 5 (1 low/poor, 5 high/good) please rate:

How do you feel about your overall dental health:. 1 2 3 4 5

Over the last ten years rate how often have you had your teeth cleaned:. 1 2 3 4 5

What is your level of sensitivity to dental procedures?:. 1 2 3 4 5

How do you feel about your smile and the look of your teeth:. 1 2 3 4 5

Date of your last dental hygiene visit? _____/_____/_____

Have you ever been treated for gum disease? Yes No If yes, when?_____

What is the main reason for your visit today?

Tooth Pain I need a check-up Cleaning

Whitening Cosmetic Dentistry Other_____

Do you have any missing teeth? Yes No If so, are you interested in replacing the missing teeth?_____

Have you ever been treated for TMJ pain? Yes No

Do you snore? Do you have sleep apnea? Yes No

Do you suffer from: Tension Headaches Migraine Headaches Muscle Tenderness in jaw

I would like to learn more about:

Whitening Cosmetic Dentistry Dental Implants Veneers

Orthodontics Night Guards

Is there additional information we need to meet your dental health goals?_____

_____

_____

SOUTHDALE DENTAL
ASSOCIATES

Authorization to Transfer Records

A patient's records are confidential. Please complete this form as an authorization to release your dental records.

DATE:_____

NAME:_____

DOB:_____

ADDRESS:_____

Previous Dentist Information:

NAME:_____

PHONE NUMBER:_____

Authorization to transfer and/or copy records on the following persons:

1._____

2._____

3._____

4._____

SIGNATURE:_____

Please send full-mouth x-ray series, panorex, bitewings, and periodontal charting to:

Southdale Dental Associates

7373 France Avenue South Suite 600

Edina, MN 55435

(P)952.896.1111 (F) 952.253.9271

records@sdadental.com

SOUTHDALE DENTAL
ASSOCIATES

Patient Name:_____

_____ **Appointment Reservations**
Initials

At Southdale Dental Associates we recognize that in today's busy world, adhering to a schedule is important in order to maximize time and meet the demands of daily life. Our goal is to provide quality care in a timely manner. With this in mind, we have implemented a missed/cancellation policy which enables us to better utilize available appointments for our patients.

A missed appointment (no show) is someone who misses an appointment without canceling/rescheduling in advance. A late cancellation is a change made to a scheduled appointment without 48 hour advance notice.

Missed appointments, late cancellations, and late arrivals are disruptive to our schedule and other patients. Please be courteous and call Southdale Dental Associates promptly if you are unable to make an appointment. This time will be reallocated to someone who is in urgent need of treatment.

A fee of $50 may be charged to the patient for missed appointments and for late cancellations. This fee is not covered by your insurance and it will be required to be paid in full before scheduling your next visit.

We reserve the right to dismiss patients from our practice after two missed/canceled appointments in a twelve month period. New patients that miss/cancel appointments are also held to this policy.

_____ **Financial Policy**
Initials

I understand that I am responsible for all charges incurred for services provided including any/all cost of collection fees up to 33%. I understand there will be a service charge of 1.5% per month or 18% annually on any account balance over ninety days past due. If I have insurance, I authorize, to the extent permitted under applicable law, release of information and submission to the insurance company on file and authorize direct payment to Southdale Dental Associates.

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SOUTHDALE DENTAL
ASSOCIATES

HIPAA
I have been informed and may request at any time a copy of this office's Notice of Privacy Practices. Southdale Dental's Notice of Privacy Practices is available at our front desk and also on our website www.sdadental.com.

NOTE: A parent or legal guardian is considered a personal representative for a minor under the HIPAA privacy regulations.

Family & Friends: It is the office policy not to release confidential protected health information regarding your treatment to family members or friends, except for (1) parent/legal guardian, (2) other persons authorized by the patient, (3) as we may reasonably infer from circumstances (for example, if you bring a family member or friend into the treatment room, we will assume, unless you object, that the person is entitled to receive information regarding your treatment), (4) in emergency situations, or (5) as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Request for Access: I understand that I may request Southdale Dental Associates to transmit my protected health information. I have been advised that there are potential security risks to my PHI being released from the practice and that Southdale Dental Associates is not liable for any potential security risks such as unauthorized disclosures of PHI. Southdale Dental Associates is not liable for what happens to the PHI once the designated party receives the information as directed by my access request. By signing this document I accept the risk of my PHI being sent as directed.

Communication

If you anticipate that you will need or want your information to be provided to family members, friends, or caregivers/babysitters, please indicate that below, so that we may best serve you. By signing below, you authorize the following persons to receive information as requested, regarding your care and treatment. If you wish to cancel or change this agreement, please issue in writing to this practice.

Name:_____ Relationship:_____

Phone Number:_____

Name:_____Relationship:_____

Phone Number:_____

Signature:_____**Date:**_____