SWOSA
SOUTHWEST ORAL SURGICAL ARTS
WISDOM TEETH, PERIODONTAL & DENTAL IMPLANT CENTER

Procedure Information

First Name: _____ M.I.: _____ Last Name: _____

Preferred Name: _____ Date of Birth: _____

Email: _____ Gender: _____

Referring Dentist: _____ Marital Status: ☐ Single ☐ Married ☐ Child

Home Phone: _____ Cell Phone: _____

Mailing Address: _____ City: _____ State: _____ ZIP: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Responsible Party: _____ Relationship: _____ Phone: _____
(If patient is under 18 years old)

Dental Insurance: ☐ Yes ☐ No **Please present insurance information prior to being seen.**

Insurance Company: _____ Name of Subscriber: _____

Date of Birth: _____ Social Security Number: _____ Employer: _____

Medical History

Have you been told that you need to PREMEDICATE prior to dental appointments?: ☐ Yes ☐ No

PLEASE INFORM PROVIDER IF YOU ARE PREGNANT.

Do you have history of any of the following?

- ☐ Single
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Bleeding Problem/Anemia
- ☐ Cancer
- ☐ Diabetes HbA1c
- ☐ Drug Abuse Treatment
- ☐ Dry Mouth
- ☐ Hearing Loss
- ☐ Heart Attack or Heart Disease
- ☐ Hepititis
- ☐ Herpes (fever blisters)
- ☐ High Blood Pressure
- ☐ Kidney Problems
- ☐ Nervous/Anxiety
- ☐ Osteoporosis
- ☐ Mental Health Condition
- ☐ Pace Maker
- ☐ Seizures/Epilepsy
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ TMJ
- ☐ Tobacco Use
- ☐ Tuberculosis
- ☐ Ulcers

Please List All Medications That You Are Taking:

_____

_____

Allergic reaction to drugs or latex (circle all that apply)

Asprin Codeine Ibuprofen Latex Local Anesthetics Metal Penicillin Other: _____

Acknowledgment and Consent

Health History
I understand that providing incorrect information can be dangerous to my health. I certify that I have read, understood, and completed the Health History Questionnaire fully and accurately to the best of my ability.

Release of Information
I understand that the dentist may need to call to collaborate with other healthcare providers and/or third-party payers in order to provide the best standard of care for me. I authorize the dentist to release any necessary information, including the diagnosis and the records of any treatment or exam rendered to me or my dependent during the period of dental care to third-party payers and/or other health care providers related to my care.

Financial Policies
I understand that SWOSA gladly accepts dental insurance. In order to prevent any future misunderstandings, disagreements, or disappointments, it is vital that our patients understand our relationship with insurance companies. In the event that your insurance company refuses payment for services rendered, you will be responsible for payment in full. A denial from your insurance does not release you from your financial obligation to us. Every attempt will be made to help you get the proper benefit, but ultimately the final decision rests with your insurance provider.

I understand that the dental office will make every effort to give me accurate estimates of what I will owe for each visit, and that they cannot guarantee exactly what my insurance will pay. I understand that if I have dental insurance, this is a contract between the insurance company and myself, and is ultimately my responsibility, not the dental office's responsibility.

I understand that if any balance remains after my insurance company has paid a claim, I will receive a statement from the dental office for this, and I am expected to pay in full within 15 days of receiving this statement. A late fee of 18% of the total balance or $25.00 (whichever is greater) will be applied to balances over 30 days.

I understand that I am expected to pay what is due for my treatment when I receive it.

I agree to be responsible for timely payment for all services rendered on my behalf or my dependent's behalf. I agree to be ultimately responsible for all charges on my account which have been applied in accordance with established office policy.

I understand that if my account remains unpaid, it may be transferred to a collections agency.

I understand that my account will be charged a $50.00 fee for any dishonored check and that I am expected to pick up the check and pay the balance and subsequent fees in cash.

I understand that these policies may be superseded by a written and signed agreement of an alternate policy specific to my account.

Rescheduling and Cancellation Policies
I understand that if I need to reschedule an appointment, or cannot keep an appointment, I must give 24 hours' notice to a staff member. If I do not give adequate notice, my account will be charged a $50.00 cancellation fee.

I understand that if I fail or cancel more than 3 consecutive appointments without appropriate notice, my active patient status will be reduced to emergency status, and I will be advised to seek an alternate dental provider.

Privacy Practices
I acknowledge receipt of Privacy Practices Notice (HIPAA) available upon request.

Printed patient name (or parent/guardian if minor): _____ Date: _____

Signature of patient (or parent/gaurdian if minor): _____ Date: _____

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Medical Information Release Form (HIPAA Release Form)

Name: _____ Date of Birth: _____

Release Of Information

☐ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

- ☐ Spouse: _____
- ☐ Child(ren): _____
- ☐ Other: _____

☐ Information is not to be released to anyone

This **Release Of Information** will remain in effect until terminated by me in writing.

Messages

Please call: ☐ my home ☐ my work ☐ my cell number: _____

If unable to reach me:

- ☐ you may leave a detailed message
- ☐ please leave a message asking me to return your call
- ☐ _____

The best time to reach me is (day): _____ between(time): _____

Signed: _____ Date: _____

Witness: _____ Date: _____