Welcome to Southside Dental Care!

Thank you for choosing Southside Dental Care and Dr. Walters as your dental provider. We look forward to working with you.

As per our conversation, attached is a copy of our New Patient paperwork that we need you to complete and sign. Please bring completed forms to your appointment and plan to arrive 10 minutes prior to your scheduled time. If you are unable to fill the forms out beforehand please arrive 20 minutes early.

Please read the financial and cancellation policy and be sure to sign.

If you have dental insurance your claims will be filed as a courtesy, however, **any charges not covered by your insurance are due at the time of service.**

We check your insurance *before* your appointment so it is important that we have accurate information for dental. It is your responsibility to keep us informed of any changes in dental insurance.

Name of Employer
Subscriber on card and their date of birth
Subscriber ID#
Group#
Dental telephone #
Dental Claims mailing address

****Children under age of 14 need to be accompanied by an adult****
****Dependents coming without a parent/guardian need to send payment with them to their appointments.

Thank you again and we look forward to meeting you!

SOUTHSIDE DENTAL CARE, INC. P.S.
1215 Old Fairhaven Parkway, Suite A
Bellingham, WA 98225
360-752-9000
Email: Southsidedental@msn.com

PERSONAL INFORMATION

NAME: _____ DATE: _____
ADDRESS: _____ CITY: _____ ZIP: _____
HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____
E-MAIL ADDRESS: _____ BIRTHDATE: _____
SOCIAL SECURITY: _____ OCCUPATION: _____
EMPLOYER: _____ REFERRED BY: _____
SPOUSE OR NEXT OF KIN: Name: _____ Relationship: _____
Address: _____ Phone: _____

PERSON RESPONSIBLE FOR PAYMENT (If other than yourself)

ACCOUNT NAME: _____
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
HOME PHONE: _____ CELL PHONE: _____
SOCIAL SECURITY: _____ BIRTHDATE: _____
EMPLOYER IF APPLICABLE: _____

PRIMARY DENTAL INSURANCE

SUBSCRIBER'S NAME: _____ RELATION: _____
EMPLOYER: _____ CONTACT: _____
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
INSURANCE COMPANY: _____ PHONE: _____
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
PLAN#: _____ GROUP#: _____ UNION# _____
SUBSCRIBER ID: _____ BIRTHDATE: _____

SECONDARY INSURANCE (if applicable)

SUBSCRIBER'S NAME: _____ RELATION: _____
EMPLOYER: _____ CONTACT: _____
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
INSURANCE COMPANY: _____ PHONE: _____
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
PLAN#: _____ GROUP#: _____ UNION# _____
SUBSCRIBER ID: _____ BIRTHDATE _____

Health History

Name of Patient (Printed) _____**Today's Date**_____

Physician _____**Dr's Phone No** _____**Date of last medical visit**_____

Pharmacy _____**Phone #**_____

Do you have, or have you had, any of the following? (Please check)

__Hepatitis-Type A_B_C_
__Heart Trouble
__Stroke
__Tuberculosis
__Diabetes
__Pacemaker/AICD
__HIV Positive
__Jaundice
__High Blood Pressure
__Rheumatic Fever
__Prolonged Bleeding
__Epilepsy/Seizure
__Sinus Trouble
__Kidney Trouble
__Herpes
__Anemia
__Arthritis
__Tumor
__Allergies
__Ulcer
__Asthma
__Psychiatric Treatment
__Drug Addiction
__Alcoholism
__X-ray/Cobalt Treatment
__Chemotherapy
__Artificial Joint/Prosthesis
__Heart Murmur
__Surgeries_____
__Screws or Plates
__Artificial Heart Valve
__TMJ Problems
__Anxiety/Panic Disorder
__Claustrophobia
__Other_____

Has anyone ever told you to take antibiotic pre-medication prior to dental treatment? _____Yes _____No
If yes, please explain _____

How is your general health? Good _____Fair _____Poor_____

Are you pregnant? _____**Month**_____

Do you use tobacco products? _____

Are you presently under the care of a physician? _____Yes _____No
If yes, explain_____

_____

Please list any medications or supplements you are using_____

_____

Are there any medications that you are allergic to or have had adverse reactions to? _____

_____

I have completed the above health history and to the best of my knowledge have answered all questions correctly.

Signature _____Date_____

Signature of guardian if patient is child or dependent adult
_____ Date_____

Signature of DDS_____

DENTAL HISTORY

Patient Name _____ **Date** _____

What is your immediate concern? _____
_____

Personal Dental History
When was your last dental visit? _____
Name of previous dentist _____
Are you fearful of dentistry? A lot, a little, not at all
Have you ever had a bad dental experience? _____Yes _____No
Have you ever had complications from past dental treatment? _____Yes _____No
Have you ever had trouble getting numb or a bad reaction to getting numb? _____Yes _____No
Did you have braces? _____Yes _____No

Smile Characteristics
How do you feel the condition of your teeth are? _____
Are you happy with the appearance of your teeth? _____Yes _____No
Are you interested in whitening your teeth? _____Yes _____No
Do you have any silver (mercury) dental fillings that you would like replaced with more modern tooth colored materials?
_____Yes _____No
Do you have any old crowns or discolored dental work that you would like replaced? _____Yes _____No

Bite and Jaw Joint
Does your jaw ever hurt? _____Yes _____No
Are your teeth starting to chip or wear down? _____Yes _____No
Do you think you grind or clench your teeth? _____Yes _____No
Do you wear a night guard? _____Yes _____No

Tooth Structure
How long since your last filling or crown? _____
Are you getting food stuck between any of your teeth? _____Yes _____No
Do any of your teeth hurt to chew on? _____Yes _____No

Gum and Bone
How many times a day do you brush your teeth? _____
Do you use an electric toothbrush? _____Yes _____No
How often do you floss? _____
Are your gums red, puffy or do they bleed? _____Yes _____No
Have you ever been told you have gum disease or had a deep cleaning? _____Yes _____No

Patient's Signature _____
Dr.'s Signature _____

FINANCIAL POLICY

DENTAL INSURANCE

Payment of estimated non-insured charges is due at the time of service. We are happy to file the necessary forms to see that you receive the full benefit of your insurance coverage. The insurance policy, however, is a contract between you and your insurance company and you are responsible to know your policy. You will be directly responsible for all charges not paid for by insurance within 60 days of your treatment.

PATIENTS WITHOUT INSURANCE

Payment is due at the time of service. We understand that every person's financial situation is different. For this reason, we have worked hard to provide a variety of payment options to help you receive the dental care needed to enjoy a healthy and confident smile with respect to your budget.

We accept:

CASH OR CHECK

DEBIT OR CREDIT CARDS – Payment is gladly accepted by VISA, MASTERCARD, DISCOVER, & AMERICAN EXPRESS.

CARE CREDIT – 6 and 12 months interest free options. Low fixed rate for extended monthly payments.

With each of our patients our goal is to help you enjoy the benefits of good oral health. With proper care, you may be able to have strong teeth and gums, a healthy and attractive smile, and keep your own natural teeth throughout your lifetime.

Patient or Guardian Signature _____Date_____

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits to be paid directly to the dentist. I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCES NOT PAID BY INSURANCE WITHIN 60 DAYS. I also authorize Southside Dental Care to release any information required for payment of my claims.

Policyholder Signature_____

SOUTHSIDE DENTAL CARE, INC. P.S.

Cancellation/Missed Appointment Policy

Our goal is to provide quality dental care in a timely manner. In order to do so, we are enforcing our appointment/cancellation policy that has been in effect since 1997. This policy enables us to better utilize available appointments for all of our patients.

In order for us to keep our level of service, we ask our patient's to give 2 business days notice to change or cancel appointments. Our office hours are Tuesday-Thursday 8-5 (Tuesdays June-August 8-3) and Friday's 7-2.

We would like you to understand how our schedule works. When you make an appointment, the time is reserved specifically for you. When patient's cancel without sufficient notice three things happen...

1. Your treatment is delayed, which in some cases can cause further complications.

2. The doctor and staff have to wait for the next scheduled patient to arrive before they can resume work.

3. Our provider's times are highly requested and when someone cancels short notice it is difficult to schedule a patient waiting to get in at the last minute.

We understand there are times when it is unavoidable to cancel an appointment, and your call before the appointment is appreciated. For the reasons stated above, however, **there will be a charge for appointments cancelled with less than sufficient notice.**

Failure to give adequate notice will result in a fee of $50 for every 30 minutes of scheduled time with a minimum fee of $50.

In the interest of conserving our patients time, we will try to complete treatment in as few visits as possible and make every effort to stay on schedule. We feel that your time is valuable and with the exception of emergency treatment of another patient, you can expect us to be prompt.

Patient/Guardian Signature X_____Date:_____

Southside Dental Care, Inc., PS Bellingham, Washington 98225

Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Southside Dental Care, Inc., PS. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Southside Dental Care, Inc., PS reserves the right to change the privacy practices currently described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed or otherwise transmitted to me.

ADDITIONAL DISCLOSURE AUTHORIZATION		
In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare Information to the person(s) identified below. (I understand that the default answer is "NO" Without indicating "YES" in answer to the each individual question, personal protected (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)		
Spouse only	YES	NO
Any Member of my immediate family: (Spouse, Children, Children's Spouses)	YES	NO
Any Member of my extended family: (Parents, Grandchildren)	YES	NO
Other:	YES	NO
Name of patient (please print):		
PATIENT SIGNATURE (REQUIRED):		
Guardian **Name and phone number** if applicable: (please print)		
Guardian Signature:		
Today's Date:		

OFFICE USE ONLY BELOW THIS LINE

Acknowledgement Not Obtained			
Provided Prior to Treatment?	YES	NO	Date Statement Provided:
Reason for not obtaining		Needed more time to review Statement of Privacy Practices	
		patient signature Wanted to consult another person before signing	
		Physically unable to sign	
		No reason offered	
		Other:	

Full Disclosure of SSDC Privacy Practices available at www.southsidedentalcare.com