SOUTH WESTERN DENTAL

PATIENT INFORMATION DATE_____

PATIENT_____ ___ ___ BIRTHDATE_____ SOC. SEC. #_____
FIRST MI LAST M F

ADDRESS_____ CITY_____ STATE_____ ZIP_____

HOME PHONE _____ CELL _____ EMAIL_____

COMMUNICATION PREFERENCES - CHECK ALL THAT APPLY: TEXT MESSAGES ____ EMAILS ____ PHONE CALLS ____

CHECK APPROPRIATE: ____MINOR ____SINGLE ____MARRIED ____DIVORCED ____WIDOWED ____SEPARATED

PATIENT'S EMPLOYER_____ WORK PHONE_____

PERSON TO CONTACT IN CASE OF AN EMERGENCY_____ PHONE(S) _____

HOW DID YOU HEAR ABOUT US?_____

SPOUSE OR PARENT'S NAME_____ SPOUSE'S EMPLOYER _____ SPOUSE'S WORK PHONE_____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT_____ RELATIONSHIP TO PATIENT_____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

HOME PHONE _____ CELL PHONE_____ BIRTHDATE_____ SOC. SEC. #_____

NAME OF EMPLOYER_____ WORK PHONE _____

DO YOU HAVE DENTAL INSURANCE? ____ YES ____ NO **IF YES, COMPLETE THE FOLLOWING:**

FAMILY COVERAGE ____ OR SINGLE COVERAGE ____

POLICYHOLDER_____ RELATIONSHIP TO PATIENT_____

POLICYHOLDER'S ADDRESS: _____

BIRTHDATE_____ SOC. SEC. #_____ NAME OF EMPLOYER_____ WORK PHONE _____

INSURANCE COMPANY_____ ID# _____ GROUP#_____

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE? ____ YES ____ NO **IF YES, COMPLETE THE FOLLOWING:**

FAMILY COVERAGE ____ OR SINGLE COVERAGE ____

POLICYHOLDER_____ RELATIONSHIP TO PATIENT_____

POLICYHOLDER'S ADDRESS: _____

BIRTHDATE_____ SOC. SEC. #_____ NAME OF EMPLOYER_____ WORK PHONE _____

INSURANCE COMPANY_____ ID# _____ GROUP#_____

We ask that your fees be paid at each appointment. We accept cash, personal checks, money orders, VISA, MC, and Discover. Please advise our business staff if you would like to apply for outside financing. Charges not paid within 60 days will have a service charge of 1.5% per month (Annual Rate of 18%)

_____

SIGNATURE

PLEASE COMPLETE BACK SIDE OF THIS FORM ALSO (OVER)

SOUTH WESTERN DENTAL

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

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.

INJURIES / MEDICATIONS / ALLERGIES

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

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

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

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____

Are you on a special diet? ◯ Yes ◯ No

Do you use tobacco? ◯ Yes ◯ No

Women: Are you ☐ Pregnant or trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Sulfa Drugs

☐ Other If yes, please explain: _____

Do you use controlled substances? ◯ Yes ◯ No

ILLNESSES / CONDITIONS

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

☐ AIDS/HIV Positive	☐ Chest Pains	☐ Frequent Headaches	☐ Hypoglycemia	☐ Rheumatic Fever
☐ Alzheimer's Disease	☐ Cold Sores/Fever Blisters	☐ Genital Herpes	☐ Irregular Heartbeat	☐ Rheumatism
☐ Anaphylaxis	☐ Congenital Heart Disorder	☐ Glaucoma	☐ Kidney Problems	☐ Scarlet Fever
☐ Anemia	☐ Convulsions	☐ Hay Fever	☐ Leukemia	☐ Shingles
☐ Angina	☐ Cortisone Medicine	☐ Heart Attack/Failure	☐ Liver Disease	☐ Sickle Cell Disease
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur	☐ Low Blood Pressure	☐ Sinus Trouble
☐ Artificial Heart Valve	☐ Drug Addiction	☐ Heart Pacemaker	☐ Lung Disease	☐ Spina Bifida
☐ Artificial Joint	☐ Easily Winded	☐ Heart Trouble/Disease	☐ Mitral Valve Prolapse	☐ Stomach/Intestinal Disease
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Osteoporosis	☐ Stroke
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Pain in Jaw Joints	☐ Swelling of Limbs
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Breathing Problem	☐ Excessive Thirst	☐ Herpes	☐ Psychiatric Care	☐ Tonsillitis
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ High Blood Pressure	☐ Radiation Treatments	☐ Tuberculosis
☐ Cancer	☐ Frequent Cough	☐ High Cholesterol	☐ Recent Weight Loss	☐ Tumors or Growths
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hives or Rash	☐ Renal Dialysis	☐ Ulcers
				☐ Venereal Disease
				☐ Yellow Jaundice

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: _____

COMMENTS

_____

_____

_____

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.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

SOUTHWESTERN DENTAL

Jon Ellenbecker DDS
Alicia Hansen DDS
Nicole Hartmann DDS
Tyson Ellenbecker DDS

Written Financial Policy

Thank you for choosing South Western Dental. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payments Options:

You can choose from the following:

- Cash, Check, Visa®, MasterCard®, or Discover Card®
- Convenient monthly payment options from CareCredit Health Credit Card (subject to credit approval)
  - Allow you to pay over time
  - No annual fees or pre-payment penalties

Please note:
South Western Dental requires payment in full at each visit.

For patients with dental insurance, we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment. However, if we do not receive payment from your insurance carrier within 60 days, you will be responsible for payment in full.
If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want and need.

Patient Name (Please Print)

Patient, Parent or Guardian Signature Date

South Western Dental

5201 S. Western Ave. • Sioux Falls, SD 57108 • Phone 605-339-2200 • Fax 605-334-5530

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient #: _____ Social Security #: _____

SECTION 6: TO THE PATIENT - PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before sighing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: **South Western Dental**

Telephone: **(605) 339-2200** Fax: **(605) 334-5530**

E-mail: **contactus@smilesbyswdental.com**

Address: **5201 S. Western Ave. Sioux Falls, SD 57108**

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Include completed Consent in the patient's chart.