PATIENT INFORMATION

Today's Date: __/__/___

Patient Name: _____

Preferred Name: _____

Birth date: __/__/____ **Age:** _____

Address: _____

_____

_____

Email: _____

Phone: Home: _____
Cell: _____
Work: _____

Gender: M/F

Marital Status: ☐Married ☐Widowed
☐Separated ☐Divorced ☐Single ☐ Minor

Social Security # _____

Occupation: _____

Employer: _____

IN CASE OF EMERGENCY, CONTACT

Name: _____
Relation: _____
Phone: Home: _____
Cell: _____
Work: _____

Whom May we thank for referring you?
Name: _____

DENTAL INSURANCE INFORMATION

Primary Insurance: _____
Subscriber's Name: _____
Subscriber's Employer: _____
Group/Plan #: _____
Subscriber's Birth date: _____
Subscriber's Social Security #: _____

Secondary Insurance: _____
Subscriber's Name: _____
Subscriber's Employer: _____
Group/Plan #: _____
Subscriber's Birth date: _____
Subscriber's Social Security #: _____

Assignment and Release: I certify that I, and/or my dependent(s) have insurance coverage with _____ and assign directly to Dr. Townsley all insurance benefits payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance claims. The above named dentist may use my health care information and may disclose such information to the above named insurance companies and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

By signing this document, I agree to give Dr. Townsley permission to distribute any relevant treatment or medical information to specialists that may be included in my treatment plan.

Responsible Party: (Print) _____ **Signature:** _____

Dr. Samuel Townsley, DDS
101 North Cedar Street
Foley, Al 36535
251-943-1521

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.

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
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 ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: _____

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

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

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

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 _____

townsley
family dentistry

101 N. Cedar Street
Foley, AL 36535
(251) 943-1521
info@townsleydental.com
www.townsleydental.com

ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

The undersigned acknowledges receipt of a copy of the current effective Notice of Privacy Practices for Dr. Samuel Townsley, DDS,

This _____day of _____, 20_____.

_____ _____

Please PRINT Name Please SIGN Name

If you are the legal representative of the patient, please print the name (s) and describe your relationship/authority_____

_____.

DISCLOSURE TO FAMILIES AND LOVED ONES (Emergency Contacts)

I authorize Dr. Samuel Townsley, DDS, to disclose my health care information and to discuss my health care needs to those that I designate. I further authorize the release of my billing information and give these individuals the ability to pick up prescriptions on my behalf. These individuals will be considered my emergency contacts. Without authorization, NO information may be shared. I authorize Dr. Samuel Townsley, DDS, to disclose my personal health information with the following people: **PLEASE PRINT**

NAME:	RELATIONSHIP:	PHONE#
NAME:	RELATIONSHIP:	PHONE#
NAME:	RELATIONSHIP:	PHONE#

Medicaid is a voluntary program. This means that you agree to be a part of Medicaid and to follow Medicaid's rules.

Some rules this office has:

- Treat others with respect and courtesy. This means showing respect to the doctor, staff and other patients/families in the waiting room.
- Show up to to your appointment on time.
- If you cannot make it to your appointment, we MUST HAVE A 48 HOUR NOTICE.
- Understanding and abiding by office policies.
- Do not bring food or drinks into the office.

These apply to any visitors/relatives who come with you or your child. If these rules are not followed, your doctor reserves the right to ask you (or your child) to go to another provider.

Acting rude, mean or threatening to the doctor or staff, may result in you losing your Medicaid privileges. This includes, but not limited to, fighting, using profanity, abusive words, carrying a weapon or being under the influence of drugs or alcohol.

If less than 24 hours' notice is given for any cancelation or no-show appointment will result in the patient and the family being dismissed from the practice. We take these appointments very serious as there are many children in need of care in our community.

Sign below if you understand all above information.

_____ _____

Signature Date

Operative Acknowledgment Form

Parents/Guardians:

In order for my child to be treated at South Baldwin Dental Associates,
I, _____, understand that parents/guardians are NOT ALLOWED back for treatment. This is done due to a medical procedure being performed on my child and allows for the best care to be provided.

AGREE: I understand and will comply with this office policy _____ (initials)

Collection Policy

All patient out of pocket expenses are expected on the date of service unless other arrangements have been made in advance. We do our best to ESTIMATE your out-of-pocket portion. The final determination is done when your insurance company finalizes their payments.

If the circumstance arises and you do not pay your balance owed, we do send our collection accounts to an outside source.

I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, all collection agency fees (33.3%), attorney fees and any court costs if necessary.

You agree South Baldwin Dental Associates may contact you via phone call, text or email in order to collect balance you may owe.

I have read and agreed upon that South Baldwin Dental Associates, its employees and agents may contact me as described above

_____ _____

Responsible Party Signature Date

Cancellation Policy

South Baldwin Dental Associates will make attempts to call, text, or email you to confirm your appointment. If you cannot make the appointment as scheduled, we ask that you notify us withing 2 business days of your set appointment. As of March 1, 2022, there will be a charge of $50 for any missed appointment or cancellation with less than 24 hours' notice.

In addition, if you do not confirm a scheduled appointment within 24 business hours, South Baldwin Dental Associates may choose to remove them from the schedule and consider it a missed or failed appointment.

_____ _____

Patient/Guardian Signature Date

Patient HIPPA Consent

I understand that as part of my healthcare, South Baldwin Dental Associates originates and maintains all necessary health records. I understand this information serves as:

- A basis for planning my care and treatment
- A means of communication among any health professionals contributing to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify services billed were provided
- A tool for routine healthcare operation

I understand and have been provided with a Notice of Information practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that South Baldwin Dental Associates reserves the right to change their notice and practices without notice. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that South Baldwin Dental Associates is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

Print Name: _____ Date: _____

Signature: _____ Relationship to Patient: _____

Medical Information Release Form

By completing this form, I authorize South Baldwin Dental Associates permission to the release of my complete medical record, confidential medical information, billing information and give the undersigned individuals permission to pick up prescriptions on my behalf. This release of information will remain in effect until terminated by me in writing. Without authorization, no information may be shared. PLEASE PRINT

	Name	Relationship	Phone Number
1.			
2.			