SOUTHPORT DENTAL, P.C.
DOCTOR RYAN M. MILLS, DDS

DATE:_____**SSN**:_____**BIRTH DATE**:_____ **AGE**:_____

NAME:_____ **(MIDDLE INITIAL)**_____

HOME PHONE:_____ **CELL**:_____ **WORK**_____

ADDRESS:_____

CITY:_____ **STATE**:_____ **ZIP**:_____

EMAIL ADDRESS:_____

(PLEASE CIRCLE)
SEX: MALE FEMALE **STATUS**: MINOR SINGLE MARRIED DIVORCED WIDOWED SEPARATED

EMPLOYER:_____**OCCUPATION**:_____

WHO CAN WE THANK FOR REFERING YOU?_____

IN CASE OF AN EMERGENCY, WHO SHOULD WE CONTACT?
NAME:_____ PHONE:_____

*****IT IS IMPORTANT THAT WE ARE ABLE TO CONTACT YOU DURING OUR BUSINESS HOURS. AT WHICH NUMBER CAN WE EASILY REACH YOU**: CELL HOME BUSINESS OTHER:_____

PRIMARY INSURANCE

PERSON RESPONSIBLE FOR ACCOUNT:_____

RELATIONSHIP TO PATIENT:_____**DATE BIRTH**:_____

SSN:_____ **ADDRESS**:_____

CITY:_____**STATE**:_____**ZIP**:_____**HOME #**:_____

RESPONSIBLE PARTY EMPLOYED BY:_____

INSURANCE COMPANY/ADDRESS:_____

SUBSCRIBER ID #:_____**GROUP #**:_____

ADDITIONAL INSURANCE

PERSON RESPONSIBLE FOR ACCOUNT:_____

RELATIONSHIP TO PATIENT:_____**DATE BIRTH**:_____

SSN:_____ **ADDRESS**:_____

CITY:_____**STATE**:_____**ZIP**:_____**HOME #**:_____

RESPONSIBLE PARTY EMPLOYED BY:_____

INSURANCE COMPANY/ADDRESS:_____

SUBSCRIBER ID #:_____**GROUP #**:_____

PATIENT MISSED APPOINTMENT AGREEMENT FOR SOUTHPORT DENTAL, P C

We make every effort to value your time and we schedule your appointment time just for you.

We truly appreciate our courtesy of giving us **48 hours notice** if you have a conflict with your appointment and need to schedule a different day or time. We are committed to your oral health and keeping our scheduled appointments allows us to be partners in our dental care.

It is our philosophy to continue to put our patients first and to make your experience a positive one. Thank you for allowing us to share our missed appointment policy with you and please let us know if you have any questions. Failure to keep your appointment may result in a longer wait time for future appointments or the ability to be seen by this office in the future.

_____

Patient/Guardian Signature

_____

Date

I give my permission for Southport Dental, PC to discus treatment, appointment dates and times and account information with the following:

Name/Relationship to Patient:

_____

_____

OFFICE POLICY

*Before treatment can be rendered, adequate radiographs of the teeth and mouth must be taken.

*Unless otherwise arranged, payment for professional service is required on the day the treatment is started. With prior approval, on certain extended procedures, payment plans can be arranged.

(Initial) _____

PERMISSION FOR TREATMENT AND PROMISE OF PAYMENT

Dental Insurance is a contract between my insurance company and me. I understand that Southport Dental, PC will submit all information to my insurance company as a courtesy to me. I agree to allow payment to be made directly to this office and realize that I am responsible for any charges that my insurance company does not cover. I agree to pay bill in a timely manner and will be responsible for all charges that are incurred in the collection of my account, including attorney fees, all billing charges, and 18% interest on overdue accounts.

Signed:_____ **Date**:_____

DENTAL HISTORY

FORMER DENTIST:_____ DATE OF LAST X-RAY'S:_____

CITY, STATE:_____ HOW OFTEN DO YOU FLOSS?_____

DATE OF LAST DENTAL VISIT:_____ HOW OFTEN DO YOU BRUSH?_____

***PLEASE CHECK ALL THAT APPLY*:**

BAD BREATH…..... _____	LOOSE TEETH OR BROKEN FILLINGS_____	SENSITIVITY TO SWEETS....._____
BLEEDING GUMS……._____	ORTHODONTIC TREATMENT…..…….._____	SENSITIVITY WHEN BITING._____
BLISTERS LIPS/MOUTH____	PAIN AROUND EAR…….._____	FREQUENT HEADACHES….._____
FINGER NAIL BITING…_____	PERIODONTAL TREATMENT……._____	JAW/HEAD/NECK INJURIES.._____
GRINDING TEETH……_____	SENSITIVITY TO COLD……_____	JAW DIFICULTY:CLICK/PAIN_____
LIP/CHECK BITING….._____	SENSITIVITY TO HEAT……_____	TOOTH PAIN……._____

MEDICAL HISTORY

ARE YOU UNDER A PHYSICIAN'S CARE? WHAT FOR?_____
WHAT MEDICATIONS ARE YOU CURRENTLY TAKING?_____
_____

HAVE YOU EVER BEEN TREATED FOR OR/ARE YOU TAKING MEDICATION FOR OSTEOPOROSIS OR ANY OTHER CONDITION RESULTING IN LOSS OF BONE DENSITY? YES NO

HAVE YOU EVER BEEN PRESCRIBED ANY OF THE FOLLOWING DRUGS: Fosamax, Boniva, Reclast, Prolia, Aredia or Zometa? _____

FAMILY PHYSICIAN:_____ PHONE NUMBER:_____
HAVE YOU EVER HAD A SERIOUS ILLNESS OR OPERATION?_____
DO YOU SMOKE? YES NO DO YOU USE ALCOHOL? YES NO

PLEASE CHECK ANY OF THE FOLLOWING PROBLEMS/CONDITIONS THAT APPLY TO YOU:

___ AIDS
___ ALLERGIES (SEASONAL)
___ ANEMIA
___ ARTHRITIS
___ ARTIFICIAL HEART VALVE
___ ARTIFICIAL JOINTS
___ ASTHMA
___ BLOOD DISEASE
___ BRUISE EASILY
___ CANCER
___ CHEMOTHERAPY
___ CORTISONE MEDICATION
___ DIABETES
___ DIZZINESS
___ DRUG ADDICTION
___ EMPHYSEMA
___ EPILEPSY
___ EXCESSIVE BLEEDING
___ FAINTING
___ GLAUCOMA
___ HEART CONDITIONS
___ HEART LESIONS (CONGENITAL)
___ HEART MURMUR
___ HEART SURGERY
___ HEPATITIS A
___ HEPATITIS B
___ HEPATITIS C
___ HIGH BLOOD PRESSURE
___ HIV POSITIVE
___ HPV
___ JAUNDICE
___ JAW JOINT PAIN
___ KIDNEY DISEASE
___ LIVER DISEASE
___ LOW BLOOD PRESSURE
___ MITRAL VALVE PROLAPSE
___ NERVOUSNESS/DEPRESSION
___ PACEMAKER
___ PREGNANT CURRENTLY
___ RADIATION (HEAD/NECK)
___ RESPIRATORY PROBLEMS
___ RHEUMATIC FEVER
___ RHEUMATISM
___ SCARLET FEVER
___ SEIZURES
___ SINUS PROBLEMS
___ SLEEP APNEA
___ STOMACH PROBLEMS
___ STROKE
___ THYROID DISEASE
___ TUBERCULOSIS
___ ULCERS
___VENEREAL DISEASES
___ OTHER:_____
_____
_____
_____
_____

***ALLERGIC OR REACTED ADVERSELY TO ANY OF THE FOLLOWING*:**

___ ASPIRIN
___ NITROUS OXIDE
___ IODINE
___ LATEX
___ LOCAL ANESTHETIC
___ TETRACYCLINE
___ CODEINE
___ ERYTHROMYCIN
___ VALIUM
___ PENICILLIN
___SULFA
___ OTHER_____
_____
_____
_____