Welcome

Thank you for choosing our practice. Please fill out this form as completely as you can. If you have any questions we'll be glad to help. **(Please Print)**

Rick Redmond Family Dentistry

101 So. Douglas Ave. (P.O. Box 1125) • Sylacauga, AL 35150 • 256-245-3645

PLEASE COMPLETE ALL INFORMATION THAT APPLIES TO YOU – THANK YOU

PATIENT LAST NAME:__________ **FIRST:**__________ **MIDDLE:**__________

Name/Nickname you prefer to be called by:__________ **DOB:**__________

❑ Minor ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Male ❑ Female

Full Time Student? ❑ Yes ❑ No School__________

Address__________

City__________ State__________ Zip__________

Telephone (Home)__________ (Work)__________ (Mobile)__________

Email__________

Employer__________ Occupation__________

Social Security Number__________

How did you hear about our practice?__________ Whom may we thank for your referral?__________

HUSBAND, FATHER OR RESPONSIBLE PARTY (IF OTHER THAN PARENT)

Last Name__________ First__________ Initial__________

Address__________ DOB__________

City__________ State__________ Zip__________

Telephone (Home)__________ (Work)__________ (Mobile)__________

Email__________

Employer__________ Occupation__________

Social Security Number__________

WIFE, MOTHER OR RESPONSIBLE PARTY (IF OTHER THAN PARENT)

Last Name__________ First__________ Initial__________

Address__________ DOB__________

City__________ State__________ Zip__________

Telephone (Home)__________ (Work)__________ (Mobile)__________

Email__________

Employer__________ Occupation__________

Social Security Number__________

NEAREST RELATIVE (Not living with you) (For Emergency Contact)

Last Name__________ First__________ Initial__________

Address__________ DOB__________

City__________ State__________ Zip__________

Telephone (Home)__________ (Work)__________ (Mobile)__________

YOUR PREFERENCES

Do you prefer appointment reminders by: [ ] Email [ ] Phone [ ] Text

Do you prefer to receive calls from our office at: [ ] Home [ ] Work [ ] Cell

__________ __________

PLEASE COMPLETE INSURANCE SECTION ON REVERSE SIDE OF THIS FORM

Dental Insurance Information

Primary Insurance Information

Name of Insured: ______________________ Relationship to Patient: ❑ Self ❑ Spouse ❑ Child ❑ Other
Insured Soc. Sec.: ______________________ Insured Birth Date: ______________________
Employer: ______________________ Ins. Company: ______________________
Address: ______________________ Address: ______________________
Address 2: ______________________ Address 2: ______________________
City, State, Zip: ______________________ City, State, Zip: ______________________
ID #: ____________ GR #: ____________

Secondary Insurance Information

Name of Insured: ______________________ Relationship to Patient: ❑ Self ❑ Spouse ❑ Child ❑ Other
Insured Soc. Sec.: ______________________ Insured Birth Date: ______________________
Employer: ______________________ Ins. Company: ______________________
Address: ______________________ Address: ______________________
Address 2: ______________________ Address 2: ______________________
City, State, Zip: ______________________ City, State, Zip: ______________________
ID #: ____________ GR #: ____________

Medical Insurance Information

Primary Insurance Information

Name of Insured: ______________________ Relationship to Patient: ❑ Self ❑ Spouse ❑ Child ❑ Other
Insured Soc. Sec.: ______________________ Insured Birth Date: ______________________
Employer: ______________________ Ins. Company: ______________________
Address: ______________________ Address: ______________________
Address 2: ______________________ Address 2: ______________________
City, State, Zip: ______________________ City, State, Zip: ______________________
ID #: ____________ GR #: ____________

Secondary Insurance Information

Name of Insured: ______________________ Relationship to Patient: ❑ Self ❑ Spouse ❑ Child ❑ Other
Insured Soc. Sec.: ______________________ Insured Birth Date: ______________________
Employer: ______________________ Ins. Company: ______________________
Address: ______________________ Address: ______________________
Address 2: ______________________ Address 2: ______________________
City, State, Zip: ______________________ City, State, Zip: ______________________
ID #: ____________ GR #: ____________

Authorization

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize the release of any information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I authorize the release of any information concerning my (or my child's) health care, advice and treatment to another dentist.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me. I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payments of services not paid, in whole or in part of my dental care payer.

I attest to the accuracy of the information on this page.

Signature______________________________________ Date____________________

SOUTHERN SMILES OF SYLACAUGA
DR. RICK REDMOND AND DR. CASEY PRICE
MEDICAL HISTORY and CONSENT

Patient Name____ **D.O.B.** ____________________

Although dental personnel treat the area in and around your mouth, your mouth is a part of your entire body. Health conditions or problems that you may have or had, or medications that you may be taking, could have an important interrelationship with the treatment you will receive. Thank you for answering the following questions:

ALLERGIES

Acrylics	Y	N
Anaphylaxis	Y	N
Latex	Y	N
Local Anesthetics	Y	N
Penicillin	Y	N
Metal	Y	N
Sulpha	Y	N
Other	Y	N

List other known allergies:

____
____
____
____
____
____
____
____

CARDIOVASCULAR

Artificial Heart Valve	Y	N
Coronary Artery Disease	Y	N
Chest Pain or Angina	Y	N
Congestive Heart Failure	Y	N
Heart Attack	Y	N
Heart Murmur	Y	N
High Blood Pressure	Y	N
High Cholesterol	Y	N
Irregular Heart Beat	Y	N
Low Blood Pressure	Y	N
Mitral Valve Prolapse	Y	N
Pacemaker	Y	N
Tachycardia	Y	N

ENDOCRINE

Diabetes	Y	N
Gout	Y	N
Thyroid Problems	Y	N

EYES, EARS, NOSE & THROAT

Change in Hearing	Y	N
Change in Vision	Y	N
Dysphagia	Y	N
Ear Pain	Y	N
Glaucoma	Y	N
Hay Fever	Y	N
Nasal Obstruction	Y	N
Nose Bleeding	Y	N
Sinus Problems	Y	N
Tonsillectomy	Y	N
Tinnitus	Y	N

GASTROINTESTINAL

Acid Reflux	Y	N
GERD	Y	N
Soft or Special Diet	Y	N
Ulcers	Y	N

GENITOURINARY

Frequent Urination	Y	N
Kidney Disease	Y	N
Nocturia	Y	N

GENERAL

Cancer	Y	N
Chemotherapy	Y	N
Fatigue/Tired	Y	N
General Weakness	Y	N
Headaches	Y	N
HIV/AIDS	Y	N
Knee/Hip Replacement	Y	N
Liver Problems	Y	N
Recent Trauma or Injury	Y	N
Rheumatic Fever	Y	N
Radiation Treatment	Y	N

HEMATOLOGICAL

Bleeding Problems	Y	N
Hepatitis	Y	N

MUSCULOSKELETAL

Back Pain	Y	N
Fibromyalgia	Y	N
Arthritis	Y	N
Joint Pain	Y	N

ORAL

Have you taken bone loss prevention drugs such as Fosomax, Actonel, Boniva or other bisphosphonates?	Y	N
Do you take or need antibotics before dental procedures?	Y	N

WOMEN ONLY

Are you pregnant?	Y	N
Are you nursing?	Y	N
Are you taking Oral Contraceptives	Y	N

NEUROLOGICAL

Alzheimer's Disease	Y	N
Dizziness	Y	N
Fainting	Y	N
Memory Loss	Y	N
Multiple Sclerosis (MS)	Y	N
Muscle Weakness	Y	N
Seizures	Y	N
Stroke	Y	N
Tingling/Numbness	Y	N
Trigeminal Neuralgia	Y	N
Tremor	Y	N
Epilepsy	Y	N

PSYCHIATRIC

ADD/ADHD	Y	N
Anxiety	Y	N
Chemical Dependency	Y	N
Depression	Y	N
Eating Disorders	Y	N
Excessive Stress	Y	N
Memory Problems	Y	N

RESPIRATORY

Asthma	Y	N
Bronchitis	Y	N
Breathing Problems	Y	N
Chest Pressure	Y	N
Congestion	Y	N
Shortness of Breath	Y	N
Emphysema	Y	N
Pneumonia	Y	N
Pulmonary Embolism	Y	N
Tuberculosis	Y	N

SLEEP

Daytime Sleepiness	Y	N
Morning Headaches	Y	N
Obstructive Sleep Apnea	Y	N
Do you use a CPAP?	Y	N

How Often?________________

Has anyone told you that you snore?	Y	N

SOCIAL HISTORY

Do you smoke N Y ____Packs a day

Do you use smokeless tobacco	Y	N

MEDICAL HISTORY and CONSENT

List any medications you are taking:

Medications	Dosage/Freq.	Prescriber	Reason
1.			
2.			
3.			
4.			
5.			
6.			

List any surgeries and hospitalizations you have had:

Date (Year)	Surgery	Surgeon	Reason

List and detail any medical condition not listed above:

____

Primary Physician's Name:____________________ Physician's Phone(______)______________

Are you under the care of other physician's? If so, please list:

Physician	Phone #	Reason

GENERAL CONSENT TO DIAGNOSE AND TREAT: The undersigned hereby authorizes **A. Rick Redmond, DMD** to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the undersigned patient's dental condition and needs. I authorize **A. Rick Redmond, DMD** to perform any and all forms of treatment, medication, and therapy that may be necessary and further consent that **A. Rick Redmond, DMD** choose and employ such assistance as deemed necessary. I understand that the use of local anesthetics agents embodies certain risk and consent to their use as deemed appropriate by **A. Rick Redmond, DMD**. To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect or incomplete information can be dangerous to my/the patient's health. It is my responsibility to inform the dental office of any change in medical health or status.

FINANCIAL CONSENT: I understand that responsibility for payment of services provided in this office for myself and my dependent(s) is mine, due and payable at the time services are rendered. I understand that I am responsible for any portion of fees for services rendered not covered by my dental or medical insurance (if any). I further consent to and agree to pay a 1-1/2% finance charge (18% annually) that will be applied to any balance over 30 days. I acknowledge that I am responsible for all fees necessary to collect my account. I authorize **A. Rick Redmond, DMD** and his staff to verify insurance coverage, if any, to submit claims and provide my insurance company with information required for a claim, to assign benefits, and to handle any necessary claim appeal(s).

Consent (adult):
Name of Patient__________________ __________________ **Date**____________
Signature of Patient

Consent (for a minor child):
Name of Parent/Guardian______________ __________________ **Date**____________
Signature of Parent/Guardian

Notice of Privacy Practices (below)

Patient privacy is important to our practice. We are required by law to maintain the privacy of Protected Health Information ("PHI") and to provide individuals with notice of our legal duties and privacy practices with respect to PHI. By signing below you are acknowledging receiving notice of our practices, policies and your rights regarding PHI. I allow release of pertinent medical records to my insurance company (if applicable) and my other medical providers.

__________________ **Date**____________
Signature of Patient

Patient Name	**DENTAL HISTORY**
Patient Account No.	Medical Alert

Welcome! So that we may provide you with the best possible care, please complete this medical/dental history form. All information is completely confidential.

What is the reason for your visit today? ______________________

____

Date of Last Dental Visit__________ **Last Dental Cleaning**__________ **Last Full Mouth X-rays** __________

What was done at your last dental visit?______________________

Previous Dentist's Name______________________ Telephone__________

Address______________________ State__________ ZIP__________

How often do you have dental examinations?______________________

How often do you brush your teeth? __________ How often do you floss? __________

Have you ever used or are you using topical fluoride? Yes No

What other dental aids do you use? (Interplak, toothpick, etc.) ______________________

Do you have any dental problems now? Yes No If yes, please describe: ______________________

Are any of your teeth sensitive to:

- Hot or Cold? Yes No
- Sweets? Yes No
- Biting or chewing? Yes No
- Have you noticed any mouth odors or bad tastes? Yes No
- Do you frequently get cold sores, blisters or any other oral lesions? Yes No

- Do your gums bleed or hurt? Yes No
- Have your parents experienced gum disease or tooth loss? Yes No
- Have you noticed any loose teeth or change in your bite? Yes No
- Does food tend to become caught in between your teeth? Yes No
- If yes, where__________

Do you:

- Clench or grind your teeth while awake or asleep? Yes No
- Bite your lips or cheeks regularly? Yes No
- Hold foreign objects with your teeth? (pencils, pipe, etc.) Yes No
- Mouth breathe while awake or asleep? Yes No
- Have tired jaws, especially in the morning? Yes No
- Snore or have other sleeping disorders? Yes No
- Smoke/chew tobacco or use other tobacco products? Yes No

Have you ever had:

- Orthodontic treatment? Yes No
- Oral surgery? Yes No
- Periodontal treatment. Yes No
- Your teeth ground or the bite adjusted? Yes No
- A bite plate or mouth guard? Yes No
- A serious injury to the mouth or head? Yes No
- Please describe, including cause__________

Have you experienced:

- Clicking or popping of the jaw? Yes No
- Pain? (joint, ear, side of face) Yes No
- Difficulty in opening or closing the mouth? Yes No
- Difficulty in chewing on either side of the mouth? Yes No
- Headaches, neck aches or shoulder aches? Yes No
- Sore muscles (neck, shoulders)? Yes No

- **Are you satisfied with your teeth's appearance** Yes No
- Would you like to replace your silver fillings? Yes No
- Would you like to keep all of your teeth all of your life? Yes No

Do you feel nervous about having dental treatment? Yes No

Please describe______________________

Have you ever had and upsetting dental experience? Yes No

Please describe______________________

Have you ever been told to take a pre-medication prior to dental treatment? Yes No

Is there anything else about having dental treatment that you would like us to know? Yes No

If yes, please describe______________________

____

A. RICK REDMOND FAMILY DENTISTRY

DR RICK REDMOND AND DR CASEY PRICE

256.245.3645

The HIPAA privacy law requires that we are only authorized to communicate with patients themselves, guardians, insurance providers and primary care physicians, unless we have authorization in writing by the patient to communicate with others on their behalf.
Please provide all family members or friends you want us to be able to speak with.

Spouses are not automatically included; their names must be explicitly stated below.

You may opt out by checking the "Do NOT Release Information" box below.

I give the following named person(s) authorization to take messages or speak with the office of Southern Smiles of Sylacauga, on my behalf regarding (please check all items authorized).

Name of authorized person(s): ______________________________ Relationship _________________________
Phone number _____________________________
__Appointments __ Financial __ Dental Treatment __ Insurance __ Other (explain) ______________________

Name of authorized person(s): ______________________________ Relationship _________________________
Phone number _____________________________
__Appointments __ Financial __ Dental Treatment __ Insurance __ Other (explain) ______________________

Name of authorized person(s): ______________________________ Relationship _________________________
Phone number _____________________________
__Appointments __ Financial __ Dental Treatment __ Insurance __ Other (explain) ______________________

___DO NOT RELEASE INFORMATION TO ANYONE

I understand that my express consent is required to release any health care information. With my signature below, I acknowledge and understand that this information will be kept in my medical record and the above parameters will remain in effect until revoked by me in writing. It is my responsibility to notify my healthcare provider(s) should I wish to change one or more contacts listed above.

Patient's Name: ____ Date of Birth ____________________

Signature of Patient or Representative: __________________________________ Date Signed: _____________

NAME:____

How Did You Hear About Our Office?

Please check all that apply:

☐ Newspaper Insert

☐ Online ads on your mobile device

☐ TV Station (Wellness Hour show)

☐ Internet search (our office came up)

☐ Referral from a dentist/specialist

☐ Radio

☐ Facebook

☐ Instagram

☐ Website

☐ Referral from a friend/family

Who may we thank for referring you? ______________________

☐ Other: ____