Welcome

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us- we will be happy to help.

Patient Information (*CONFIDENTIAL*)

Name ____ Preferred Name ________________________

Birthdate _____________________ SS# _______________________

Address ____ City ______________________________
State _________ Zip__________

Home Phone ________________________Work Phone ________________________ Cell Phone _________________

Email ____

Check Appropriate Box: □ Minor □ Single □ Married □ Divorced □ Widowed □ Separated

Patient or Parent/Guardian's Employer
____

Whom may we thank for referring you? ____

Person to contact in case of emergency _____________________________________ Phone _______________________

Responsible Party
Name of person responsible for this account ____

Relationship to Patient ________________________

Driver's License # ____________________ Date of Birth ________________

Employer _________________________________ Work # ________________

Insurance Information
Do you have Insurance? □ Yes □ No IF YES, PLEASE PROVIDE INSURANCE CARD

Name of Insured _____________________________ Relationship to Patient ________________
Date of Birth ___________________

SS# ______________________ Name of employer ___________________________________

Do you have any additional Insurance? □ yes □ no IF YES, PLEASE PROVIDE INSURANCE CARD

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment is due in full at each visit.

□ Cash □ Personal Check □ Visa □ Discover □ MasterCard □ American Express □ CareCredit

Health Information

Physician ______________________________ Office Phone ____________________ Date of Last Exam______________

Are you under medical treatment now? □ yes □ no

Have you been hospitalized for any surgical operation or serious illness within the last 5 years? □yes □ no

If yes, please explain ____

Are you taking any medication(s)?

If yes, please list ____

Are you allergic to or have you had any reactions to any medications? □ yes □ no

If yes, please list ____

Are you allergic to or have you had any reaction to Latex Rubber or any Metals? □ yes □ no

Have you ever taken Fosamax, Boniva, Actonel or any cancer medication containing bisphosphonates? □ yes □no

Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours? □ yes □ no

Do you use tobacco? □ yes □ no

Do you have a persistent cough or throat clearing not associated with a know illness (lasting more than 3 weeks)? □ Yes □ No

Women Only: a) Are you pregnant or think you may be pregnant? □ yes □ no b) Are you nursing? □ yes □ no

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

	Yes	No		Yes	No		Yes	No
High Blood Pressure	□	□	Heart Disease	□	□	Chest Pains	□	□
Heart Attack	□	□	Cardiac Pacemaker	□	□	Easily Winded	□	□
Rheumatic Fever	□	□	Heart Murmur	□	□	Stroke	□	□
Swollen Ankles	□	□	Angina	□	□	Hay Fever/Allergies	□	□
Fainting/Seizures	□	□	Frequently Tired	□	□	Tuberculosis	□	□
Asthma	□	□	Anemia	□	□	Radiation Therapy	□	□
Low Blood Pressure	□	□	Emphysema	□	□	Glaucoma	□	□
Leukemia	□	□	Arthritis	□	□	Liver Disease	□	□
Kidney Disease	□	□	Hepatitis/Jaundice	□	□	Respiratory Problems	□	□
AIDS or HIV	□	□	STD	□	□	Mitral Valve Prolapse	□	□
Thyroid Problems	□	□	Stomach Troubles	□	□	Ulcers	□	□
Epilepsy/Convulsions	□	□	Cancer	□	□	Diabetes	□	□
Joint Replacement	□	□	Implant	□	□	Other ______________________		

Patient Dental History

Name of Previous Dentist and Location ________________________________ Date of Last Exam _______________

	Yes	No
Do your gums bleed while brushing or flossing?	□	□
Are your teeth sensitive to hot or cold liquids/foods?	□	□
Are your teeth sensitive to sweet or sour liquids/foods?	□	□
Do you have any sore or lumps in or near your mouth?	□	□
Have you ever had any difficult extractions?	□	□
Have you had any head, neck or jaw injuries?	□	□
Have you ever experienced any of the following Problems in your jaw?		
Clicking …………………………………………	□	□
Pain (joint, ear, side of face) …………………	□	□
Difficulty in opening or closing ……………..	□	□
Difficulty in chewing ………………………...	□	□

	Yes	No
Do you have frequent headaches?	□	□
Do you clench or grind your teeth?	□	□
Do you bite your lips or cheeks frequently?	□	□
Do you feel pain to any of your teeth?	□	□
Have you had any orthodontic treatment?	□	□
Do you wear dentures or partials?	□	□
Do you like your smile?	□	□
Have you ever had any prolonged bleeding following extractions? ……………………...	□	□
Have you ever received oral hygiene instructions regarding the care of your teeth and gums? ……………………………	□	□

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

*X*____

Signature of patient (or parent/guardian if minor)

Lowcountry Dentistry
Financial Payment Policy

Thank you for choosing us as your dental health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. **The following is a statement of our Financial Policy, which we require you read and sign prior to any treatment.**

Payment for services is due at the time services are rendered. We accept cash, personal checks, MasterCard, Discover, and Visa. For your convenience we offer an extended payment plan with credit approval with CareCredit.

Regarding Insurance

- Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract. Our financial relationship is with you, not your insurance company.
- All charges are your responsibility whether your insurance company pays or not. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
- Fees for these services, along with unpaid deductibles and co-payments are due at the time of treatment.
- If the insurance company does not pay your balance in full within 30 days, we will ask that you contact the carrier to help speed things up.
- If the insurance company does not pay in full within 45 days, we will require you to pay the balance due with cash, personal check, MasterCard, Discover, Visa or Care Credit.

Collection Procedures

- Balances older than 90 days may be subject to additional collection fees of $80.00 and interest charges of 1.5 per month (18% annual rate). Returned checks will have an additional fee of $30.00 added to the amount of the returned check.

Minor Patients

- The adult accompanying a minor or the parents (or guardian of the minor) is responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa, MasterCard, Discover, Care Credit or payment by cash or check at time of service has been verified.

Missed Appointments

- We can not tolerate missed appointments or cancellations with less than 24 hours notice. If more than 3 of these occur, we will no longer continue providing service.

I have read the Financial Policy. I understand and agree to this Financial Policy:

_______________________________________ ______________

Signature of Patient or Responsible Party Date

Lowcountry Dentistry

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I have received a copy of this office's Notice of Privacy Practices.

____

{Signature}

____

{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: ____________________________ **Address:** ____

Telephone: ________________________ **Social Security Number:** ____________________________________

SECTION B: 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 signing 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: Amee Meetze Telephone: (843)549-5584 Fax: (843)549-2011

E-mail: LowcountryDentistry@comcast.net Address: 1133 North Jefferies Blvd. Walterboro SC 29488

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 heath 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: ____