Patient Information

Patient Name: _____ Date: _____
Last *First* *MI*

□ Male □ Female □ Married □ Single □ Child □ Other _____

Social Security #: _____ Date of Birth: _____ Email: _____

Phone - Home: _____ Cell: _____ Work: _____, ext.: _____

Address: _____
Street *City* *State* *Zip Code*

Health Information

Medical History

1) Are you under the care of a physician? Y / N If yes, provider's name: _____ phone: _____
2) Do you have or have you ever had any of the following? Please check those that apply:

- □ Cardiovascular Disease (Heart Attack, Congestive Heart Failure, Stroke, Chest Pain, High Blood Pressure, Arrhythmia)
- □ Congenital heart defect
- □ Artificial heart valve
- □ Anemia or bleeding disorder
- □ Lung Disease (Asthma, Tuberculosis, COPD, Emphysema, Shortness of breath)
- □ Sinus or nasal problems
- □ Diabetes
- □ Thyroid Disease
- □ Liver Disease (Jaundice, Hepatitis, etc.)
- □ Stomach ulcers, Colitis
- □ Kidney or Bladder Disease
- □ Artificial joint replacement
- □ Arthritis
- □ Lupus
- □ Glaucoma
- □ Frequent/persistent headaches or migraines
- □ Epilepsy, Seizures, Fainting
- □ Mental Disorder (Anxiety, Depression, Bipolar, Schizophrenia, etc.)
- □ Cancer or Tumor
- □ Sexually Transmitted Infection
- □ HIV, AIDS
- □ Other: _____
  _____
  _____
  _____
  _____
  _____

3) Do you currently take any medications or vitamins? Y / N. If yes, please list _____
   _____
   a. Do you take a blood thinner? Y / N
   b. Have you taken steroids (now or in the last 30 days)? Y / N
   c. Do you take antibiotics routinely? Y / N
4) Do you now or have you ever taken Bisphosphonates (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa, etc.)? Y / N
   If yes, what type? _____ When taken? _____
5) Have you had any serious illness, operation, or hospitalization within the past 5 years? Y / N
   If yes, please expound: _____
6) Are your pregnant or do think you might be? Y / N If yes, due date: _____
7) Are you allergic to or had an adverse reaction to the following? Please check all that apply; if not listed, please specify:

- □ Antibiotics: _____
- □ Aspirin or Ibuprofen
- □ Codeine
- □ Latex
- □ Local Anesthesia
- □ Sulfa drugs
- _____
- _____
- _____

8) Do you use any tobacco products? Y / N. If yes, what and how much per day? _____
9) Do you have any current use or history of alcohol abuse or drug use? Y/ N

Dental History

1) What is your primary dental concern? _____
2) Do you have any of the following? Please check those that apply:

- □ Bleeding/sensitive gums
- □ Sensitivity to hot/cold
- □ Sensitivity to sweets
- □ Broken fillings
- □ Food trapping between teeth
- □ Loose teeth
- □ Sensitivity to biting
- □ Grinding / clinching
- □ Clicking/popping jaw
- □ Sores in the mouth
- □ Bad breath

3) Do you have anxiety or fear related to dental treatment? Y / N
4) Have you ever had any complications following dental treatment? Y / N
5) Is there anything about your teeth that you want to change? _____

To the best of my knowledge, all the preceding answer and information are true and correct. If I have changes in my health, I will inform the doctor at the next appointment.

Patient / Guardian Signature: _____ **Date:** _____

FOREST ACRES DENTISTRY

Notice of Privacy Practices for Protected Health Information

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully and sign the second page.

With your consent, Forest Acres Dentistry is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information (PHI) is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Example of uses of your health information:

- **For treatment purposes**: We may share treatment information with specialists or physicians to obtain input and collaborate on patient care.
- **For payment purposes**: We may use and disclose your health information with insurance companies to obtain payment for services we provide you.
- **For health care operations**: We may use and disclose your health information in connection with our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, certification, licensing or credentialing activities.

Your Health Information Rights

The health record we maintain and billing records are the physical property of the practice. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office. Although we are not required to grant the request, we will strive to comply with any request made;
- Request a restriction on disclosures of medical information to a health plan for purposes of carrying out payment or health care operations; and the PHI pertains solely to a health care service for which the provider has been paid out of pocket in full;
- Request that you be allowed to inspect and copy your health record and billing record—you may exercise this right by delivering the request in writing to our office;
- Appeal a denial of access to your protected health information except in certain circumstances;
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office;
- File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information;
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office. An accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request, or disclosures made to family members or friends in the course of providing care;
- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office; and,
- Revoke authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to our office.

If you want to exercise any of the above rights, please contact Rachelle Adams at 803-782-0965 in person or in writing, during normal hours. She will provide you with assistance on the steps to take to exercise your rights.

Our Responsibilities

The practice is required to:

- Maintain the privacy of your health information as required by law;

- Provide you with a notice of our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request;
- Accommodate your reasonable requests regarding methods to communicate health information with you, and
- Notify you if you are affected by a breach of unsecured PHI

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our Notice, by visiting our office and picking up a copy, or on our website at www.forestacresdentistry.com.

To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact Jeanette Wingate at 803-782-0965. Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office. You may also file a complaint by mailing it or e-mailing it to the Secretary of Health and Human Services.

Other Disclosures and Uses

Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition.

- **Communication with Family:** Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.
- **Food and Drug Administration (FDA):** We may disclose to the FDA your protected health information relating to adverse events with respect to products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.
- **Workers Compensation:** If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.
- **Public Health:** As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.
- **Abuse & Neglect:** We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.
- **Correctional Institutions:** If you are an inmate of a correctional institution, we may disclose to the institution, or its agents, your protected health information necessary for your health and the health and safety of other individuals.
- **Law Enforcement:** We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecutions, or to the extent an individual is in the custody of law enforcement.
- **Health Oversight:** Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.
- **Judicial/Administrative Proceedings:** We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your consent, or as directed by a proper court order.

Effective Date: 11/4/2015

I, _____, hereby acknowledge that I have received a copy of this practice's Notice of Privacy Practices. I have been given the opportunity to ask any questions I may have regarding this Notice.

_____ _____

Signature Date

For parent/guardian signatures, patient name: _____

relationship to patient: _____

FOREST ACRES DENTISTRY

Finance and Appointment Policies

Fees

Before any dental treatment begins, we review the fees for your next appointment. We attempt to keep our fees at a fair level that reflects the quality of care provided by our office. Prompt payment will enable us to keep our fees lower for everyone; **payment is due at the time services are rendered**. All fees quoted in a treatment plan will be honored for 3 months from the date presented. I understand that I will be responsible for all payments for all services rendered to the patient herein regardless of insurance coverage. ***PLEASE NOTE*** Divorced Parents: The parent who is present with the patient at the time of appointment will be considered the "financially responsible party" and will be accountable for all fees incurred.

List of all patients that this financial agreement applies to (please list spouse and children if you want them included):

_____ _____
_____ _____
_____ _____

We accept cash, check, Visa, MasterCard, Discover, and American Express. We also offer financing through Care Credit and Citi Health, which offer several no interest plans up to 12 months or longer payment terms with competitive interest rates.

Insurance

We will file your insurance claim and allow you to pay your estimated co-payment as services are rendered. **Please remember that the contract is between you and your insurance company, and your total balance due in our office is always your responsibility**. We make every effort to give you an accurate estimate of what your portion of our fees will be based on information provided to us. **However, we have no way to guarantee the actual terms of your insurance policy. If for any reason there is a balance remaining after your insurance company's payment, you will be sent a statement**. Disputes regarding reimbursement are between you and your insurance carrier, but we will be happy to assist you as best we can.

Appointments

Your appointment is a time we have reserved specifically for your dental treatment. If you are unable to keep your appointment, **we require 24 hour notice of the cancellation**. Inadequate notice will render the appointment broken, and we may issue a broken appointment fee based on the circumstances. You may contact us after hours by leaving a voicemail at our office phone number (803-782-0965) or by e-mail at info@forestacresdentistry.com.

"I have read and understand the office guidelines that are state above."

_____ _____

Signature **Date**

FOREST ACRES DENTISTRY

Patient Contact Preferences

I, _____, wish to be contacted in the following manner:

for telephone communication (*check all that apply*):

- ☐ Home telephone
  - ☐ OK to leave message with detailed information
  - ☐ Leave message with call-back number only
- ☐ Cell phone
  - ☐ OK to leave message with detailed information
  - ☐ Leave message with call-back number only
- ☐ Work telephone
  - ☐ OK to leave message with detailed information
  - ☐ Leave message with call-back number only

for written communication (*check all that apply*):

- ☐ Home address
- ☐ Work / office address
- ☐ Text message to cell phone
- ☐ E-mail

I allow you to give my clinical information to or answer questions from (*check all that apply*):

- ☐ Spouse
- ☐ Parent
- ☐ Child
- ☐ Other (specify) _____
- ☐ None

Patient Signature: _____ Date: _____

If parent or legal guardian, please list relationship to patient: _____

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Another patient, relative ☐ Dental Office
☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____
☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext:_____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #:_____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Address: _____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #:_____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Address: _____

I hereby authorize payment directly to Forest Acres Dentistry of the group insurance benefits otherwise payable to me.

Signature_____ Date_____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party