



9153 Medcom Street, Suite A / Charleston, SC 29406-9167
843-797-0404

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have questions at any time, please ask us. We are happy to help.

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

Name _____ SSN _____ Birthdate _____
 Name you wish our office to call you _____ Email _____ Home Phone _____
 Name of Parent (if Child) _____ Name of School Attending _____ City _____

The Parent or Guardian who accompanies the child is responsible for payment at the time of service unless arrangements have been approved.

Home Address: _____
 (Street) (City) (State) (Zip)

How long at this address? _____ Previous address if less than three years _____
 (Street) (City) (State) (Zip)

Place of employment _____ Address _____ Work Phone _____

Years Employed? _____ Occupation _____ Pager or Cell Phone _____

Spouse's Full Name _____ Spouse's DOD _____ Dental Insurance? Yes No

Spouse's Employer _____ Work Phone _____

Address _____ Years Employed? _____

Primary Dental Ins. _____ Address _____ Group Number _____

Secondary Dental Ins. _____ Address _____ Group Number _____

Emergency (Not Living With You) _____ Address _____ Phone _____

Closest Relative (Not Living With You) _____ Address _____ Phone _____

Physician _____ City _____ Phone _____ Date of Last Physical (Year)? _____

Is Another Family Member a Patient Here at Our Office? Yes No Name of patient(s) _____

Whom May We Thank For Referring You To Our Office? _____

Medical History

Yes No Are you taking any medicine? _____
 Yes No Are you allergic to any medications or substances? _____
 Yes No Have you been seriously ill in the last five years? _____
 Yes No Have you ever been hospitalized? _____
 Yes No Do you use any tobacco products? _____

For Women Only:
 Yes No Are you pregnant?
 If yes, how far along? _____
 Yes No Are you taking birth control pills? _____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

Yes No	Yes No	Yes No
_____ AIDS/HIV Positive	_____ Liver disease	_____ Have any other dental condition that I should know about? _____
_____ Allergies	_____ Prosthetic joint/heart valve	
_____ Arthritis	_____ Psychological problems	
_____ Asthma	_____ Radiation-head/neck cancer	
_____ Bleeding problems	_____ Rheumatic fever	
_____ Blood disease	_____ Shortness of breath	
_____ Blood transfusion	_____ Stomach/intestinal disease	
_____ Cancer or tumor	_____ Stroke	
_____ Chest pains (angina)	_____ Swelling of hands/feet	
_____ Contact Lenses	_____ Thyroid disease	
_____ Cortisone/Steroids	_____ Tuberculosis/Lung disease	
_____ Diabetes	_____ Venereal disease	
_____ Drug addiction	_____ Do you have any other medical condition that I should know about.	
_____ Drug reaction		
_____ Epilepsy (seizures)	DO YOU:	
_____ Fainting (recurrent)	_____ Have any dental pain or problems now?	
_____ Headaches (frequent)	_____ Grind or frequently clench your teeth?	
_____ Head injury	_____ Have an unpleasant taste in your mouth?	
_____ Heart disease or murmur	_____ Have pain opening/closing your mouth?	
_____ Hepatitis (jaundice)	_____ Have gums which bleed when brushing?	
_____ High/Low pressure (circle one)	_____ Floss your teeth less than once per day?	
_____ Kidney disease		

ARE:
 _____ Your teeth sensitive to hot, cold, or sweets?
 _____ You dissatisfied with the condition or appearance of your teeth? If so, locate.
 _____ Had problems with dental anesthesia (Novocaine)?
 _____ Had prolonged bleeding after tooth extraction?
 _____ Noticed any shifting of your teeth?
 _____ Worn braces?
 _____ Ever been told you have periodontal disease?
 _____ Ever had a full mouth set of X-rays?
 If so, when? _____
 Date of most recent dental cleaning? _____

SERVICE CHARGE

If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month. I realize that failure to keep this account current may result in you being unable to provide additional dental service except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances. I understand that where appropriate, credit bureau reports may be obtained.

Signature _____ Date _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient: _____

Signature: _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:
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