Patient Information

Date ______________ Home Phone ______________________

Work Phone______________________

Email____ Mobile Phone______________________

Whom may we thank for recommending our office? ____

* I consent to receive office memos & appointment confirmations via phone, text, &/or email: Y or N
* I would like to receive emails regarding facial aesthetics specials (Botox and Dermal Filler): Y or N

PATIENT INFORMATION

Title: First name ________________________ Last ________________________ M.I. _______

Preferred Name _____________________________________

SSN __________________________ Age _________ Date of birth ______________ Gender

Marital Status: M S W D Address____

City ______________________________________ State ______________________ Zip _______________

Patient Employer______________________________ Occupation ______________________________

Spouse Name ______________________________ Spouse Birthdate ___________________________

Spouse Employer______________________________ Occupation ______________________________

Spouse SSN ________________________________

GUARANTOR INFORMATION (the Guarantor is the responsible party for insurance payments and charges)

_____ Check here if same as patient information

Guarantor Name ____ SSN ____________________________

Relationship to patient ______________________________ Occupation ____________________________

Home Address ____

City ___________________________________ State _________________ Zip _______________________

Home or Mobile phone ____________________________ Work Phone ______________________________

PRIMARY INSURANCE INFORMATION

Insurance Company name _________________________ Policy Holders name _________________________

Group number ___________________________________ Policy/ ID # ______________________________

Policy holder's DOB ___________________ SSN __________________ Relationship to patient ___________

City ___________________________________ State _________________ Zip ______________________

Home or Mobile phone ____________________________ Work phone _____________________________

SECONDARY INSURANCE INFORMATION

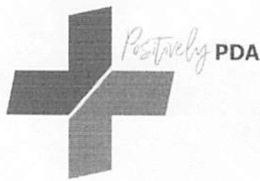
Insurance Company name _________________________ Policy Holders name _________________________

Group number ___________________________________ Policy/ ID # ______________________________

Policy holder's DOB ___________________ SSN __________________ Relationship to patient ___________

City ___________________________________ State _________________ Zip ______________________

Home or Mobile phone ____________________________ Work phone _____________________________



Medical History Form

Name ______________________________ **Date** ______________

If you are completing this form for another person, what is your relationship to that person? ______________
For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential.
* Please note that during your initial visit, you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health since it is our top-priority.

1) Are you in good health? ______ YES NO
2) Has there been any change in your general health within the past year? ______ YES NO
3) My last physical examination was on the following approximate date: ______
4) Are you now under the care of a physician? ______ YES NO
   If so, what is the condition being treated? ______
5) The name and address of my physician (s) is: ______
   ______ Phone Number ______
   ______ Phone Number ______
6) Have you had any serious illness, operation or been hospitalized in the past 5 years? ______ YES NO
   If so, what was the illness or problem? ______
7) Are you taking any medicine (s) including non-prescription medicine? ______ YES NO
   If so, what medicine(s) are you taking? (Please list and give dosage) ______
   ______
   ______
8) Do you have or have you had any of the following diseases or problems?
   a. Damaged heart valves or artificial heart valves, including heart murmur or rheumatic heart? ______ YES NO
   b. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, arteriosclerosis, stroke)? ______ YES NO
      - Do you have chest pain upon exertion? ______ YES NO
      - Are you ever short of breath after mild exercise or when lying down? ______ YES NO
      - Do your ankles swell? ______ YES NO
      - Do you have heart defects from birth? ______ YES NO
      - Do you have a cardiac pacemaker? ______ YES NO
   c. Allergy ______ YES NO
   d. Sinus trouble ______ YES NO
   e. Asthma or hay fever ______ YES NO
   f. Fainting spells or seizures ______ YES NO
   g. Persistent diarrhea or weight loss ______ YES NO
   h. Diabetes ______ YES NO
   i. Hepatitis, jaundice, liver disease ______ YES NO
   j. AIDS or HIV infection ______ YES NO
   k. Thyroid problems ______ YES NO
   l. Respiratory problems, emphysema ______ YES NO
   m. Arthritis or painful swollen joints ______ YES NO
   n. Stomach ulcer or reflux ______ YES NO
   o. Kidney trouble ______ YES NO
   p. Tuberculosis ______ YES NO
   q. Persistent cough or cough produces blood ______ YES NO
   r. Persistent swollen glands in neck ______ YES NO
   s. High or low blood pressure (circle which) ______ YES NO
   t. Sexually transmitted disease ______ YES NO
   u. Epilepsy or other neurological disease ______ YES NO
   v. Problems with mental health ______ YES NO
   w. Cancer ______ YES NO
   x. Problems of the immune system ______ YES NO
9) Have you ever had abnormal bleeding? ______ YES NO
   a. Have you ever required a blood transfusion? ______ YES NO
10) Do you have any blood disorder such as anemia? ______ YES NO
11) Have you ever had any treatment for a tumor or growth? ______ YES NO
12) Have you ever had an adverse, allergic-type reaction to:
   a. Local anesthetics ______ YES NO
   b. Penicillin/ other antibiotics ______ YES NO
   c. Sulfa drugs ______ YES NO
   d. Barbiturates, sleeping pills ______ YES NO
   e. Aspirin ______ YES NO
   f. Iodine ______ YES NO
   g. Codeine or other narcotics ______ YES NO
   h. Other ______ YES NO
13) Have you ever had any serious trouble associated with previous dental treatment? ______ YES NO
   If so, explain: ______
14) Do you have any disease, condition or problem not listed above? ______ YES NO
   If so, explain: ______
15) Do you have an artificial joint? YES NO If so, which one and when: ______
16) Are you pregnant? ______ YES NO
17) Do you have any problems associated with your menstrual period? ______ YES NO
18) Are you nursing? ______ YES NO
19) Are you taking birth control pills? (Be aware that antibiotics can decrease their efficacy.) ______ YES NO

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist or any other member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

____
Signature of patient or guardian

Dental History

Patient name: ______________________ **Medical Alert:** ______________

Welcome to Palmetto Dental Associates! So that we are able to provide you with the best possible care, please complete this dental history form. All information provided is completely confidential.

What is the reason for your visit today? ______________________
Date of Last Dental Visit ______________ Date of Last Dental Cleaning ______________
Date of Last Full Mouth X-rays ______________________
What was done at your last dental visit? ______________________

____
Previous Dentist's Name & Address ______________________
______________________ Phone ______________
How often do you have dental examinations? ______________________
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 bad mouth odors or tastes?	YES	NO
Do you frequently get cold sores, blisters or 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 between your teeth?	YES	NO

If yes, where? ______________

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 mouth?	YES	NO
Headaches, neckaches or shoulder aches?	YES	NO
Sore muscles (neck, shoulders)?	YES	NO
Are you satisfied with your teeth's appearance?	YES	NO
Do you feel nervous about having dental treatment?	YES	NO

If so, what is your biggest concern? ______________________

Do you:

Clench or grind your teeth while awake or asleep?	YES	NO
Bite lips or cheeks regularly?	YES	NO
Hold foreign objects with teeth? (pencils, pipes, pens, fingernails)	YES	NO
Mouth breath while awake or asleep?	YES	NO
Have tired jaws, especially in the morning?	YES	NO
Smoke/chew tobacco?	YES	NO

Have you ever had:

Orthodontic treatment?	YES	NO
Oral surgery?	YES	NO
Periodontal treatment?	YES	NO
Your bite adjusted?	YES	NO
A bite plate or mouth guard?	YES	NO
A serious injury to mouth/head?	YES	NO

If so, please describe: ______________
____

Have you ever had an upsetting dental experience? YES NO
If yes, please describe: ______________________

Is there anything else about having dental treatment that you would like us to know? YES NO
If yes, please describe: ______________________

Is there anything you would like to change about your smile? YES NO
If yes, please describe: ______________________

Would you like to know more about dental implants? YES NO

I give permission for my dental chart to be discussed with the following people: ______________________

Signature of patient or guardian: ______________________ **Date:** ______________

Terms of Payment

At Palmetto Dental Associates, we are committed to providing our patients with the best care possible and encourage you to take an active role in your treatment. In order to keep the lines of communication open, we ask that you review our financial policies stated below. Our team members are always available to answer any questions regarding insurance or other financial matters.

Terms of Payment

For patients with no dental insurance, payment is due at the time services are rendered. VISA, MasterCard, American Express, Discover, Cash, and personal check (no post-dated checks) are acceptable forms of payment. We will make arrangements for large scale treatment, but these arrangements must be made prior to treatment being performed. For your convenience we also offer Care Credit and Lending Club Financing Plans.

Insurance

Patients who have dental insurance, must provide a current copy of their insurance card in order for claims to be submitted properly. We are not a preferred provider for any insurance; however, we will file claims (excluding medicare or medicaid) as a courtesy. It is the sole responsibility of the patient to cover whatever insurance does not pay, and the remaining balance must be paid the day that services are rendered.

Failed Appointment Policy

In order to allow the best possible care for our patients, we ask that you give our office twenty-four hours notice for any changes or cancellations with your appointment. This allows us the opportunity to give that appointment to another patient in need. A fee of $25.00 per appointment hour will incur without twenty-four hours notice.

Authorization

By signing below, you are confirming that you are ultimately financially responsible for services rendered by Palmetto Dental Associates. As stated above, all fees are due at the time of service. In the event that your account becomes delinquent and is therefore turned over to a collection agency to obtain payment, you understand that you are responsible for any fees levied by the collection agency. A copy of your signature shall have the same force and effect as the original.

____ ____________________

Patient Signature (or Guarantor) **Date**

(Rev. 5/2022)

Palmetto Dental Associates & The Aesthetic Collective

Acknowledgement of Receipt
Of Notice of Privacy Practices

Patient Name & Address: ____

____

____

I have received a copy of the Notice of Privacy Practices for the above named practice.

____________________________ ____________________

Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ☐ An emergency existed & a signature was not possible at the time.
- ☐ The individual refused to sign.
- ☐ A copy was mailed with a request for a signature by return mail.
- ☐ Unable to communicate with the patient for the following reason:

  ____

- ☐ Other:____

  ____

Prepared By ____

Signature ____

Date ____

(Rev. 5/2022)

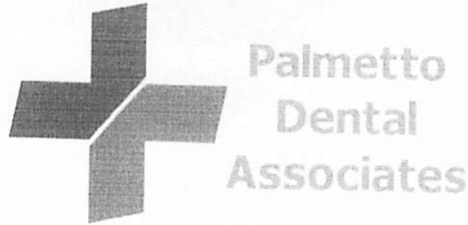


Photo Release Form

Date: ___________________

Patient's Name (Please print): ____

*I hereby give Palmetto Dental Associates the permission to use my study models, radiographs, and/or photographs of my teeth in publications, on the website/social media, or in lecture presentations. * We will not use your full-face photograph anywhere without additional consent.*

I release and discharge Palmetto Dental Associates from any and all claims, actions and demands arising out of or in connection with the use of said study models, radiographs, and/or photographs.

I represent that I am over the age of eighteen years and that I have read and completely understand the contents hereof.

Signature of patient (or guardian if patient is under 18 years of age):

____

Witnessed by (Please print): ____

Signature of Witness: ____

Palmetto Dental Associates & Aesthetic Collective

Authorization to Release Health Information

Patient Information:

Name of Patient: ______________________ Date of Birth: ______________

Address: ____

City, State, Zip: ______________________ Phone: ______________

Palmetto Dental Associates request the release the following information:

- ☐ Entire record
- ☐ Financial records
- ☐ Office visit notes
- ☐ X-Rays

Entity or person who will receive the information:

Name: Palmetto Dental Associates

Address: 216 Palmetto Park Blvd.

City, State, Zip: Lexington, SC, 29072 Phone: T: 803-808-0888 F: 803-808-0891

☐ **Send the information electronically. Email address: __positivelypda@gmail.com___**

This authorization shall be in effect until the information has been forwarded as requested or until the course of treatment is complete.

Patient Rights:

- I have the right to revoke this authorization at any time by contacting our office.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I may refuse to sign this authorization and that my treatment will not be conditioned on signing.
- I understand released information may include a communicable disease diagnosis such as HIV.

This authorization will remain in effect until revoked by the patient.

Signature of Patient or Personal Representative: ______________________Date: ________

*Description of Personal Representative's Authority (attach necessary documentation)

☐ Revoked by patient or personal representative on ____________________.
DATE

How revoked: ☐ orally (in person or via phone) ☐ in writing (place copy in patient's file)

Palmetto Dental Associates

Authorization for Release of Information – Compound Release

Name of Patient ______________________________ Date of Birth ____________

Palmetto Dental Associates is authorized to release protected health information about the above named patient in the following manner and to identified persons.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
☐ Voice Mail ☐ Text	☐ Appointment Reminders ☐ Other ____________________
☐ Other person (s) (provide name and phone number) (Example: **Spouse, Parent, Friend, Relative etc.)** ☐ ______________________ ______________________ ☐ ______________________ ______________________	 ☐ **Financials** ☐ **Treatment** ☐ **Financial** ☐ **Treatment**
☐ For **text communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive text communication as selected.	
☐ Email communication-Provide email address* ______________________	☐ Financial ☐ Medical ☐ Appointment reminders ☐ Breach notification

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.
- This authorization will remain in effect until revoked by the patient.

____ Date ______________

Signature of Patient or Personal Representative- Attach necessary documents if you are a personal representative

Revised Oct 2014