SUMMERVILLE DENTISTRY

PATIENT REGISTRATION

Patient Information:

Patient First Name:_____ Last Name:_____ Middle Initial:_____

Preferred Name:_____

Patient is : □ Responsible Party □ Policy Holder

Address:_____

City, State, Zip:_____

Cell Phone:_____ Work Phone:_____ Home Phone:_____

Sex: ○ Female ○ Male Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth date:_____ Social Security #:_____

E-mail:_____ □ I would like to receive email correspondences

Name of Spouse:_____

Patient Information (section 2):

Employment Status: ○ Full Time ○ Part Time ○ Self Employed ○ Retired ○ Unemployed

Student Status: ○Full Time ○ Part Time

Preferred Dentist:_____ Preferred Pharmacy:_____

Responsible Party(If other than the patient):_____ Relation:_____

Primary Phone:_____ Birth Date:_____ SS #:_____

Billing Address:_____

Primary Insurance Information:

Name of Insured:_____ Relationship to Insured: ○Self ○Spouse ○Child ○ Other

Insured Social Security #: _____ Insured Birth date:_____

Employer:_____ Insurance Company:_____

Secondary Insurance Information:

Name of Insured:_____ Relationship to Insured: ○Self ○Spouse ○Child ○ Other

Insured Social Security #:_____ Insured Birth date:_____

Employer:_____ Insurance Company:_____

Emergency Contact Information:

Name:_____ Relation To Patient:_____

Primary Phone:_____

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions**. CIRCLE YES OR NO.**

Are you under a physician's care now?	Yes	No	If yes, please explain: _____
Have you ever been hospitalized or had a major operation?	Yes	No	If yes, please explain: _____
Have you ever had a serious head or neck injury?	Yes	No	If yes, please explain: _____
Are you taking any medications, pills, or drugs?	Yes	No	If yes, List: _____
Have you ever taken Fosamax, Boniva, Actonel, or any bisphosphonates?	Yes	No	
Are you on a special diet?	Yes	No	
Do you use tobacco?	Yes	No	
Do you use controlled substances?	Yes	No	
Do you need to PRE-MEDICATION?	Yes	No	If yes, please explain: _____
Do you take aspirin or blood thinners daily?	Yes	No	If Yes, List:_____

Women: Are you Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following? **CIRCLE ALL THAT APPLY**.

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other If yes, please explain:_____

Do you have, or have you had, any of the following? CIRCLE YES OR NO.

AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Renal Dialysis	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Rheumatic Fever	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Rheumatism	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Scarlet Fever	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Shingles	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	Hives or Rash	Yes	No	Sickle Cell Disease	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hypoglycemia	Yes	No	Sinus Trouble	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Irregular Heartbeat	Yes	No	Spina Bifida	Yes	No
Asthma	Yes	No	Fainting Spells/Dizziness	Yes	No	Kidney Problems	Yes	No	Stomach/Intestinal Disease	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Leukemia	Yes	No	Stroke	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Liver Disease	Yes	No	Swelling of Limbs	Yes	No
Breathing Problem	Yes	No	Frequent Headaches	Yes	No	Low Blood Pressure	Yes	No	Thyroid Disease	Yes	No
Bruise Easily	Yes	No	Genital Herpes	Yes	No	Lung Disease	Yes	No	Tonsillitis	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No	Mitral Valve Prolapse	Yes	No	Tuberculosis	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Pain in Jaw Joints	Yes	No	Tumors or Growths	Yes	No
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Murmur	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disorder	Yes	No	Heart Pace Maker	Yes	No	Radiation Treatments	Yes	No	Yellow Jaundice	Yes	No
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Recent Weight Loss	Yes	No			

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

CONSENT TO TREATMENT: The undersigned hereby authorizes dentists and staff to take x-rays, photographs, or any other diagnostic aids deemed appropriate by the dentist to make a diagnosis and perform all recommended treatment mutually agreed upon by me and to use appropriate medication and therapy indicated for such treatment in connection with the above. I understand that using anesthetic agents embodies a certain risk.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

SUMMERVILLE DENTISTRY

ACKNOWLEDGEMENT OF PRIVACY PRACTICES/HIPAA COMPLIANCE

AUTHORIZATION FOR RELEASE OF INFORMATION TO FAMILY MEMBERS

Patient Name: _____

Print

Acknowledgement that Summerville Dentistry is compliant with HIPAA and privacy policies. A copy of our privacy practices/HIPAA compliance procedures will be made available upon request.

Signature:_____ Date:_____

I authorize Summerville Dentistry to disclose my dental treatment and account information to family members/responsible parties listed below, this is in accordance with requirements of HIPAA.

1._____Relation to Patient:_____

2._____Relation to Patient:_____

3._____Relation to Patient:_____

I understand I have the right to revoke this authorization at any time and I have the right to inspect or copy the protected health information to be disclosed.

I understand that information disclosed to any above recipient is no longer protected by federal or state law.

SUMMERVILLE DENTISTRY
FINANCIAL POLICY

Thank you again for choosing our practice to provide your total dental health care. Your dental health is our utmost priority. Please understand that payment of your account is considered part of our treatment.

The following is a statement of our financial policy which we require you to read and sign prior to any treatment.

Full payment is due at time of service. We accept cash, check or Visa, MasterCard, Discover, and American Express. **Returned check fee is $35.**

REGARDING INSURANCE:

We will gladly file your insurance for you on each visit. However, we do require that you pay any deductible and or balance not covered by your insurance at the time of your visit. In order for us to bill your insurance company, you must provide us with the necessary insurance information, i.e.,SSN#, birth date of the policy holder and the company at which the main policy holder works. We will need a copy of your DENTAL insurance card. If you have a copy of your dental benefits we can help you determine what your insurance will and won't cover. Please remember that your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We, as a courtesy to our patients, file dental claims but are not responsible for those services not covered or not considered reasonable and customary. This also authorizes assignment of insurance benefits directly to the provider for services rendered.

USUAL AND CUSTOMARY:

Our practice is committed to providing the highest quality treatment for our patients and our fees reflect what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

MINOR PATIENTS:

The adult accompanying a minor and the parents; or guardians of the minor, are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized by the parent, and financial arrangements have been made.

CANCELLATION POLICY:

Cancellation of any appointments must be made 48 hours in advance. Failure to provide 48 hours advance notice will result in a charge of $50.00 being billed to you. Please help us serve you better by keeping your scheduled appointments.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I HAVE READ THE FINANCIAL POLICY AND UNDERSTAND AND AGREE TO THIS ARRANGEMENT:

X_____

Signature of Patient/Responsible party Date

SUMMERVILLE DENTISTRY
DENTAL INTERVIEW

Name_____Date_____

Last dental visit_____

What is your major concern? _____

1. Food Traps that Bother you……Y N
2. Loose, Cracked, or Broken Fillings……...Y N
3. Cracked, Broken, or Sharp Edges on any Teeth……Y N
4. Discolored or Stained Teeth that you would like Whitened……..Y N
5. Problems with Dental Anesthetic Not Working……Y N
6. Negative Reaction to Dental Anesthetic in Past……Y N
7. Any Problems or Complications with Dental Treatment in Past……...Y N

If so, please explain_____

8. Is there anything we can do to make your visits more comfortable…...Y N

If so, please explain_____

9. If you could wave a magic wand, how would you change your smile/teeth?

_____

10. How important is it to eliminate future problems? _____

11. Why did you change dentists? _____

12. Tell me about your home care. Brush____Times Daily Floss___Daily/Weekly

13. Would you like to discuss cosmetic dentistry options? Y N

_____

SUMMERVILLE DENTISTRY

Name_____

Last First

Date_____

Please tell us how you learned about our dental practice. (Select ALL that apply)

_____ Friend, Family Name:_____

_____ Staff Member Name:_____

_____ Other dentist/doctor Name:_____

_____ Our website

_____ Internet Search (a basic search for “dentist”)

_____ Insurance Company Name of company:_____

_____ Radio Ad

_____ Referral Cards From Our Office

_____ Smile Savings

_____ Direct Mail Campaign

_____ St. Mary’s Publication

_____ Augusta Christian Ad

_____ Riverwood