PATIENT REGISTRATION

Patient Information

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

Address: _____ City: _____ State: _____ Zip: _____

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

Email: _____ Birth Date: _____ Age: ____ Social Security_____

Employer: _____ Job Title:_____

◯ Male ◯ Female Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Widowed

Patient is Responsible Party ◯ Yes ◯ No Patient is Policy Holder ◯ Yes ◯ No

Responsible Party if not patient: _____ Spouse ◯ Parent ◯ Other ◯
(Name)

Policy Holder Information

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

Address: _____ City: _____ State: _____ Zip: _____

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

Email: _____ Birth Date: _____ Social Security_____

Employer: _____ Job Title:_____

◯ Male ◯ Female Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Widowed

Dental Insurance

Insurance Company _____ Employer _____

Person to contact for Emergency: _____ Relationship: _____

Phone Number: _____

Who may we thank for your referral: _____ Relationship: _____

Is another member of your family a patient at our office? ◯ Yes ◯ No

Name: _____ Relationship: _____

I hereby authorize Dr. Templeton, Dr. Batson, or designated staff to take x-rays, study models, photographs or other diagnostic aids to make a thorough diagnosis of _____'s dental needs.
(Name)

Patient's Signature _____*Date* _____

DENTAL HISTORY

PATIENT NAME _____ Birth Date _____

What is the reason for your visit today? _____

Date of Last Dental Visit _____ **Last Dental Cleaning** _____ **Last X-rays** _____

What was done at your last dental visit? _____

Previous Dentist's Name _____ Phone _____

How often do you have dental examinations?_____

How often do you brush your teeth? _____ How often do you floss? _____

Have you ever used or are currently using topical fluoride? Yes No

What other dental aids do you use?

_____

Do you have any dental problems now? Yes No

If yes, please describe:

_____

Are any of your teeth sensitive to:

Hot or Cold?	O Yes	O No
Sweets?	O Yes	O No
Biting or Chewing?	O Yes	O No
Have you noticed any mouth odors or bad tastes?	O Yes	O No
Do you frequently get cold sores, blisters, or any other oral lesions?	O Yes	O No
Do your gums bleed/hurt?	O Yes	O No
Have your parents experienced gum disease or tooth loss?	O Yes	O No
Have you noticed any loose teeth or change in your bite?	O Yes	O No
Does food become caught in between your teeth?	O Yes	O No

Do you:

Grind your teeth while awake or asleep?	O Yes	O No
Bite your lips or cheeks?	O Yes	O No
Mouth breathe while awake or asleep?	O Yes	O No
Have tired jaws, especially in the morning?	O Yes	O No
Snore or have any sleeping disorders?	O Yes	O No
Smoke/chew tobacco or use other tobacco products?	O Yes	O No

Have you ever had:

Orthodontic treatment?	O Yes	O No
Oral Surgery?	O Yes	O No
Periodontal Treatment?	O Yes	O No
Your teeth ground or the bite adjusted?	O Yes	O No
A bite plate or mouth guard?	O Yes	O No
A serious injury to the mouth / head?	O Yes	O No

Have you experienced:

Clicking or popping of the jaw?	O Yes	O No
Pain? (joint, ear, side of face)	O Yes	O No
Difficulty in opening/closing the mouth?	O Yes	O No
Headaches, neck aches, or shoulder aches?	O Yes	O No
Sore muscles (neck, shoulders)?	O Yes	O No

Are you satisfied with your teeth's appearance? O Yes O No

Would you like to keep all of your teeth all of your life? O Yes O No

Do you feel nervous about having dental treatment? O Yes O No

If so, what is your biggest concern? _____

Have you ever had an upsetting dental experience? O Yes O No

If yes, please describe _____

Have you ever been told to take a pre-medication prior to dental treatment? O Yes O No

To the best of my knowledge, the questions on this form have been accurately answered.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ **DATE** _____

MEDICAL HISTORY

PATIENT NAME _____ BIRTH DATE _____

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/neck injury?	○Yes	○ No	If yes, please explain: _____
Are you taking any medications, pills or drugs?	○Yes	○ No	If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux?	○Yes	○ No	_____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○Yes	○ No	_____
Are you on a special diet?	○Yes	○ No	
Do you use tobacco?	○Yes	○ No	
Do you use controlled substances?	○Yes	○ No	

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?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: _____

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

Have you ever had any serious illness not listed above? ○Yes ○ No _____

Comments: _____

_____

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Doctor's Signature _____

Financial Policy
Fort Mill Dentistry, LLC

Fort Mill DENTISTRY

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship.

Payment for services is due at the time services are rendered. We accept cash, money order, debit card, credit card, or personal check. There is a $50 service charge for returned checks**. PAYMENT-IN-FULL IS EXPECTED AT THE TIME OF SERVICE**. We offer an adjustment to those with no insurance coverage as well as to our patients 65 & over when paying in full at the time of service, for amounts under $200 it is 5%, for amounts over $200 it is 10%. For those who need to extend their payments beyond the date of service: we accept Care Credit. Please let us know if you have any questions regarding this policy.

We will be happy to process your insurance claim for your reimbursement as long as you provide complete insurance information. However, you must understand the following:

1. Emergency visits or treatment for patients "not of record", for patients who have been out of the practice for over one year, or for patients who have an existing balance or bad credit with our office, will be asked for payment at appointment reservation. _____
Initial Here

2. **Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract. Our relationship is with you, NOT your insurance company. Please note we are ONLY IN NETWORK WITH DELTA DENTAL PREMIER.** _____
Initial Here

3. **All charges are *your* responsibility whether your insurance company pays or not. Not all services are covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.** The reasonable and customary fee limits are determined by premium levels, regional averages, and your plan purchaser's decision on reimbursement levels. Fees for services, along with unpaid deductibles and co-payments are due at the time of treatment. _____
Initial Here

4. **We require you to pay any balance your insurance has not paid within 30 days**. _____
Initial Here

5. If you are covered by a PPO or HMO or other managed care company that requires your treatment be performed by a "participating provider", it is your responsibility to notify us about this. Please understand that if we do not participate with your insurance plan, you are responsible for full payment of your dental fees. If we do participate with your plan, you are responsible for unpaid deductibles and co-payments that are due.

6. **For all major restorative work that involves a lab fee, the patient's portion is due on date of service.**

_____
Initial Here

Please note that, unless cancelled 24 hours in advance, you will be charged for missed appointments, including prophylaxis (dental cleanings). Please call if you have to reschedule. 803-547-7508 _____
Initial Here

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems so that we can assist you in the management of your account.

Again, thank you for choosing us as your dental health care providers. We appreciate the opportunity to serve you.

_____

Patient, Parent, or Guardian Signature

Updated: May 20, 2020

I have read the NOTICE OF PRIVACY PRACTICES document and have been offered a copy for my records.

_____

Signature

Authorization for Release of Information

Name of Patient _____ Date of Birth _____

Fort Mill Dentistry 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	☐ Appointment Reminders ☐ Other_____
☐ Other person (s) (provide name and phone number)	☐ Financial ☐ Medical ☐ Appointment Reminders
☐ Email communication-Provide email address* _____ *For email communication to occur, please accept the disclosure below:	☐ Financial ☐ Medical ☐ Appointment reminders ☐ Breach notification
☐ Text communication – Provide number * _____ *For text communication to occur, accept the disclosure below:	☐ Appointment reminders ☐ Other: _____
☐ For **email and/or 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 email and/or text communication as selected.	
☐ Photo taken by staff (Example: pre/post procedure) ☐ Other	☐ May be posted in office ☐ May be posted on website ☐ Other_____

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 (description of Personal Rep. on back or attached)