Beaufort
FAMILY DENTISTRY

Patient Information

Patient Name_____ Date_____

DOB _____/_____/_____ Social Security # _____ Gender: Male Female

Address_____ City_____ State_____ Zip_____

E-mail_____

Phone: Home_____ Work_____ Cell _____

Check appropriate box: □ Minor □ Single □ Married □ Separated □ Divorced □ Widowed

Who May We Thank For Referring You? _____

Person to Contact in Case of Emergency _____ Phone_____

Responsible Party

Name _____ Relationship_____

Address_____ City_____ State_____ Zip_____

Phone: Home_____ Work_____ Cell _____

DOB _____/_____/_____ Social Security # _____ Gender: Male Female

Insurance Information

Name of Policy Holder _____ Relationship_____

Address_____ City_____ State_____ Zip_____

Phone: Home_____ Work_____ Cell _____

DOB _____/_____/_____ Social Security # _____ Gender: Male Female

Employer _____ Insurance Company _____

Insurance Phone _____ Address _____

Group Number _____ Policy Number_____ Rank _____

Do you have any additional dental insurance? □ Yes □ No (If yes, please complete the following)

Name of Policy Holder _____ Relationship_____

Address_____ City_____ State_____ Zip_____

Phone: Home_____ Work_____ Cell _____

DOB _____/_____/_____ Social Security # _____ Gender: Male Female

Employer _____ Insurance Company _____

Insurance Phone _____ Address _____

Group Number _____ Policy Number_____ Rank _____

Authorization and Release

I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of Patient (or parent/guardian if minor) **Date**

Beaufort
FAMILY DENTISTRY

Patient Medical History

Physician _____ Office Phone _____ Date of last Exam _____

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.

Are you under a physician's care now? Y N Explain _____
Have you ever been hospitalized or had a major operation? Y N Explain _____
Have you ever had a serious head or neck injury? Y N Explain _____
Are you taking any medications, pills, drugs, or herbal supplements? Y N Explain _____
Do you take, or have you ever taken Phen-Fen or Redux? Y N Explain _____
Are you on a special diet? Y N Explain _____
Do you use tobacco? Y N Explain _____
Do you use controlled substances? Y N Explain _____

Women: Are you Pregnant/ Trying to get pregnant? Y N Taking oral contraceptives? Y N Nursing? Y N

Are you allergic to any of the following?

□ Aspirin □ Penicillin □ Codeine □ Local Anesthetics □ Acrylic □ Metal □ Latex □ Sulfa drugs □ Epinephrine □ Other_____

Do you have any, or have had, any of the following?

Acid Reflux	Y N	Convulsions	Y N	Heart Trouble/ Disease	Y N	Radiation	Y N
AIDS/HIV Positive	Y N	Cortisone Medicine	Y N	Hemophilia	Y N	Scarlet Fever	Y N
Alzheimer's Disease	Y N	Diabetes	Y N	Hepatitis A	Y N	Shingles	Y N
Anaphylaxis	Y N	Drug Addiction	Y N	Hepatitis B or C	Y N	Sickle Cell Disease	Y N
Anemia	Y N	Easily Winded	Y N	Herpes	Y N	Sinus Trouble	Y N
Angina	Y N	Eating Disorder	Y N	High Blood Pressure	Y N	Spina Bifida	Y N
Arthritis/Gout	Y N	Emphysema	Y N	Hives or Rash	Y N	Stomach/IntestinalDisease	Y N
Artificial Heart Valve	Y N	Epilepsy or Seizures	Y N	Hypoglycemia	Y N	Stroke	Y N
Artificial Joint	Y N	Excessive Bleeding	Y N	Irregular Heartbeat	Y N	Treatments	Y N
Asthma	Y N	Excessive Thirst	Y N	Kidney Problems	Y N	Recent Weight Loss	Y N
Blood Disease	Y N	Fainting Spells/ Dizziness	Y N	Leukemia	Y N	Rheumatism	Y N
Blood Transfusion	Y N	Frequent Cough	Y N	Liver Disease	Y N	Swelling of Limbs	Y N
Breathing Problem	Y N	Frequent Diarrhea	Y N	Low Blood Pressure	Y N	Thyroid Disease	Y N
Bruise Easily	Y N	Frequent Headaches	Y N	Lung Disease	Y N	Tonsillitis	Y N
By- Pass Surgery	Y N	Genital Herpes	Y N	Mitral Valve Prolapse	Y N	Tuberculosis	Y N
Cancer	Y N	Glaucoma	Y N	Pain in Jaw Joints	Y N	Tumors or Growths	Y N
Chemotherapy	Y N	Hay Fever	Y N	Parathyroid Disease	Y N	Ulcers	Y N
Chest Pains	Y N	Heart Attack/ Failure	Y N	Psychiatric Care	Y N	Venereal Disease	Y N
Cold Sores/Fever Blisters	Y N	Heart Murmur	Y N	Rheumatic Fever	Y N	Yellow Jaundice	Y N
Congenital Heart Disorder	Y N	Heart Pacemaker	Y N	Renal Dialysis	Y N		

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

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of my treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners.

Signature of Patient (or parent/guardian if minor) **Date**

Acknowledgement of Receipt of Notice of Privacy Practices

Signature of Patient (or parent/guardian if minor) **Date**

Beaufort Family Dentistry

DENTAL HISTORY

Patient Name _____ Date of Birth ___/___/___ Age ____

Referred by _____ How would you rate your mouth? □ Excellent □ Good □ Fair □ Poor

Previous Dentist _____ How long were you a patient? _____ Months/ Years

Date of most recent treatment (other than a cleaning) ___/____/___

I routinely see my dentist every: □ 3 mo. □ 4 mo. □ 6 mo. □ 12 mo. □ Not routinely

What is our immediate concern? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

PERSONAL HISTORY

1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [___]_____	**YES**	**NO**
2. Have you had an unfavorable dental experience?_____	**YES**	**NO**
3. Have you ever had complications from past dental treatment? _____	**YES**	**NO**
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____	**YES**	**NO**
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? _____	**YES**	**NO**
6. Have you had any teeth removed? _____	**YES**	**NO**

SMILE CHARACTERISTICS

7. Is there anything about the appearance of your teeth that you would like to change? _____	**YES**	**NO**
8. Have you ever whitened (bleached) your teeth? _____	**YES**	**NO**
9. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____	**YES**	**NO**
10. Have you been disappointed with the appearance of previous dental work? _____	**YES**	**NO**

BITE AND JAW JOINT

11. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)? _____	**YES**	**NO**
12. Do you/ would you have any problems chewing gum? _____	**YES**	**NO**
13. Do you/ would you have any problems chewing bagels, baguettes, protein bars, etc?_____	**YES**	**NO**
14. Have your teeth changed in the last 5 years, become shorter, thinner or worn?_____	**YES**	**NO**
15. Are your teeth crowding or developing spaces? _____	**YES**	**NO**
16. Do you have more than one bite and squeeze to make your teeth fit together? _____	**YES**	**NO**
17. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____	**YES**	**NO**
18. Do you clench your teeth in the daytime or make them sore? _____	**YES**	**NO**
19. Do you have any problems with sleep or wake up with awareness of your teeth? _____	**YES**	**NO**
20. Do you wear or have you ever worn a bite appliance? _____	**YES**	**NO**

TOOTH STRUCTURE

21. Have you had any cavities within the past 3 years? _____	**YES**	**NO**
22. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?	**YES**	**NO**
23. Do you feel or notice any holes (i.e. pitting, craters) on the biting surfaces of your teeth? _____	**YES**	**NO**
24. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? _____	**YES**	**NO**
25. Do you have grooves or notches on your teeth near the gum line? _____	**YES**	**NO**
26. Have you ever broken teeth, chipped teeth, or had a toothache or crack filling? _____	**YES**	**NO**
27. Do you frequently get food caught between any teeth? _____	**YES**	**NO**

GUM AND BONE

28. Do your gums bleed or are they painful when brushing or flossing? _____	**YES**	**NO**
29. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____	**YES**	**NO**
30. Have you ever noticed an unpleasant taste or odor in your mouth? _____	**YES**	**NO**
31. Is there anyone with a history of periodontal disease in your family? _____	**YES**	**NO**
32. Have you ever experienced gum recession? _____	**YES**	**NO**
33. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?_____	**YES**	**NO**
34. Have you experienced a burning sensation in your mouth? _____	**YES**	**NO**

Patient's Signature _____ **Date** _____

Beaufort
FAMILY DENTISTRY

1274 Ribaut Rd | Beaufort SC, 29902
(843) 524-6363 | (843)522-9735(fax)
www.beaufortfamilydentistry.com

Financial Policy

Thank you for choosing Beaufort Family Dentistry. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Check, Visa, Mastercard, American Express or Discover Card
- NO INTEREST[1] and INTEREST Payment Plans[2] from CareCredit or Springstone
    - Allow you to pay over 6-12 months with NO INTEREST[1]
    - Convenient, low monthly payment plans[2] for extended periods of time available
    - No annual fees or pre-payment penalties

Please note:

Beaufort Family Dentistry requires payment either the day services are rendered or by financial agreement with our office. If payment is made later than 30 days from the date due, you are responsible for late charges, which will accrue at a rate of 1.5% to overdue given balance per month.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.[3] We accept most insurance policies and our general dentists are currently network providers for Delta Dental, Medicaid, Metlife, and United Concordia. You will be responsible for any estimated insurance benefits that are not paid by your insurance company. For those patients with insurance policies that we are out-of-network providers, we require payment in full for the initial appointment.

Restorations will have a one year warranty. Beyond one year, due to the individuality of each patient, the warranty may be extended at the discretion of the doctor. In all instances proper diet and home care as well as recommended preventive maintenance appointments must be maintained.

Beaufort Family Dentistry charges $30 for returned checks.

Please be aware that you will be responsible for any court fees, collection agency fees, attorney's fees and any other cost associated with collecting your bill should you fail to remit any amounts due to Beaufort Family Dentistry, LLC.

We ask for at least 24 hour notice to cancel an appointment. Should 24 hour notice not be given you may be subjected to a failed appointment fee of up to $100 per scheduled hour. Please note that we try very hard to maintain our schedule so that all our patients can be treated promptly.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want and need.

Patient, Parent or Guardian Signature _____ Date _____

Patient Name (Please Print) _____

[1]If paid within the promotional period. Otherwise, interest assessed from purchase date. Minimum monthly payment required.

[2]Subject to credit approval

[3]However, if we do not receive payment from your insurance carrier within 90 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

Beaufort Family Dentistry

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (05/01/09), and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person involved with your care to the extent necessary to help with your healthcare or with payment for your healthcare **{You must make your request in writing if you choose not to allow.}**

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

Treatment Alternatives and Health-Related Benefits and Services: We may use and disclose your health information to tell you about treatment options or alternatives or health-related benefits and services that may be of interest to you.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.50 for each page, $10 per hour for staff time to copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: [illegible] E-Mail: [illegible]

Telephone: (843)524-6363 Fax: (843)522-9 735

Address: 1274 RIBAUT ROAD, BEAUFORT, SC 29902

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002; April 30, 2009).