Palmetto Smiles
DRS. SANG & MOSS
PATIENT REGISTRATION

WELCOME – We are pleased to have you in our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you.

PATIENT INFORMATION:

Name _____ SSN (18 +) _____
Preferred Name_____ Salutation: Please Circle: Mr. Mrs. Ms. Miss Dr.
Home Address _____ City/Zip _____
Home Phone _____ Work Phone _____ Cell Phone _____
Date of Birth _____ Sex: ____ Male ____ Female Marital Status: ____Single ____ Married
Patient/Parent Employer _____ Referred By _____
Patient Occupation:_____
Email Address _____
Notify in case of Emergency: _____ Phone _____
Person financially responsible for account_____
Date of Birth _____ SSN_____ Pharmacy _____

PRIMARY DENTAL INSURANCE INFORMATION:

Insurance subscriber's Name: _____
Relation to Patient _____ Date of Birth _____ SSN_____
Address (if different from patient) _____ City/Zip _____
Phone _____ Responsible Person's Employer _____
Dental Insurance Company _____ Business Phone _____
Name of other dependents on this plan _____

ADDITIONAL DENTAL INSURANCE INFORMATION

Is patient covered by additional dental insurance: _____ Yes _____ No
Subscriber Name _____ Date of Birth _____ Relation to Patient _____
Address (if different from patient) _____ City/Zip _____
Home Phone _____ Cell Phone _____SSN _____
Subscriber Employed by _____ Business Phone _____
Dental Insurance Company _____

PREFERRED METHOD OF PAYMENT (CHECK ALL THAT APPLY) PAYMENT IS DUE WHEN SERVICES ARE RENDERED.

____ Cash ____ Check/Debit Card ____ Credit Card ____ Care Credit

I understand that my dental insurance is filed as a courtesy to me and in many cases will not cover the entire amount of charges. I also understand that any and all unpaid balances are to be paid by the person financially responsible for this account.

Signature of Patient or Guardian _____ Date _____

***** PLEASE TURN THE PAGE TO COMPLETE YOUR REGISTRATION *****

PLEASE ANSWER THE FOLLOWING QUESTIONS TO HELP US EVALUATE YOUR DENTAL HEALTH.

1. What prompted you to seek dental care at this time? _____
2. How long since your last thorough dental exam? _____
3. When were dental x-rays last taken? _____
4. Previous dentist _____ Phone # _____

   May we request your dental records? ___ Yes ___ No
5. Have you experienced any discomfort from your teeth or gums lately? ___Yes ___No
6. Has the fear of dental treatment kept you from regular visits? ___Yes ___No
7. Would you prefer a local anesthetic (Novocain) for most dental treatment? ___Yes ___No

   Nitrous Oxide (Gas)? ___Yes ___No if so, have you had nitrous oxide gas before? ___Yes ___No
8. How often do you brush your teeth? _____
9. How often do you use dental floss? _____
10. Does food wedge between certain teeth? ___Yes ___No If so, where? _____
11. Do your gums bleed easily, feel tender or irritated? ___Yes ___No
12. Are your teeth sensitive to hot, cold or sweets? ___Yes ___No
13. Have you ever had periodontal or gum surgery? ___Yes ___ No If so, when? _____
14. Have you had your wisdom teeth removed? ___Yes ___ No If so, when _____
15. Are you self-conscious about the appearance of your teeth? ___ Yes ___ No
16. Are you aware of grinding or clenching your teeth? ___ Yes ___ No
17. Have you lost any teeth other than wisdom teeth? ___ Yes ___ No Have they been replaced? ___ Yes ___ No
18. Have you noticed any loose teeth? ___Yes ___ No
19. Have you ever had root canal treatment? ___Yes ___ No
20. Have you ever had orthodontic treatment? ___ Yes ___ No If so, when? _____
21. Are you satisfied with your past dentistry? ___ Yes ___ No If not, why? _____

*** WE LOOK FORWARD TO YOUR FUTURE OF HEALTHTY SMILES ***

Palmetto Smiles Medical Form(Copy)

Patient Name: Birth Date: Date Created:

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	
Do you use controlled substances?	◯ Yes ◯ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

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

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	Drug Addiction	◯ Yes ◯ No
Hepatitis B or C	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No	Anemia	◯ Yes ◯ No	Herpes	◯ Yes ◯ No
Rheumatic Fever	◯ Yes ◯ No	Angina	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No
Artificial Joint	◯ 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
Leukemia	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Bruise Easily	◯ Yes ◯ No
Genital Herpes	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Cancer	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No
Thyroid Disease	◯ Yes ◯ No	Chemotherapy	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Mitral Valve Prolapse	◯ 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	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		

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

Comments:

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.

Signature of Patient, Parent or Guardian:

X _____ Date: _____

Palmetto Smiles

Drs. Sang & Moss

Cancellation Policy / No Show Policy

1. **Cancellation / No Show Policy for Doctor and Hygiene Appointment**

We understand that there are times when you must miss an appointment, due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

If an appointment is not cancelled at least 24 hours in advance you will be charged a fifty dollar ($50.00) fee; this will not be covered by your insurance company.

2. **Scheduled Appointments**

We understand that delays happen; however, we must try to keep the other patients and doctor / hygienist on time.

If a patient is 15 minutes past their scheduled time we will have to reschedule the appointment.

3. **Cancellation / No Show Policy for Surgery**

Due to the large block of time needed for surgery, last minute cancellations can cause problems and added expenses for the office.

If surgery is not cancelled at least 10 days in advance you will be charged a seventy-five dollar ($75.00) fee; this will not be covered by your insurance company.

4. **Account Balances**

We will require that patients with self-pay balances do pay their account balances to zero (0) prior to receiving further services by our practice.

Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to a business office representative with whom they can review their account and concerns.

Patients with balances over one hundred dollars ($100.00) must make arrangements prior to future appointments being made.

_____ _____ ____/____/____

Print Name Signature Patient / Guardian Date

Palmetto Smiles

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 _____

PHOTO AND TESTIMONIAL RELEASE FORM

I, _____, hereby grant permission to Palmetto Smiles, to use my photograph and any testimonial I give regarding the dental care I receive from any such office, in any marketing, contests, advertising or teaching materials used to market or advertise their dental practice, including use on Palmetto Smiles' web site. I acknowledge Palmetto Smiles' right to crop or otherwise treat the photograph at their discretion. I also acknowledge that Palmetto Smiles may choose not to use my photograph and testimonial at this time, but may do so at their own discretion at a later date. I also understand that once my image is posted on Palmetto Smiles' web site, the image can be downloaded by any computer user, which is beyond the control of Palmetto Smiles, and I will hold them and any of their affiliated offices harmless from any such use or download.

I hereby freely and voluntarily consent to the use of my photograph and testimonial as stated above until I revoke this consent in writing.

_____	_____
ignature	Parent/Guardian Signature (If under age of 18)
_____	_____
rinted Name	Parent/Guardian Printed Name (If under age of 18)
_____	_____
_____	_____
ddress	Parent/Guardian Address (If under age of 18)
_____	_____
ate	Date

ffice Use Only

ate: _____

ame of Patient: _____

atient REFUSED _____ **Patient Accepted** _____ **Other** _____ **Witness** _____

Authorization for Release of Information – Compound Release

Name of Patient _____ Date of Birth _____

PALMETTO SMILES is authorized to release protected health information about the above named patient in the following manner and/or to selected persons.

Check each person/entity approved to receive information.	Check type of information that can be given to person/entity on the left in the same section.
☐ Voice Mail	☐ Results of lab tests/x-rays ☐ Other_____
☐ Other person (s) (provide name and phone number)	☐ Financial ☐ Medical
☐ 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 reminder ☐ 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 of patient received by patient or legal guardian ☐ 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 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 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 Representative's Authority (attach necessary documentation) Revised Jan 2018

AUTHORIZATION TO FILE CLAIMS/SIGNATURE ON FILE

Employee/Subscriber's Name as shown on dental card or with Insurance Company:

First: _____ Middle Initial: _____ Last: _____

Employee/Subscriber's ID # or SS #: _____ Date of Birth: _____

Employee/Subscriber's Address: _____

_____

Group/Employer Name: _____ Group#: _____

Insurance Co: _____ Insurance Company Phone #: _____

*Please list patient's Palmetto Smiles is authorized to file Employee/Subscriber's Insurance on: **(please include self)***

1. _____ Date of Birth: _____
2. _____ _____
3. _____ _____
4. _____ _____
5. _____ _____

○ I authorize release of any information concerning my or my child's healthcare recommendations and treatment for the purpose of evaluation and administering claims for insurance benefits.
○ I authorize all insurance benefits payable by my plan to be paid directly to Palmetto Smiles.
○ I understand that if the insurance company pays the subscriber/policyholder directly, all balances are due immediately.
○ I understand that Palmetto Smiles does not guarantee payment from your insurance company and any estimates given are based on coverage provided from you insurance provider.
○ I understand that any portion of my treatment not covered by insurance is my responsibility.

Patient/Responsible Party's Signature: _____Date:_____

Yearly, this form must be signed and a copy of your **dental (not medical) insurance card** and/or a claim form from your insurance company with the address, phone#, group# and Employee ID# on it must be obtained to file your insurance benefits. Thank you