PENINSULA
COSMETIC & FAMILY
DENTISTRY

538 SAVANNAH HIGHWAY ● CHARLESTON, SC 29407 ● (843)722-1676

PATIENT INFORMATION FORM

DATE: _____

NAME: _____ NICKNAME: _____

DATE OF BIRTH: _____ SOCIAL SECURITY # _____

ADDRESS: _____ _____

CITY: _____ STATE: _____ ZIP: _____

EMAIL: _____

HOME PH: _____CELL PH: _____ WORK PH: _____

CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

PATIENT/PARENT'S EMPLOYER _____

SCHOOL (IF ATTENDING): _____ GRADE: _____

EMERGENCY CONTACT: _____ PHONE: _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

RESPONSIBLE PARTY/INSURANCE INFORMATION

NAME: _____ RELATIONSHIP TO PATIENT: _____

DATE OF BIRTH: _____ SOCIAL SECURITY # _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

EMAIL: _____ EMPLOYER: _____

INSURANCE COMPANY: _____

INSURANCE CO ADDRESS: _____

GROUP NAME: _____ GROUP ID: _____ MEMBER ID: _____

HOME PH: _____CELL PH: _____ WORK PH: _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

PLEASE PRESENT INSURANCE CARD TO THE FRONT DESK

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PATIENT DENTAL HISTORY

DATE: _____

PATIENT NAME: _____ BIRTH DATE: _____

PREVIOUS DENTIST (NAME & LOCATION): _____

DATE OF LAST EXAM: _____

REASON FOR THIS VISIT: _____

DO YOU PRE-MEDICATE FOR DENTAL VISITS? ☐ YES ☐ NO

IF YES, WHAT DO YOU NORMALLY TAKE? _____

	YES	NO		YES	NO
1. DO YOU LIKE YOUR SMILE? …….....	☐	☐	9. DO YOU HAVE FREQUENT HEADACHES?.....	☐	☐
2. ARE YOU HAPPY WITH THE APPEARANCE OF YOUR TEETH? …….....	☐	☐	10. DO YOU CLENCH/GRIND YOUR TEETH?.....	☐	☐
3. DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING? …….....	☐	☐	11. HAVE YOU HAD ANY ORTHODONTIC TREATMENT? ……	☐	☐
4. ARE YOUR TEETH SENSITIVE TO HOT, COLD, OR SWEET LIQUIDS/FOODS? ……...	☐	☐	12. DO YOU EXPERIENCE SNORING/SLEEP APNEA? ……..	☐	☐
5. DO YOU FEEL PAIN IN ANY OF YOUR TEETH? ..	☐	☐	13. DO YOU WISH YOUR TEETH WERE WHITER?.....	☐	☐
6. DO YOU HAVE ANY SORES OR LUMPS IN/NEAR YOUR MOUTH?	☐	☐	14. HAVE YOU NOTICED ANY LOOSENING OF YOUR TEETH? ……...	☐	☐
7. HAVE YOU EVER HAD ANY HEAD, NECK OR JAW INJURIES? ……	☐	☐	15. HAVE YOU EVER HAD PERIODONTAL TREATMENT? ……	☐	☐
8. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?			16. EVER WORN A DENTURE OR OTHER APPLIANCE? ……...	☐	☐
CLICKING ……..... PAIN (JOINT,EAR,SIDE OF FACE)……..... DIFFICULTY OPENING OR CLOSING…… DIFFICULTY IN CHEWING……....	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	17. DO YOU WISH YOUR TEETH WERE STRAIGHTER? ……...	☐	☐
			18. DO YOU HAVE ANY MISSING TEETH YOU WOULD LIKE REPLACED? …….	☐	☐

IF YOU COULD CHANGE <u>ANYTHING</u> ABOUT YOUR SMILE, WHAT WOULD YOU CHANGE? _____

_____

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: _____ **DATE:** _____

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PATIENT MEDICAL HISTORY

PATIENT NAME: _____**DOB:** _____ **DATE:** _____

Although your 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 medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

PHYSICIAN NAME: _____

ARE YOU UNDER A PHYSICIAN'S CARE NOW? ☐ YES ☐ NO

IF YES, PLEASE EXPLAIN: _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING? (PLEASE CHECK ALL THAT APPLY)

☐ AIDS/HIV	☐ DIGESTIVE PROBLEMS	☐ JOINT REPLACEMENT
☐ ANEMIA	☐ EPILEPSY/CONVULSIONS	☐ LIVER DISEASE
☐ ARTHRITIS	☐ EXCESSIVE BLEEDING	☐ ORGAN TRANSPLANT
☐ ARTIFICIAL HEART VALVE	☐ FAINTING/SEIZURES	☐ RADIATION THERAPY
☐ BACK PROBLEMS WHICH KEEP YOU FROM RECLINING IN CHAIR	☐ GENERAL ALLERGIES/HAY FEVER	☐ RESPIRATORY PROBLEMS
☐ CANCER/CHEMOTHERAPY	☐ HEART ATTACK/DISEASE	☐ SINUS INFECTION
☐ CARDIAC PACEMAKER	☐ HEPATITIS/JAUNDICE	☐ STROKE
☐ CHEST PAINS/ANGINA	☐ HIGH BLOOD PRESSURE	☐ TUBERCULOSIS
☐ DIABETES	☐ INDIGESTION/ACID REFLUX	
☐ OTHER (PLEASE EXPLAIN): _____		

PLEASE LIST ALL MEDICATIONS, INCLUDING OVER THE COUNTER: _____

_____

ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO THE FOLLOWING? (PLEASE CHECK ALL THAT APPLY)

☐ PENICILLIN OR OTHER ANTIBIOTICS	☐ LATEX RUBBER	☐ SULFA DRUGS
☐ METAL (NICKEL,ZINC, ETC)	☐ OTHER (PLEASE EXPLAIN): _____	

WOMEN ONLY:

ARE YOU PREGNANT OR THINK YOU MIGHT BE PREGNANT? ☐ YES ☐ NO

ARE YOU NURSING? ☐ YES ☐ NO

ARE YOU TAKING ORAL CONTRACEPTIVES? ☐ YES ☐ NO

DO YOU USE TOBACCO? ☐ YES ☐ NO **IF YES, HOW OFTEN**? _____

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: _____ **DATE:** _____

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PATIENT CONSENT & PAYMENT POLICY

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependents, have insurance coverage with _____ and assign directly to Peninsula Dentistry all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges regardless of insurance coverage or whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

I consent Peninsula Dentistry may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services. I agree to provide the necessary information needed in determining insurance benefits or the benefits payable to related services. I understand that payment is due at the time services are rendered and any estimated portion from treatment plans are estimates only and are estimated on information obtained by my dental insurance company. _____Initial

CONSENT FOR USE OF RECORDS

I hereby give my permission for the use of dental records, including photographs and radiographs, made in process of examinations, treatment and retention purposes of professional consultations, research, education, or publication in professional journals. _____Initial

PAYMENT POLICY

IF YOU HAVE DENTAL INSURANCE: As a courtesy, we will be happy to assist you in sending forms and coordinating benefits. However, if payment from the insurance company is not sufficient to pay the balance in full, the patient (and/or insured) is responsible for the remaining balance.

IF YOU DO NOT HAVE DENTAL INSURANCE: Payment is due at the time of services rendered, unless prior written arrangements have been made. We do offer financial plans and third-party financing options for more extensive treatments.

DIVORCED PARENTS: If the patients being seen are children from a divorced family, the parent who brings the child to the appointment is responsible for the entire payment of services. A receipt will be provided.

Your signature indicates your acknowledgement of your responsibility for payment of fees and acceptance of the terms outlined as above.

_____ _____

Name of Patient **Name of Responsible Party**

_____ _____

Signature **Date**

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538 Savannah Highway ● Charleston, SC 29407

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

For Office Use Only:
W attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	**Initials:**	**Reason:**