PENINSULA
COSMETIC & FAMILY
DENTISTRY

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

DENTAL HISTORY

Name: ____

Reason for today's visit: ____

Previous dentist: ___________________________ Previous dentist's phone number: _____________

Date of last dental care: _______________________ Last dental x-rays: _________________________

Please indicate any of the following issues that apply with a ☒:

- ☐ Bad Breath
- ☐ Grinding Teeth
- ☐ Sensitivity to Cold
- ☐ Bleeding Gums
- ☐ Loose Teeth
- ☐ Sensitivity to Heat
- ☐ Clicking or Popping Jaw
- ☐ Broken Teeth
- ☐ Sensitivity when Biting
- ☐ Food Collection Between Teeth
- ☐ Periodontal Treatment
- ☐ Sores in your Mouth
- ☐ Fear of Dental Treatment
- ☐ Lost or Broken Fillings

How often do you floss? _______________ How often do you brush? _____________

Within the last year have you had any Hospitalizations, Illnesses, or Operations? ☐Yes ☐No

If YES, please describe:

Have you ever had a blood transfusion? ☐YES ☐ NO If YES, *approximated* date: ____________

WOMEN: Are you taking Birth Control? ☐YES ☐ NO

Are you pregnant? ☐ YES ☐NO ☐MAYBE Are you nursing? ☐ Yes ☐No

Please indicate any of the following issues with a ☒:

- ☐ Cortisone Treatments
- ☐ Hepatitis; *Type:* _____
- ☐ Rheumatic Fever
- ☐ Anemia
- ☐ Cough, Persistent
- ☐ High Blood Pressure
- ☐ Scarlet Fever
- ☐ Arthritis, Rheumatism
- ☐ Diabetes
- ☐ HIV Positive
- ☐ Stroke
- ☐ Artificial Heart Valves
- ☐ Epilepsy
- ☐ Jaw Pain
- ☐ Thyroid Problem
- ☐ Artificial Joints
- ☐ Fainting
- ☐ Kidney Disease
- ☐ Tobacco Habit
- ☐ Asthma
- ☐ Glaucoma
- ☐ Liver Disease
- ☐ Tonsillitis
- ☐ Back Problems
- ☐ Headaches
- ☐ Mitral Valve Prolapse
- ☐ Tuberculosis
- ☐ Blood Disease
- ☐ Heart Murmur
- ☐ Nervous Problems
- ☐ Ulcer
- ☐ Cancer
- ☐ Heart Problems
- ☐ Pacemaker
- ☐ Chemical Dependency; *Describe:* _________
- ☐ Psychiatric Care
- ☐ Chemotherapy
- ☐ Latex Allergy
- ☐ Radiation Treatment
- ☐ Circulatory Problems
- ☐ Hemophilia
- ☐ Respiratory Disease

List *all* the medications you are taking:____

____

ANY ALLERGIES? (*including medications*): ____

TREATMENT CONSENT

I consent to treatment which is advisable and agreeable to both myself and the dentist knowing that certain rare complications may occur. These may include the following:

1) Injury to adjacent restorations, teeth or other tissues
2) *Trismus*: a prolonged stiffness of muscle(s)
3) *Fistula*: small openings between the mouth and sinus following the removal of upper teeth
4) Bone fractures
5) *Paresthesia*: a nerve involvement that may result in numbness of the chin, tongue, teeth, lips, or gums.
6) Dry socket

I understand that there isn't a guaranteed outcome for any treatment result or cure. I realize that additional procedures may become apparent during treatment and allow the Dentist to utilize his judgment.

SIGNATURE: ______________________________________ DATE:____________________

PATIENT OR RESPONSIBLE PARTY

YEARLY UPDATE: Are there any new changes? ☐ Yes ☐ No

SIGNATURE: ______________________________________ DATE:____________________

PATIENT OR RESPONSIBLE PARTY

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PATIENT INFORMATION

FIRST NAME: _______________ MIDDLE INITIAL: _____ LAST NAME: ___________________________

Mailing Address: ____

City, State: _______________ ZIP: _____________ SSN: ________________________________

Home Phone: ________________________ Work Phone: __________________________

Cell Phone: __________________________ Other Phone: __________________________

Sex: ☐ MALE ☐FEMALE Age: ________ Birth Date: ___________ Married: ☐ YES ☐NO

Employer: __________________________ Occupation: ___________________________

EMERGENCY CONTACT: _______________________ Phone #: ______________________________

How did you hear about our practice? : ____

Do you have any other family members in our practice? ☐ NO ☐YES: Who?: ___________________________

PERMISSION TO RELEASE PRIVATE HEALTH INFORMATION

☐ PLEASE DON'T SHARE DENTAL INFORMATION

By checking box, you don't have to fill out any further information.

I hereby give permission to the following people to have access to my private health information:

NAME: ___________________________________ RELATIONSHIP: ________________________

NAME: ___________________________________ RELATIONSHIP: ________________________

I give permission to employees and staff of Peninsula Cosmetic & Family Dentistry to share my dental care and/or health history including records, diagnosis, recommended treatment, dates of any treatment recommended or rendered and costs of services and payment received associated with them. I acknowledge that this permission is optional and can be revoked by me in writing at any point in time. I also understand that this permission is in addition to permissions granted by signing Peninsula Cosmetic & Family Dentistry Privacy Practices and shall remain in effect until revoked.

PATIENT SIGNATURE: ___________________________________ DATE: _____________________________

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INSURANCE INFORMATION

☐NO INSURANCE

By checking this box, I acknowledge that I have no insurance and that all costs are to be paid by me at the time of service.

PRIMARY INSURANCE

SUBSCRIBERS'S NAME: ____

SOCIAL SECURITY #: ______________ RELATIONSHIP TO PATIENT: ____________

BIRTH DATE: __________ EMPLOYER: __________________________________

OCCUPATION: _____________________________Work phone: ______________

BUSINESS ADDRESS: ____

INSURANCE COMPANY: ____

INSURANCE PHONE: ______________________GROUP NUMBER ______________

INSURANCE ID NUMBER: ____

SECONDARY INSURANCE

SUBSCRIBERS'S NAME: ____

SOCIAL SECURITY #: ______________ RELATIONSHIP TO PATIENT: ____________

BIRTH DATE: __________ EMPLOYER: __________________________________

OCCUPATION: _____________________________Work phone: ______________

BUSINESS ADDRESS: ____

INSURANCE COMPANY: ____

INSURANCE PHONE: ______________________GROUP NUMBER ______________

INSURANCE ID NUMBER: ____

*Insurance is a contract between you and your insurance company. We are **NOT** a party to this contract. We will bill your insurance company as a courtesy to you. Although we may estimate what your insurance company might pay, it is the insurance company that makes the final determination of payments made on your behalf. You agree to pay any portion of the charges not covered by insurance. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. This means it is your responsibility to know the limitations associated with your insurance policy. Failure to obtain the referral and/or preauthorization may result in a lower payment or no payment from your insurance company.*

PATIENT SIGNATURE: ___________________________ DATE: _______________

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OFFICE POLICIES

Welcome to our office and thank you for choosing Peninsula Cosmetic & Family Dentistry to serve your dental needs! We are dedicated to providing the highest quality dental care and services to our patients. We ask that you take a couple of minutes to thoroughly read over our office policies. If you have *any* questions, please don't hesitate to ask.

APPOINTMENTS:

We see patients on an appointment basis only. We consider an appointment made to be a commitment between our office and our patient. We are counting on you to be here, on time for your scheduled appointment. If an appointment is cancelled or missed without a 24 hour notice we may apply a charge of $50.00 per hour at our discretion. If this fee is applied, all previously scheduled appointments will be cancelled until this fee is paid in full. Once you have paid this fee you will have the option of rescheduling an appointment. If multiple appointments are missed we may have no choice but to dismiss you from our practice. If you have an extenuating circumstance we are unaware of please call and let us know. We would be happy to remove any charge that was applied inappropriately.

REGULAR VISITS:

Regular follow-up care is very important in preventing cavities and maintaining long-lasting dental health. We encourage our patients to return for their recommended visits and will inform you when you are due for your next visit at the end of each appointment. We may contact you via mail, email, and/or telephone to ensure you are aware that you are due for your regular preventive care.

EMERGENCIES:

If you have an emergency, please call the office **right away** and we will do everything possible to get you in at the earliest opportunity. If we are out of the office or it is after hours, we have an answering machine with instructions on how to reach one of our providers. Please understand we try to keep your waiting time to a minimum and we know your time is valuable. Sometimes there are circumstances out of our control that dictate a waiting time longer than usual. When this happens we try to give our patients a courtesy call to let them know there may be an additional waiting time. Please make sure we have current contact information for you on file so that we may contact you when needed.

I have read and understand the Office Policies listed above and I had the opportunity to ask any questions. I agree to comply with the policies above. I certify to the best of my knowledge that all information I have provided is accurate and true.

SIGNATURE: ____ DATE: _____________

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FINANCIAL POLICIES

When you are in the midst of treatment for a dental problem, it's easy to forget that a dentist office is also a business. We understand that. We also want you to understand that an important part of any business is collecting payment for the services that are provided. We have created this Financial Policy to help alleviate any miscommunications regarding our billing practices. Please let us know *immediately* if you have any questions.

This is an agreement between Peninsula Cosmetic & Family Dentistry as creditor/practice, and the patient/debtor named on this form. In this agreement the words "you," "your," and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we," "us," "our" refer to Peninsula Cosmetic & Family Dentistry.

By signing this agreement, you agree to pay for any costs we estimate due to us prior to services being provided.

TYPES OF INSURANCE:

Contracted: We are Participating Providers with Delta Dental, Cigna, and Blue Cross/Blue Shield of South Carolina, Metlife, Connection Dental Plans, United Health Care, United Concordia. Every policy is different and even though we are participating providers there are some policies that limit the reimbursements paid to us. It is each patient's responsibility to be familiar with their insurance coverage and to determine whether or not we are the appropriate type of participating provider for their policy.

Non-contracted: Insurance is a contract between you and your insurance company. We are **NOT** a party to this contract. We will bill your insurance company as a courtesy to you. Although we may estimate what your insurance company might pay, it is the insurance company that makes the final determination of payments made on your behalf. You agree to pay any portion of the charges not covered by insurance. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. This means it is your responsibility to know the limitations associated with your insurance policy and to see that your insurance company covers your bill. Failure to obtain the referral and/or preauthorization may result in a lower payment or no payment from your insurance company.

MONTHLY STATEMENT**:**

If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the finance charge, if any, and any payments or credits applied to your account during the month. It will also reflect any amounts we estimate to be paid on your behalf from your insurance provider if applicable. The amount shown as your balance is *due immediately*.

PAYMENT OPTIONS:

Estimated amounts not covered by insurance are due *prior* to the services being rendered. There are NO exceptions unless pre-arrangements have been made. Any Dental insurance claim remaining unpaid by 90 days from the date the treatment was rendered will be due immediately from the patient.

If you have insurance:

1. You pay your deductible and any estimated costs prior to services being rendered by cash or credit card.
2. You choose to pay your treatment in full by cash or credit and have your insurance company send payments on your behalf directly to you.

If you don't have insurance:

1. You pay by cash or credit card on the day that treatment is rendered.
2. On extensive treatment, you may prefer to secure a bank, credit union, or other third-party financing for the entire amount and make payments to the lending institution.
3. We honor Care Credit, on approval of credit. Care Credit is a third party lender and we are not associated with Care Credit in any way.

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FEES AND PAST DUE ACCOUNTS:

A **LATE FEE** of ten dollars ($10) per month may be applied to accounts that are not paid within twenty-five (25) days of the statement date.

A **FINANCE CHARGE** will be imposed on each item of your account that has not been paid within ninety (90) days of the time the item was added to the account. The finance charge will be computed at a *Monthly Percentage Rate* of one percent (1%), or at an *Annual Percentage Rate* of twelve percent (12%) year. You also agree to pay all attorney fees and costs of collection incurred if your account is not paid as agreed.

A **MISSED APPOINTMENT FEE** will be fifty dollars ($50) when an appointment is either abandoned (no-call, no-show) or cancelled within 24 hours of appointment date without a valid reason. This fee is **NOT** covered by your insurance. Any appointments scheduled after the fee is applied to your account will be cancelled until paid in full.

Patients missing excessive appointments will be dismissed from our practice

CREDIT BALANCES AND REFUNDS:

Occasionally an insurance company will pay more than we estimated on your behalf. If this occurs we will issue you a *refund check*. We issue these checks on a *monthly* basis and it is your responsibility to monitor your Explanation of Benefits (EOB) from your insurance company to see if there has been an overpayment on your behalf. If you have a credit balance *less than* ten dollars ($10) it will remain on your account for future treatment unless you contact us to request a check be issued to you.

WORKERS COMPENSATION/PERSONAL INJURY:

We require full payment up front unless other arrangements have been made prior to your appointment.

CREDIT HISTORY/WAIVER OF CONFIDENTIALITY:

You give us permission to answer questions about your credit experience with us. We have the option to report your account status to any credit reporting agency such as a credit bureau. You understand that if this account is submitted to an attorney or collection agency, if we litigate in court, or if your past-due status is reported to a credit reporting agency, any treatment received at our office may become a matter of public record.

DIVORCE:

In case of divorce or separation, the party responsible for the account initially remains responsible for the account afterwards. The parent authorizing treatment for a child will remain responsible for any subsequent charges. If the divorce decree requires the other parent to pay part or all of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

TRANSFERRING OF RECORDS:

You must sign a written request if you want to have copies of your records and/or x-rays sent to another office. By doing this, you authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive such information.

CO-SIGNATURE:

If this or another Financial Policy is signed by another person, that co-signature remains in effect until cancelled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

PATIENT'S NAME: ______________________________

RESPONSIBLE PARTY: ______________________________
(if not patient)

SIGNATURE: ______________________________ DATE: ______________

CO-SIGNATURE: ______________________________ DATE: ______________

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PRIVACY PRACTICES ACKNOWLEDGEMENT AND RECEIPT

You May Refuse to Sign this Acknowledgement

I, ____, have received a copy of Peninsula Cosmetic & Family Dentistry's Notice of Privacy Practices.

____

SIGNATURE

____

DATE

____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign.

☐ Communications barriers prohibited obtaining the acknowledgement.

☐ An emergency situation prevented us from obtaining acknowledgement.

☐ Other: *please specify*

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PATIENT CONSENT FOR ELECTRONIC COMMUNICATION

Our office would like to communicate with you electronically via email. By utilizing our practice's electronic services, you agree that Peninsula Cosmetic & Family Dentistry may communicate with you regarding any selected information below to the email you give us.

☐ **DECLINE SERVICE**
By checking box, you don't have to fill out any further information.

PATIENT CONSENT:

I, ____, in the presence of my dentist or the dental practice's privacy representative, agree that the practice may electronically communicate with me at the following email address:

EMAIL ADDRESS: ____

PATIENT'S DATE OF BIRTH (*for verification purposes*): ____________________________

I acknowledge that the practice may send the following to my email:

Check and **initial** each item that applies:

- ☐ Information about my invoice or accounts payable. ______
- ☐ Information about a specific dental visit. ______ *Specify a date*: ______
- ☐ Information about any dental visit. ______

ACKNOWLEDGEMENT:

Before we can communicate electronically with you, you must acknowledge by initialing each of the following:

_______All electronic communications from our practice will be encrypted.
_______I am responsible for updating my email address with the dental practice.
_______I am able to receive information electronically and store it securely away from any publicly accessible computers.
_______ I can withdraw my consent at anytime for electronic communication by calling *(843)722-1676*.

PATIENT SIGNATURE: ______________________________ DATE: ________________