BEACH FAMILY DENTISTRY

TODAY'S DATE:_____

PATIENT'S NAME:_____D.O.B:_____EMAIL:_____

PATIENT'S ADDRESS:_____CITY, STATE, ZIP:_____

HOME PHONE:_____WORK PHONE:_____CELL PHONE:_____

MARITAL STATUS:_____SOCIAL SECURITY NUMBER:_____

EMERGENCY CONTACT:_____PHONE #:_____

PHYSICIAN'S NAME:_____PHONE #:_____

WHOM MAY WE THANK FOR THIS REFERRAL?_____

MEDICAL HISTORY

YES	NO		YES	NO		YES NO		YES	NO	
___	___	ABNORMAL BLEEDING	___	___	DIABETES	___	___ HEART PROBLEMS	___	___	RADIATION THERAPY
___	___	ALCOHOL ABUSE	___	___	DIFFICULTY BREATHING	___	___ HEMOPHELIA	___	___	MARIJUANA USE/HISTORY
___	___	ANEMIA	___	___	DRUG ABUSE	___	___ HIGH BLOOD PRESSURE	___	___	SHINGLES
___	___	ANGINA PECTORIS	___	___	EMPHYSEMA	___	___ HIV/AIDS	___	___	SICKLE CELL DISEASE
___	___	ARTHRITIS	___	___	EPILEPSY/SEIZURE	___	___ KIDNEY PROBLEMS	___	___	SMOKING USE/HISTORY
___	___	ARTIFICAL HEART VALVE	___	___	FAINTING SPELLS	___	___ LIVER DISEASE	___	___	SINUS PROBLEMS
___	___	BLOOD THINNER	___	___	FREQUENT HEADACHES	___	___ LOW BLOOD PRESSURE	___	___	STROKE
___	___	BLOOD TRANSFUSION	___	___	GLAUCOMA	___	___ MITRAL VALVE PROLAPSE	___	___	THYROID PROBLEMS
___	___	CANCER-CHEMOTHERAPY	___	___	GERD/ACID REFLUX	___	___ MRSA	___	___	TUBERCULOSIS
___	___	COLOTIS	___	___	HEART ATTACK	___	___ PACE MAKER	___	___	ASTHMA
___	___	CONGENITAL HEART DEFECT	___	___	HEART SURGERY	___	___ PNEUMOCYSTOSIS	___	___	LIVER DISEASE
___	___	ARTIFICIAL BONES & JOINTS	___	___	HEART STENT	___	___ PSYCHIATRIC PROBLEMS	___	___	HEPATITIS

Other(list all known medical conditions not listed above):_____

_____

ALLERGIES TO ANY MEDICATIONS (LIKE PENICILLIN, ASPIRIN, ETC.) ____YES ____NO *ARE YOU ALLERGIC TO LATEX___YES___NO

PLEASE LIST ANY ALLERGIES:_____

PLEASE LIST ANY SURGERIES WITH DATE _____

LIST MEDICATIONS:

_____

968 International Drive
Myrtle Beach, SC 29579
Office (843) 903-8800 Fax (843) 903-8575
office@carolinaforestdentist.com
www.carolinaforestdentist.com

BEACH FAMILY DENTISTRY

_____

HAVE YOU EVER BEEN TOLD YOU NEED PRE-MEDICATION WITH ANTIBIOTICS FOR DENTAL WORK? ____YES ____NO

DO YOU TAKE OR HAVE YOU EVER TAKEN ANY OSTEOPOROSIS MEDICATIONS (BISPHOSPHONATES) EX. RECLAST, BONIVA, FOSAMAX, OR ACTONEL? ____YES____NO(IF YES, LIST MEDICATION NAME AND THE TIME PERIOD DURING WHICH IT WAS TAKEN):_____

_____

DENTAL HISTORY:

Date of last dental visit:_____ Date of last x-rays (bitewings, panoramic, full mouth series):_____

Dentist's name and contact information:_____

Check if you have had problems with any of the following:

__Grinding or clenching	__Sensitivity to cold or hot	__Fever Blisters	__Sensitivity when biting
__Bleeding gums	__Loose teeth or broken fillings	__Sensitivity to sweets	__ Bad Breath
__Clicking or popping jaw	__Sores or growths in your mouth	__Periodontal treatment	__Food collection between teeth

WOMEN ONLY: Are you pregnant? __**Y** __**N** If YES, #of weeks:____ Are you nursing?__**Y** __**N** Are you taking birth control? __**Y**__**N**

FINANCIAL INFORMATION:

Place of employment with address:_____

How will you pay for today's visit? ____Cash ____Check ____Visa ____MC ____Discover ____American Express ____Care Credit

Do you have dental insurance? __Yes ___No

Subscriber's Name _____ Relationship to Subscriber _____

Subscriber's Employer _____Insurance Company:_____

Social Security Number:_____Subscriber's Date of Birth:_____

APPOINTMENT CONFIRMATION

968 International Drive
Myrtle Beach, SC 29579
Office (843) 903-8800 Fax (843) 903-8575
office@carolinaforestdentist.com
www.carolinaforestdentist.com

BEACH FAMILY DENTISTRY

May we confirm appointments by:

YES NO
___ ___Telephone
___ ___Email
___ ___Text Message

I prefer communication by (select one primary method for your default communication): ___Telephone ___Email ___Text Message

PERMISSION FOR TREATMENT AND PROMISE OF PAYMENT

THIS IS TO CERTIFY THAT I, UNDERSIGNED, CONSENT TO THE PERFORMING OF ANY AND ALL PROCEDURES AGREED TO BE NECESSARY OR ADVISABLE, INCLUDING THE USE OF GENERAL OR LOCAL ANESTHETIC AS INDICATED. I ALSO AGREE TO THE RELEASE OF ANY INFORMATION TO MY INSURANCE COMPANY AND I WILL ASSUME ALL RESPONSIBILITY FOR FEES ASSOCIATED WITH ANY OF THE ABOVE. ADDITIONALLY, I AUTHORIZE THE ASSIGNMENT OF INSURANCE BENEFITS TO BEACH FAMILY DENTISTRY. WE RESERVE THE RIGHT TO CHARGE FOR CANCELLED OR BROKEN APPOINTMENTS WITHOUT 48-HOUR ADVANCE NOTICE. WE ALSO RESERVE THE RIGHT TO CHARGE FINANCE CHARGES TO ANY ACCOUNT DELIQUENT BY OVER 90 DAYS (REGARDLESS OF INSURANCE STATUS).

PATIENTS SIGNATURE OR GUARDIAN _____

OUR OFFICE IS COMMITEED TO MEETING OR EXCEEDING THE STANDARDS OF INFECTION CONTROL MANDATED BY OSHA, THE CDC AND THE ADA.

NOTES:

968 International Drive
Myrtle Beach, SC 29579
Office (843) 903-8800 Fax (843) 903-8575
office@carolinaforestdentist.com
www.carolinaforestdentist.com

BEACH FAMILY DENTISTRY

Financial and Appointment Policies

Thank you for choosing Beach Family Dentistry for your dental care, where we are committed to the success of your treatment. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial and Appointment Policies. Please **read, initial, and sign** that you understand each of our office's expectations from you.

_____**Co-Payments:** All applicable deductibles, co-insurance amounts, and non-covered service fees are due at the time service is rendered. For your convenience our office accepts cash, personal checks, Master Card, Visa, and Discover.

_____**Dental Insurance:** As a courtesy, we file any dental insurance claim as long as you provide us with the correct insurance information, a copy of the insurance card, the insured's social security number and date of birth. Our office will attempt to call your insurance company prior to any treatment to verify dental benefit coverage. The benefits you receive are based on the contract between you and/or your employer and the dental insurance company, not our office. Some services you may need or want may not be covered by your dental plan.

_____**Unpaid Insurance Balances:** Every effort is made to process your dental claim efficiently and quickly as well as to calculate your patient co-insurance amounts for each date of service. However, they are still estimates based on the current information you and your dental benefit plan provided to our office. The exact amounts are not known until the claim has been paid. You are responsible and will be required to pay for any remaining account balance after your insurance has paid their portion.

_____**Appointment Cancellations:** We make every effort to accommodate you when scheduling an appointment. Thus, we trust that no change in your appointment will be necessary. However, if this becomes necessary we require a 48 hour business hour notice to make changes in your reserved appointment time. We recognize that emergencies do occur, but abuse of our time and policies could result in dismissal from our practice. WE DO NOT WANT THIS TO HAPPEN.

_____**Cancellation Fees:** We reserve the right to charge $50.00 for any appointment missed or not cancelled within 48 business hours. As a result, this could also lead to dismissal from our practice. WE DO NOT WANT THIS TO HAPPEN.

968 International Drive
Myrtle Beach, SC 29579
Office (843) 903-8800 Fax (843) 903-8575
office@carolinaforestdentist.com
www.carolinaforestdentist.com

BEACH FAMILY DENTISTRY

Financial and Appointment Policies

We will be glad to discuss any questions you may have about our financial or appointment policies. We hope by presenting our policies we will avoid any misunderstanding and therefore have more time to dedicate to your dental care.

I hereby authorize all claims to be filed on myself or my dependents' behalf, for the use of "my signature on file" for all insurance claims and for the benefits to be assigned to Beach Family Dentistry. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my healthcare information for the purpose of obtaining payment for services rendered and determining benefits. This consent will remain in effect for as long as I or my dependents are a patient of record.

PATIENT NAME: _____ **DATE:**_____

PRINT PARENT/GUARDIAN NAME: _____

PATIENT/GUARDIAN SIGNATURE:_____

968 International Drive
Myrtle Beach, SC 29579
Office (843) 903-8800 Fax (843) 903-8575
office@carolinaforestdentist.com
www.carolinaforestdentist.com

BEACH FAMILY DENTISTRY

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name:_____

Address: _____

Telephone: _____E-mail:_____

Patient #:_____Social Security #:_____

SECTION B: TO THE PATIENT — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: _Courtney Suggs

968 International Drive
Myrtle Beach, SC 29579
Office (843) 903-8800 Fax (843) 903-8575
office@carolinaforestdentist.com
www.carolinaforestdentist.com

BEACH FAMILY DENTISTRY

Telephone: __843-9033-8800_____Fax:_____843-903-8575_____

E-mail: __office@carolinaforestdentist.com_____

Address: 968 International Drive, Myrtle Beach, SC 29579__ _____

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature:_____Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name:_____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT. Include completed Consent in the patient's chart.

BEACH FAMILY DENTISTRY

Authorization for Release of Dental Records and X-rays

I, (print patient name) _____ date of birth _____,

hereby authorize the doctors and staff of _____ to release all records or knowledge concerning my dental health to:

Beach Family Dentistry
968 International Drive
Myrtle Beach, SC 29579
(843) 903-8800

I specifically request that you release copies of:
- all x-rays - all treatment notes-

Signed (patient or guardian name) _____

Printed name (patient or guardian name)_____

Please email x-rays and any pertinent information to office@carolinaforestdentist.com. If email is not an option please mail x-rays to the above address.

968 International Drive
Myrtle Beach, SC 29579
Office (843) 903-8800 Fax (843) 903-8575
office@carolinaforestdentist.com
www.carolinaforestdentist.com

BEACH FAMILY DENTISTRY

Beach Family Dentistry
Acknowledgement of Receipt of Notice of Privacy Practices

You May Refuse to Sign This Acknowledgment

I, _____, have received a copy of this office's Notice of Privacy Practices.

Name_____

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)

_____

This material is educational only, does not constitute legal advice, and covers only federal, not state, law. Changes in applicable laws or regulations may require revision. Dentists should contact their personal attorneys for legal advice pertaining to HIPAA compliance, the HITECH Act, and the U.S. Department of Health and Human Services rules and regulations.

968 International Drive
Myrtle Beach, SC 29579
Office (843) 903-8800 Fax (843) 903-8575
office@carolinaforestdentist.com
www.carolinaforestdentist.com

BEACH FAMILY DENTISTRY

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL 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 to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by accessing our website or calling the office and request that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your physician's practice.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider.

Payment: **Your** protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider.

Health Care Operations: We may use or disclose, as needed, your protected health information to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, fundraising activities, and conducting or arranging for other business activities.

Your Authorization: In addition to our use of your health information in connection with our healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose.

968 International Drive
Myrtle Beach, SC 29579
Office (843) 903-8800 Fax (843) 903-8575
office@carolinaforestdentist.com
www.carolinaforestdentist.com

BEACH FAMILY DENTISTRY

To Your Family and Friends, or Persons Involved In Care: : Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition, or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. You will be notified, if required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury, or disability.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including, to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law.

Workers' Compensation: We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally established programs.

968 International Drive
Myrtle Beach, SC 29579
Office (843) 903-8800 Fax (843) 903-8575
office@carolinaforestdentist.com
www.carolinaforestdentist.com