3901-C EDMUND HWY. • WEST COLUMBIA, S.C. 29170 • (803) 755-3953

# Welcome

## Thank you for selecting us.

To help us meet all your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us and we will be happy to help.

## Patient Information (Confidential)

Patient Number _____

Name _____ Date _____

Soc. Sec. # _____ Birthdate _____ Home Phone _____

Address _____ City _____ State/ Prov. _____ Zip/Post. Code _____

E-mail _____ Cell Phone _____ Marital Status Single Married Separated Divorced Widowed

If Student, Name of School/College _____ City _____ State/ Prov. _____ ☐ Full Time ☐ Part Time

Patient's or Parent's Employer _____ Work Phone _____

Business Address _____ City _____ State/ Prov. _____ Zip/Post. Code _____

Spouse or Parent's Name _____ Employer _____ Work Phone _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ Phone _____

## Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Driver's License # _____ Birthdate _____ Cell Phone _____

Employer _____ Work Phone _____ SS# _____

Is this Person Currently a Patient in our Office? ☐ Yes ☐ No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

☐ Cash ☐ Personal Check Credit Card ☐ VISA ☐ MasterCard ☐ I wish to discuss the office's payment policy.

## Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____ Cell Phone _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Employer Address _____ City _____ State/ Prov. _____ Zip/Post. Code _____

Insurance Company _____ Group # _____ Policy/ID # _____

Ins. Co. Address _____ City _____ State/ Prov. _____ Zip/Post. Code _____

How Much is Your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

**Do You Have Any Additional Insurance?** ☐ Yes ☐ No If Yes, Complete the Following

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____ Cell Phone _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Employer Address _____ City _____ State/ Prov. _____ Zip/Post. Code _____

Insurance Company _____ Group # _____ Policy/ID # _____

Ins. Co. Address _____ City _____ State/ Prov. _____ Zip/Post. Code _____

How Much is Your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

Over Please

## Release:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I understand that this examination is going to address my immediate problem or emergency and should not be confirmed as a complete examination with resulting treatment.

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by dental or medical care payor.

FINANCE CHARGE. If I don't pay the entire New Balance within 25 days of the monthly billing date, a FINANCE CHARGE will be added to the account for the current monthly billing period. The FINANCE CHARGE will be a periodic rate of 1.5% per month (or a minimum charge of $2.00 for a balance under $134) which is an ANNUAL PERCENTAGE RATE of 18% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account.

PATIENT'S OR GUARDIAN'S SIGNATURE _____ DATE _____

## Medical Information

Name of Your Physician _____ Last Physical _____

Are You Taking Any Medications? _____ Please List _____

_____

_____

Are You Allergic To Any Medications/Food? _____ Please List _____

_____

Have You Been Hospitalized In The Last 5 Years? _____ Why? _____

_____

| Do You Have, Or Have You Ever Had? | Please Circle | |
|---|---|---|
| Heart Murmur | YES | NO |
| Fainting Spells | YES | NO |
| Heart Condition | YES | NO |
| Malignancy | YES | NO |
| Abnormal Blood Pressure | YES | NO |
| Tuberculosis | YES | NO |
| Abnormal Bleeding | YES | NO |
| Positive HIV Test | YES | NO |
| Anemia | YES | NO |
| Radiation Therapy | YES | NO |
| Diabetes | YES | NO |
| Venereal Disease | YES | NO |
| Epilepsy/Seizure | YES | NO |
| Hepatitis | YES | NO |
| Asthma | YES | NO |
| Rheumatic Fever | YES | NO |
| Might You Be Pregnant? | YES | NO |

## Dental Information

How Long Has It Been Since Your Last Dental Visit? _____

What Was Done At That Time? _____

_____

What Is Your Problem or Complaint At This Time? _____

_____

_____

How Long Has It Been A Problem? _____

Comments _____

_____

_____

## Medical Updates -- Dental and Medical Histories -- Updates

I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states past & present conditions.

| DATE | EXCEPTIONS | | PATIENTS SIGNATURE | B.P. | | REVIEWED BY |
|---|---|---|---|---|---|---|
| _____ | _____ | NONE ❑ | _____ | _____ | DR. | _____ |
| _____ | _____ | NONE ❑ | _____ | _____ | DR. | _____ |
| _____ | _____ | NONE ❑ | _____ | _____ | DR. | _____ |
| _____ | _____ | NONE ❑ | _____ | _____ | DR. | _____ |
| _____ | _____ | NONE ❑ | _____ | _____ | DR. | _____ |
| _____ | _____ | NONE ❑ | _____ | _____ | DR. | _____ |
| _____ | _____ | NONE ❑ | _____ | _____ | DR. | _____ |