**Palmetto Dental Arts**
347 Red Cedar St
Bluffton, SC 29910
(843) 815-6500
palmettodental.com

## Welcome!

**So that we may provide you with the best possible care, please complete these forms.**
**All information is completely confidential.**

## Patient Registration

Date: _____

Patient Name: _____ _____ ____ _____
(last name) (first name) (initial) (preferred name)

Home Phone: _____ Cell Phone: _____

Street Address: _____

City: _____ State: _____ Zip: _____

SSN: _____ E-Mail Address: _____

Sex: ◯ Male ◯ Female Age: _____ Birth Date: _____ Marital Status: _____

Employed by: _____ Occupation: _____

Business Address: _____ Work Phone: _____

Person responsible for account: _____ Relationship: _____

In case of emergency, who should be notified? _____ Phone: _____

How did you hear of Palmetto Dental Arts ? _____

This office requires payment at the time of service. However, for your convenience, we will file your insurance for the reimbursement check to be sent directly to you.

Do you have dental insurance? ◯ Yes ◯ No

Subscriber's Name: _____ SSN: _____ DOB: _____

Name of insurance carrier: _____ Group Number: _____

Address and phone number: _____

Employer who sponsors insurance plan: _____

I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of the signature on all insurance submissions.

_____ _____
Responsible Party Signature Date

## Dental Inquiry

Patient Name: _____

Welcome to Palmetto Dental Arts. This might be the most important dental visit you will ever have. We feel that helping you determine your present and future dental needs is the most important service we offer. Although there are issues you have probably never thought of in detail, please answer the following to your best ability...Thank you!

- What is your primary concern for this visit and what did you want to accomplish?

  _____

- Have you ever had any unpleasant experiences associated with previous dental visits?

  _____

- Have you ever been treated for gum disease?

  _____

- What are your expectations of this office?

  _____

## Treatment Recommendations or Treatment Options

We prefer to give you options based on how you would like to treat your dental health. We are here to make recommendations on how to achieve your goals.

The following questions help us determine what is important to you…please rate on the following scale from 1 to 10, with 10 being the most important. (please check one)

How healthy would you like your mouth to be?

◯1 ◯2 ◯3 ◯4 ◯5 ◯6 ◯7 ◯8 ◯9 ◯10

How preventive (or proactive) would you like to be regarding your dental health?

◯1 ◯2 ◯3 ◯4 ◯5 ◯6 ◯7 ◯8 ◯9 ◯10

How important are dental cosmetics to you?

◯1 ◯2 ◯3 ◯4 ◯5 ◯6 ◯7 ◯8 ◯9 ◯10

Anything else you would like to mention? _____

# MEDICAL HISTORY

**Patient Name:** _____ **Birth Date:** _____

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

Are you currently under a physician's care? : _____ If yes, pls explain:_____

Please list your current medications : _____

_____

_____

_____

Prescribing Physician: _____

Have you ever been hospitalized or had a major operation? : ☐ If yes, pls explain:_____

Do you take, or have you taken, Phen-Fen or Redux? : ☐Yes ☐No

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing biosphosphonates? : ☐Yes ☐No

Are you on a special diet? ☐Yes ☐No | Do you use tobacco? ☐Yes ☐No | Do you use controlled substances? ☐Yes ☐No

Women: Are you ☐Pregnant/trying to concieve? ☐Nursing? ☐Taking oral contraceptives?

Are you allergic to any of the following: ☐Aspirin ☐Penicillin ☐Codeine ☐Acrylic ☐Metal ☐Latex ☐Sulfa Drugs

☐Local Anesthetics (including Lidocaine) ☐Egg ☐Other: _____

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

- ☐ AIDS/HIV Positive
- ☐ Angina/Chest Pain
- ☐ Asthma/Easily Winded
- ☐ Cancer _____
- ☐ Congenital Heart Disorder
- ☐ Drug Addiction
- ☐ Excessive Bleeding
- ☐ Frequent Diarrhea
- ☐ Heart Attack/Failure
- ☐ Hepatitis A B C (please circle)
- ☐ Hypoglycemia
- ☐ Low Blood Pressure
- ☐ Organ Transplant _____
- ☐ Peripheral Vascular Neuropathy
- ☐ Renal Dialysis
- ☐ Shingles
- ☐ Stomach/Intestinal Disease
- ☐ Tonsillitis
- ☐ Alzheimer's/Dementia
- ☐ Arthritis/Gout
- ☐ Blood Disease
- ☐ Cardiac Pacemaker
- ☐ Convulsions
- ☐ Easily Winded/ Breathing Problems
- ☐ Excessive Thirst
- ☐ Frequent Headaches
- ☐ Heart Infection/Endocarditis
- ☐ High Blood Pressure
- ☐ Irregular Heartbeat
- ☐ Lung Disease/COPD
- ☐ Osteoporosis
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Sickle Cell Disease
- ☐ Stroke/TIAs
- ☐ Tuberculosis
- ☐ Anaphylaxis
- ☐ Artificial Heart Valve
- ☐ Blood Disease
- ☐ Chemotherapy
- ☐ Cortisone Medicine
- ☐ Emphysema
- ☐ Fainting Spells/Dizziness
- ☐ Glaucoma
- ☐ Heart Trouble/Disease
- ☐ High Cholestrol
- ☐ Kidney Problems/Disease
- ☐ Mitral Valve Prolapse/ Heart Murmur
- ☐ Pain In Jaw Joints
- ☐ Radiation Treatments
- ☐ Rheumatism
- ☐ Sinus Trouble
- ☐ Swelling of Limbs
- ☐ Tumors/Growths
- ☐ Anemia
- ☐ Artificial Joint _____
- ☐ Bruise Easily
- ☐ Cold Sores/Fever Blisters
- ☐ Diabetes
- ☐ Epilepsy/Seizures
- ☐ Frequent Cough
- ☐ Hay Fever
- ☐ Hemophilia
- ☐ Hives/Rash
- ☐ Liver Problems/Jaundice
- ☐ Neuromuscular Junction Disorders
- ☐ Parathyroid Disease
- ☐ Recent Weight Loss
- ☐ Scarlet Fever
- ☐ Spina Bifida
- ☐ Thyroid Disease
- ☐ Ulcers/Acid Reflux

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

Additional 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 patients) health. It is my responsibility to inform the dental office of any changes in medical status.

**Signature of Patient, Parent or Guardian:** _____ **Date:** _____

# HIPAA NOTICE OF PRIVACY PRACTICES

**PALMETTO DENTAL ARTS - 347 RED CEDAR ST - BLDG 400 - BLUFFTON - SC - 29910**

## Your Information. Your Rights. Our Responsibilities.

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.

**Your Rights**

You have the right to: get a copy of your paper or electronic medical records, correct your paper or electronic medical records, request confidential communication, ask us to limit the information we share, get a list of those with whom we've shared your information, get a copy of this privacy notice, choose someone to act for you and file a complaint if you believe your privacy rights have been violated.

**Your Choices**

You have some choices in the way that we use and share information as we: tell family and friends about your condition, provide disaster relief, include you in a hospital directory, provide mental health care, market our services and sell your information, or raise funds.

**Our Uses and Disclosures**

We may use and share your information as we: treat you, run our organization, and bill for your services. We are allowed or required to share your information in other ways – usually in ways that contribute to the public good. Examples of these are help with public health and safety issues, do research, comply with the law, respond to organ and tissue donation requests, work with a medical examiner or funeral director, address workers' compensation law enforcement, and other government requests and respond to lawsuits and legal actions. We have to meet many conditions in the law before we can share your information for these purposes.

**Your Choices**

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to: share information with your family, close friends, or others involved in your care, share information in a disaster relief situation, include your information in a hospital directory.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission: marketing purposes, sale of your information, most sharing of psychotherapy notes. We may contact you for fundraising efforts, but you can tell us not to contact you again.

**Our Responsibilities**

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it upon request.
- We will not share your information other than as described here unless your permission is given in writing. If you do choose to share your information in other ways, you can change your mind at any time by letting us know in writing.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

**Changes to the Terms of this Notice**

We can change the terms of this notice, and the changes will apply to all information we have about you.
The new notice will be available upon request, in our office, and on our web site.
Effective Date of this notice is April 13, 2003.
This form can be viewed in its entirety at palmettodental.com/new-patient-forms/

Signature _____ Date _____