Patient Information

First Name:_____ Last Name:_____ Middle Initial:_____

Preferred Name:_____ Patient is: ☐ Policy Holder ☐ Responsible Party ☐ Child

Address:_____City/State/Zip:_____

Cell:_____Home:_____Work:_____

Birth Date:_____/_____/_____ Social Security:_____-_____-_____ Sex: ☐ Male ☐ Female ☐ Gender Binary

Driver's License Number:_____ State Issued:_____ Email:_____

Marital Status: _____ Married _____ Single _____Other:_____

Emergency Contact Name:_____ Phone Number:_____ Relationship:_____

Who can we thank for referring you to our office:

☐ Doctor:_____ ☐ Google ☐ Radio/Newspaper ☐ Other
☐ Existing Patient:_____ ☐ Other Internet Source ☐ Postcard/Mailer
☐ Insurance Provider List:_____ ☐ Office Sign ☐ Magazine

Primary Insurance Information

Ins. Company:_____ Ins. ID#:_____ Group#:_____

Name of Insured:_____ Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Social Security:_____-_____-_____ Insured Birth Date:_____/_____/_____ Employer:_____

Secondary Insurance Information

Ins. Company:_____ Ins. ID#:_____ Group#:_____

Name of Insured:_____ Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Social Security:_____-_____-_____ Insured Birth Date:_____/_____/_____ Employer:_____

I give consent to dental treatment by Trident General Dentistry, which includes its Doctors, Dentists, Associates, Hygienists, Assistants and any Supporting Staff selected by my dentist to provide procedures authorized by me. I am aware the practice of dentistry is not an exact science and I acknowledge that no guarantees will be made to me concerning the success of my dentistry and the associated treatment and procedures except if given in writing. I authorize the release of any information relative to filing my insurance in order to process my dental claims so that payment can be made directly to Trident General Dentistry.

_____ _____

Signature of Patient/Guardian/Responsible Party **Date**

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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.

Are you under a physician's care now?	☐ Yes	☐ No	If yes:_____
Have ever been hospitalized/major operation?	☐ Yes	☐ No	If yes:_____
Have ever had a serious head or neck injury?	☐ Yes	☐ No	If yes:_____
Are you taking any medications?	☐ Yes	☐ No	If yes:_____
Are you on a special diet?	☐ Yes	☐ No	
Do you use tobacco?	☐ Yes	☐ No	
Do you use controlled substances?	☐ Yes	☐ No	If yes:_____
Do you require premedication prior to dental care?	☐ Yes	☐ No	If yes:_____

Women: Are you…..

☐ Pregnant ☐ Nursing ☐ Trying to get pregnant ☐ Taking oral contraceptives

Are you allergic to any of the following:

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs

☐ Local Anesthetics ☐ Other:_____

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

AIDS/HIV Positive	☐ Yes	☐ No	Excessive Thirst	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No
Alzheimer's Disease	☐ Yes	☐ No	Fainting/Dizziness	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No
Anaphylaxis	☐ Yes	☐ No	Frequent Cough	☐ Yes	☐ No	Pain in Jaw Joints	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Frequent Diarrhea	☐ Yes	☐ No	Parathyroid Disease	☐ Yes	☐ No
Angina	☐ Yes	☐ No	Frequent Headaches	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No
Arthritis/Gout	☐ Yes	☐ No	Genital Herpes	☐ Yes	☐ No	Radiation Treatments	☐ Yes	☐ No
Artificial Heart Valve	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Recent Weight Loss	☐ Yes	☐ No
Artificial Joint	☐ Yes	☐ No	Hay Fever	☐ Yes	☐ No	Renal Dialysis	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Heart Attack/Failure	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Rheumatism	☐ Yes	☐ No
Blood Transfusion	☐ Yes	☐ No	Heart Pacemaker	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Breathing Problems	☐ Yes	☐ No	Heart Trouble/Disease	☐ Yes	☐ No	Shingles	☐ Yes	☐ No
Bruise Easily	☐ Yes	☐ No	Hemophilia	☐ Yes	☐ No	Sickle Cell Disease	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Hepatitis A	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Hepatitis B or C	☐ Yes	☐ No	Spina Bifida	☐ Yes	☐ No
Chest Pains	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Stomach/Intestinal Disease	☐ Yes	☐ No
Cold Sores	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No			
Congenital Heart Disorder	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
			Hives or Rash	☐ Yes	☐ No	Swelling of Limbs	☐ Yes	☐ No
Convulsions	☐ Yes	☐ No	Hypoglycemia	☐ Yes	☐ No	Thyroid Disease	☐ Yes	☐ No
Cortisone Medicine	☐ Yes	☐ No	Irregular Heartbeat	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Kidney Problems	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Drug Addiction	☐ Yes	☐ No	Leukemia	☐ Yes	☐ No	Tumors or Growths	☐ Yes	☐ No
Easily Winded	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Epilepsy/Seizures	☐ Yes	☐ No	Lung Disease	☐ Yes	☐ No	Yellow Jaundice	☐ Yes	☐ No

Have you ever had any serious illness not listed above?	☐ Yes	☐ No	If yes:_____
Do you have any artificial body parts or organs?	☐ Yes	☐ No	If yes:_____

_____ _____

Signature of Patient/Guardian/Responsible Party **Date**

Financial Agreement

Our promise is to provide you with the best possible dental care.

In order to better serve the dental needs of our patients, we have revised our financial policy. Full payment will be due at the time dental service is rendered unless special financing arrangements have been made in ADVANCE of service date with one of our third party financers.

When we schedule your appointment, the time is reserved just for you. We require **48 business hours notice** if changing your appointment. Our appointments are valuable to our patients and our staff and without notice denies other patients appointment opportunities.

Please help us serve you better by keeping scheduled appointments. Your appointment time is reserved exclusively for you and appointments missed, broken or cancelled with less than 48 hours notice a charge of $50-100 maybe assessed. This assessment is based on the amount of chair time scheduled. If you have any questions, please feel free to as one of our staff members.

We offer the following payment options:

* **Care Credit/Lending Club** – We offer 6-12 month interest free financing for your convenience as well as extended payments if financing over $1000.00.

* **Lowcountry Savings Plan** – For those without insurance, we offer a LSP membership. The yearly membership is $99 for the 1st Adult ($89 for any additional adults) and $59 for the 1st Child ($49 for any additional children). You get X-Rays & 1st Limited Exam for FREE, 50% off healthy mouth cleanings and comprehensive exams and 30% off restorative services. You may ***not*** use Care Credit or Lending Club for the membership fee, but are able to use it for treatment. (All-On-Four discounted plans do not apply).

Your dental insurance is a benefit to you and a contract between you, your employer and your insurance company. We will gladly file your claims and follow up on the processing of your claims as a courtesy. However, we cannot render services on the assumption that our charges will be paid by an insurance company. You are ultimately responsible for the charges. If insurance has not responded to a claim within 60 days of submittal, the full account balance becomes your responsibility.

A Service charge of **1.5% per month (18% per annum)** on the unpaid balance will be charged on all accounts exceeding 60 days.

I authorize the verification of my credit worthiness as necessary and understand that if my account becomes delinquent, the office may submit account information to the credit bureaus. Should I not make payment as set in this agreement, I authorize the addition of all collection and legal fees for any actions that are taken to secure payment for any debt.

_____ _____

Signature of Patient/Guardian/Responsible Party **Date**

Reserved Appointment Agreement

The health and wellness of our patients is a top concern of this office. Providing the best possible care to every patient is our primary goal. The only way we can meet this goal is if we work together. We make every effort to value your time and schedule your appointment time just for you. We truly appreciate your courtesy of giving us **48 business hours notice** if you have a conflict with your appointment and need a different time or day. We are committed to your oral health and keeping your scheduled appointments allows us to be partners in your dental care.

- I acknowledge my appointment is a reservation
- I acknowledge I am required to provide a **48 business hours notice** to make any changes to my appointment.
- I acknowledge the practice asks that I pre-pay a 50% deposit for Doctor and periodontal therapy appointments: This deposit is credited toward treatment when the appointment is kept.
- I acknowledge after I have missed or changed 2 appointments for which I did not provide **48 business hours notice**, I will be required to leave a deposit in order to schedule any appointments.
- I acknowledge that early morning and evening appointments are considered VIP appointments, and if I miss an appointment without providing **48 business hours notice**, I may not be able to schedule another VIP appointment in the future.
- I acknowledge if I miss 3 or more appointments and do not provide proper notification, I may not be able to pre-appoint and will be seen on a same day appointment basis only.

_____ _____

Signature of Patient/Guardian/Responsible Party Date

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

Trident General Dentistry is authorized to release protected health information about the above named patient in the following manner and to identified persons.

Entity to Receive Information: **How would you prefer to receive correspondence from our office?**
Check each entity that you approve to receive information.
_____ Voice Mail _____ Text _____ Email

Who do you give permission to release your health information to (i.e. Spouse, Parent, Grandparent, Stepparent, Friend)

_____	_____
Name	Phone Number
_____	_____
Name	Phone Number
_____	_____
Name	Phone Number
_____	_____
Name	Phone Number

Description of information to released:
Check each that can be given to person/entity listed in above section.

_____ Appointment Reminders
_____ Financial
_____ Treatment

_____ Email communications – Provide email address

_____

_____ Text communications –Provide number

_____

_____ Appointment reminders
_____ Treatment
_____ Financial
_____ Breach notification

***For email/text communications to occur, please accept the disclosure below.**

_____ For email and/or text communication I understand that if information is not received or sent in an encrypted manner, there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.
- This information will remain in effect until revoked by the patient in writing.

_____ _____

Signature of Patient/Guardian/Responsible Party Date

* Description of Personal Representative's Authority (Please attach necessary documentation)

Acknowledgement of Receipt
Of Notice of Privacy Practices

Patient Name:_____ Address: _____

I have received a copy of the Notice of Privacy Practices for Trident General Dentistry.

_____ _____

Signature of Patient/Guardian/Responsible Party Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt for the Notice of Privacy Practices because:

- An emergency existed and a signature was not possible at the time.
- The individual refused to sign.
- A copy was mailed with a request for a signature by return mail.
- Unable to communicate with the patient for the following reason:

  _____
  _____
  _____
- Other:

  _____
  _____
  _____

Prepared By: _____

Signature: _____

Date: _____

Dental Inquiry

Thank you for choosing Trident General Dentistry. We feel that helping you determine your present and future dental needs are the most important service we offer. Although these 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 complications or serious problems associated with previous dental visits?

  _____
  _____
  _____

- When was your last dental appointment?

  _____

- What would you like to change about your smile?

  _____
  _____
  _____

Treatment Recommendations or Treatment Options

We are here to make recommendations on how to achieve your dental health goals. The following questions help us to determine what is important to you. Please rate on the following scale from 10 to 1, with 10 being the most important.

1. How healthy would you like your teeth and mouth to be?

   10 9 8 7 6 5 4 3 2 1

2. How preventive or proactive would you like to be regarding preventing emergencies or unnecessary added expenses when planning your dental care?

   10 9 8 7 6 5 4 3 2 1

3. How important are dental cosmetics to you?

   10 9 8 7 6 5 4 3 2 1

Anything else you would like to mention about your oral health?

_____