(PLEASE PRINT)

Patient Information

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

Dental Insurance

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

Phone Numbers

Home (_____) _____ Work (_____) _____ Ext _____ Alt. Phone (_____) _____

Spouse's Work (_____) _____ Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Phone (_____) _____ Alt. Phone (_____) _____

Dental History

Reason for today's visit _____

_____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No
Cigarette, pipe, or cigar smoking	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No
Fingernail biting	☐ Yes	☐ No
Food collection between the teeth	☐ Yes	☐ No
Foreign objects	☐ Yes	☐ No
Grinding teeth	☐ Yes	☐ No
Gums swollen or tender	☐ Yes	☐ No
Jaw pain or tiredness	☐ Yes	☐ No
Lip or cheek biting	☐ Yes	☐ No
Loose teeth or broken fillings	☐ Yes	☐ No
Mouth breathing	☐ Yes	☐ No
Mouth pain, brushing	☐ Yes	☐ No
Orthodontic treatment	☐ Yes	☐ No
Pain around ear	☐ Yes	☐ No
Periodontal treatment	☐ Yes	☐ No
Sensitivity to cold	☐ Yes	☐ No
Sensitivity to heat	☐ Yes	☐ No
Sensitivity to sweets	☐ Yes	☐ No
Sensitivity when biting	☐ Yes	☐ No
Sores or growths in your mouth	☐ Yes	☐ No

How often do you floss? _____

How often do you brush? _____

Dental Registration and History

Health History

Physician's Name _____ Date of last visit_____

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. ☐ Yes ☐ No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Fainting or dizziness	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Artificial Heart Valves	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Heart Problems	☐ Yes	☐ No	Skin Rash	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	Hepatitis Type _____	☐ Yes	☐ No	Special Diet	☐ Yes	☐ No
Bleeding abnormally, with			Herpes	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
extractions or surgery	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Swollen Feet or Ankles	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No	Swollen Neck Glands	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Jaw Pain	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Tumor or growth on head		
Congenital Heart Lesions	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No	or neck	☐ Yes	☐ No
Cortisone Treatments	☐ Yes	☐ No	Nervous Problems	☐ Yes	☐ No	Ulcer	☐ Yes	☐ No
Cough, persistent or bloody	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No	Weight Loss, unexplained	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No			
Do you wear contact lenses?	☐ Yes	☐ No						

Women:

Are you pregnant? ☐ Yes ☐ No Due date_____ Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

Medications

List any medications you are currently taking and the correlating diagnosis:

_____

_____

Pharmacy Name _____

Phone (_____) _____

Allergies

☐ Aspirin ☐ Local Anesthetic

☐ Barbiturates (Sleeping pills) ☐ Penicillin

☐ Codeine ☐ Sulfa

☐ Iodine ☐ Other _____

☐ Latex _____

Updates (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications?_____ If so, what?_____

Patient's Signature_____ Date_____

Doctor's Signature_____ Date_____

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications?_____ If so, what?_____

Patient's Signature_____ Date_____

Doctor's Signature_____ Date_____

Crescent Beach Dental

602 17th Ave. South
North Myrtle Beach, SC 29582
843-272-1121 office
888-310-6058 fax
info@crescentbeachdental.com

Welcome!!!

As a new patient in our office, we will need to take X-rays. X-rays allow us to see in and around a tooth that the Dentist can not see with his/her naked eye.

If you have had a full mouth or Panorex X-ray within the last 3 to 5 years at another dental office we will have them transferred to our office; your insurance will only pay for these X-rays once every 3 to 5 years depending on your plan.

Date: _____

Past Dentist Name: _____

Fax: _____ Phone: _____

Address: _____ City:_____
State:_____

Patient Name: _____ DOB:
_____

Patient Signature: _____

The above mentioned patient has requested that you transfer their record/X-rays.

Consent for Treatment

1. I hereby authorize doctor or designated staff to take radiographs, study models, photographs, and other diagnostic aids appropriate by doctor to make a thorough diagnosis of _____ dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon my/me and to employ such assistance as required to provide care.
3. I agree to the use of anesthetics sedative and other medication as necessary. I fully understand that using anesthetic agent embodies certain risk. I understand that I can ask for a complete recital of any possible complication.
4. I give consent to the doctor's or designated staff's use and disclosure of any oral, written, or electronic health record that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operation. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available. *I authorize the doctor/staff to give/leave information to _____ and they can leave a message on my answering machine: yes _____ or no _____.*

Patient's
Signature_____Date_____Witness_____

Patient/Responsible Party' Signature_____
Relationship to Patient_____

Do you take Viagra or any other similar drugs?_____YES_____NO_____

I am aware that street drugs (including alcohol) may cause life threatening reaction with dental procedures. Please Initial_____

Have you taken any weight loss drugs including Fen-Phen, Pondimen or Redux?_____YES_____NO_____

Do you take any Herbs, supplements____YES_____NO_____

Crescent Beach Dentistry

602 17th Avenue South
North Myrtle Beach, South Carolina 29582
843-272-1121
888-310-6058 Fax

Office Policies

In order for us to continue to provide you with outstanding customer service and care, please review the following policies of our office.

Regular office hours: Our office is open Monday through Thursday from 8:00am until 5:00pm. We close from 12:00 to 1:00pm for lunch.

Payment is due when services are rendered. We accept cash, checks, Visa, Master Card and Discover. Additional financing is available pending approval through Care Credit.

Insurance: We accept assignment of many dental plans. However, **we do require the estimated co-payment portion of your bill to be paid at the time of service.** The balance is your responsibility whether your dental plan pays or not. We cannot bill your dental plan unless you give us the correct information. Your policy is a contract between you and the insurance company; we are not a party of that contract. If your dental plan has not paid your account in full within 45 days, the balance must be paid once you receive your statement. Please be aware that some, and perhaps all of the services provided may be non-covered services and are not considered reasonable and customary under your dental plan. Our practice is committed to providing the best treatment for our patients and we charge what usual customary to our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Please be advised that if your treatment is not covered under your specific plan, full payment is due at the time of service.

Adult/Minor Patients: Adult patients are responsible for full payment of their portion at the time of service. The adult accompanying a minor and the parent (or guardian of the minor) is responsible for full payment of their portion at the time of service. Children under the age of 16 must be accompanied by a parent or guardian at all times. For unaccompanied minors, non-emergencies treatment will be denied unless changes have been pre-arranged.

Guarantee of work: Dr. Riley guarantees restorative works for five years depending upon you maintaining your individual home care needs. This is also contingent upon you keeping your recommended treatment and preventative care appointments. The non-compliance of the above will make this guarantee null in void.

Missed Appointments: We certainly understand that scheduling conflicts occur. ***In order to prevent assessing a broken appointment fee of $35.00,*** **we require 48 hours' notice for cancellations.** For an appointment on Monday, please call Thursday morning as our office is closed on Fridays. This time is reserved exclusively for and not shared with others, please help us by keeping your reserved appointment time.

Interest: We reserve the right to charge interest in the amount of 1 1/2% (18% APR) as provided by state law.

I have read and understand this financial policy and agree to all terms stated above.

X_____**Date**_____

Signature of Patient or Responsible Party

Crescent Beach Dental
D. Calvin Riley, Jr., D.M.D.

Acknowledgement of Receipt of Privacy Practices

May we discuss your Dental/Medical condition with any member of your family?

Yes or No

If YES, please name the members allowed, relationship and phone numbers:

_____

_____

Patient Name (Print): _____

Signature: _____

Date: _____

For Office Use Only:

We attempted to obtain written acknowledgement of receipt of notice of privacy practices but acknowledgement could not be obtained because:

Individual refused to sign: _____

Communication barriers prohibited signing: _____

CLIENT RIGHTS AND HIPAA AUTHORIZATIONS

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("*HIPAA*").

1. Tell your provider if you do not understand this authorization, and the provider will explain it to you.
2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to provider at the following address (insert address of provider):

   _____
3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, payment, enrollment or your eligibility for benefits. However, you may be required to complete this authorization form before receiving treatment if you have authorized your provider to disclose information about you to a third party. If you refuse to sign this authorization, and you have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a patient in their practice.
4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA. If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.
5. You may inspect or copy the protected dental information to be used or disclosed under this authorization. You do not have the right of access to the following protected dental information: psychotherapy notes, information compiled for legal proceedings, laboratory results to which the Clinical Laboratory Improvement Act ("CLIA") prohibits access, or information held by certain research laboratories. In addition, our provider my deny access if the provider reasonably believes access could cause harm to you or another individual. If access is denied, you may request to have a licensed health care professional for a second opinion at your expense.
6. If this office initiated this authorization, you must receive a copy of the signed authorization.
7. ***Special Instructions for completing this authorization for the use and disclosure of Psychotherapy Notes.*** HIPAA provides special protections to certain medical records known as "Psychotherapy Notes." All Psychotherapy Notes recorded on any medium by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separate from the rest of the client's medical records to maintain a higher standard of protection. "Psychotherapy Notes" are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separate from the rest of the individual's medical records. Excluded from the "Psychotherapy Notes" definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. Except for limited circumstances set forth in HIPAA, in order for a medical provider to release "Psychotherapy Notes" to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other dental records.
8. You have a right to an accounting of the disclosures of your protected dental information by provider or its business associates. The maximum disclosure accounting period is the six years immediately preceding the accounting request. The provider is not required to provide an accounting for disclosures: (a) for treatment, payment, or dental care operations; (b) to you or your personal representative; (c) for notification of or to persons involved in an individual's dental care or payment for dental care, for disaster relief, or for facility directories; (d) pursuant to an authorization; (e) of a limited data set; (f) for national security or intelligence purposes; (g) to correctional institutions or law enforcement officials for certain purposes regarding inmates or individuals in lawful custody; or (h) incident to otherwise permitted or required uses or disclosures. Accounting for disclosures to dental oversight agencies and law enforcement officials must be temporarily suspended on their written representation that an accounting would likely impede their activities.