Implant and Sedation Dentistry of Charleston

Thank you for choosing us! Your dental care is very important to us.

First Name: _____ Last Name: _____Birth date: _____
SS#: _____ Male ◯ Female ◯ (please circle)

Address: _____City: _____State: _____Zip: _____

Home phone: _____Work: _____Cell phone: _____

E-mail Address: _____Employed by: _____

Who carries dental insurance? _____

Does this plan cover all family members? _____Yes _____No

Spouse's name: _____Birth Date: _____SS#_____

Spouse employed by: _____

In the event of an emergency, please notify: _____Phone#:_____

Why did you leave your last dentist?_____

Who may we thank for referring you to our office:_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I_____ have received a copy of this office's Notice of privacy practices.
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.**
- ❑ **Communication barriers prohibited it.**
- ❑ **An emergency situation prevented us obtaining**
- ❑ **Acknowledgement.**
- ❑ **Other {Please specify}_____**

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Adult: Medical and Dental History

Physician's Name: _____Phone #_____
Date Last Complete Physical: _____

The treatment of your teeth, gums, jaws, and over all dental health is a combinations of many factors. The success of treatment depends on a thorough examination. All of the questions are related to your oral health. Each factor has a contributing influence.

Medical: Have you been hospitalized recently? ____Yes ____No
Are you taking any medications? ____Yes____No

If Yes List:_____

- ☐ Pacemaker
- ☐ Heart Problems
- ☐ Rheumatic Fever
- ☐ Heart Murmur
- ☐ Heart Attack
- ☐ Stroke
- ☐ Liver or Kidney Disease
- ☐ Hepatitis
- ☐ AIDS/HIV
- ☐ High or low blood pressure
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Blood Transfusions {within the last 5 years}
- ☐ Medications For Osteoporosis {BONE}
- ☐ Thyroid
- ☐ Tumors, Cancer
- ☐ Joint Replacement
- ☐ Endocrine/Glandular Disorder
- ☐ Radiation Therapy
- ☐ Asthma or Hay Fever
- ☐ Blood Disorder /Blood Thinners
- ☐ Respiratory Problems
- ☐ T.B. or Pneumonia
- ☐ Nervous / Emotional Disorders
- ☐ Woman: Are you Pregnant

Drug Allergies: Please List: _____

Dental: **Do you have, or have ever had:**

- ☐ Periodontal surgery? {Gum scaling / root planning}_____When?_____
- ☐ Orthodontics {braces}?_____When_____
- ☐ Partial Dentures or full dentures?_____
- ☐ A fixed {permanent} bridge?_____
- ☐ Some mouth or acute pain?_____
- ☐ Ulcers or sores in your mouth that do not heal? _____
- ☐ Burning tongue? _____
- ☐ Bleeding gums? _____
- ☐ Unpleasant mouth odor or taste? _____
- ☐ Collections or wedging of food between teeth? _____Where_____
- ☐ Jaw problems {example: aching, clicking, popping, out of joint}? _____
- ☐ Clenching or grinding of teeth? _____
- ☐ If you have partial or full dentures, do you wear them? _____
- ☐ Are you self conscious about you smile? _____
- ☐ Do you need dental floss instruction? _____
- ☐ Do you feel that you may need to see a gum specialist? _____

Please tell us in one or two sentences, what are your thoughts about your teeth and gums, and how we can help you: _____
_____

Health History Verified_____ ***Signature_____{patient}***
Staff_____ Dr._____

Implant and Sedation Dentistry of Charleston

Financial Responsibility Agreement and Consent for services

Implant and Sedation Dentistry of Charleston

We gladly accept all Major Credit Cards & we will promptly file your Dental Insurance as a courtesy to you. Please bring in your benefit booklet or insurance ID Card.
We know questions can arise on insurance matters, so we encourage you to discuss such questions with our staff. We will be happy to help you receive the maximum benefits, however; **The agreement of the insurance company to pay your dental care is a contract between you, your employer and your employer's insurance company. Please note that insurance estimates and pre-estimates are not a guarantee from your insurance company.** The deductible and or the percentage that the insurance company does not cover is due as the dental care is completed. For Patients with dental insurance, please read and sign below. This will expedite the filing of your insurance claim and eliminate your having to sign each form.

I authorize the release of any information needed for filing dental claims and authorize payment directly to Implant and Sedation Dentistry of Charleston
Sign:_____Date:_____

Payment Policies:As a condition of treatment by this office, financial agreements must be made in advance. We will discuss financial options with you before rendering treatment.
By signing below, you are agreeing to all of the terms contained in this Financial Responsibility Agreement.

1. Payments is due in full at the time of service unless prior written financial arrangements have been made.
2. There is a $50 service charge on all returned checks.
3. We reserve the right to charge a $50 missed appointment fee for no-shows or cancellations with less than 24hrs notice.
4. I understand and agree that any account balance not paid within 90 days will be subject to collection activity.
5. I understand and agree that, ultimately, I am responsible for payment on my account. As a guarantor, I am responsible for any outstanding balances for other family members listed on the same account, due to Implant and Sedation Dentistry of Charleston.

Print Patient Name: _____ Sign: _____

Guarantor Signature: _____ Date: _____

If you are happy with our services, please refer us to a friend.
A referral is the best compliment you can give us!
Please like us on Facebook for special promotions!

Implant and Sedation Dentistry of Charleston
Consent
For Dental Treatment during COVID-19 Outbreak

1. I**, _____**, knowingly and willingly consent to have dental treatment completed during the COVID-19 pandemic at Implant and Sedation Dentistry of Charleston.
2. I understand that carriers of the COVID-19 virus may not exhibit any symptoms, and if they do, the virus has a long incubation period of up to 14 days or longer before symptoms are apparent. Therefore, prior to confirmation of the infection with specific COVID-19 testing, it is impossible to determine who has been infected with and can transmit it to others. **_____** (Initials)
3. I understand that the CDC recommends social distancing of at least six (6) feet to reduce the transmission of the virus, and that this is impossible with dental treatment. _____ (Initials)
4. Has anyone in your household been tested for COVID19 within the last four days? **_____ Yes _____ No**

I confirm that I am not presenting with any of the following symptoms listed here:

• Fever • Shortness of breath • Dry cough • Runny nose • Sore throat _____ (Initials)

I understand that air travel as well as other forms of mass transit significantly increases my risk of contracting and transmitting the COVID-19 virus. I verify that I have not traveled by commercial airline, bus, or train within the past 14 days. _____ (Initials)

_____ _____

Name – Signature Date