Implant and Sedation Dentistry of Charleston

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

{Please Print} **If under 18 years of age must be filled out by a parent**

Child's First Name: _____ Last Name: _____ Age: _____
Birth date: _____ Male ◯ Female ◯ (please circle)

Home address: _____ City: _____ State: _____ Zip: _____

Home Phone #: _____ _____ _____ Work #: _____ _____ _____ Cell phone#: ____ ____ _____

E-mail Address: _____

Mother's name: _____ Father's name: _____

SS#_____ _____ _____ DOB _____ SS # _____ _____ _____ DOB _____

Mother employed by: _____ Father employed by: _____

Who carries dental insurance? ☐ Mother ☐ Father ☐ Both

Insurance policy name: _____ Group name: _____ Group#_____

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

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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Child: Medical and Dental History

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

All of these questions below will help in the treatment of your child in the most thorough manner. The success of treatment is a combination of many factors.

Medical: Do you consider your child in good health? ____Yes ____No
Has your child been hospitalized recently? ____Yes ____No
Is your child taking medications? ____Yes ____No
If Yes List: _____

Does your child have or has ever had {please Check}

- ☐ Heart Problems
- ☐ Rheumatic Fever
- ☐ Heart Murmur
- ☐ Heart Disease
- ☐ Liver or Kidney disease
- ☐ Hepatitis
- ☐ High or low blood pressure
- ☐ Anemia
- ☐ Prolonged Bleeding/Blood disorder
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Emotional/Nervous Disorder
- ☐ Blood Transfusions {within the last 5 years}
- ☐ AIDS/HIV
- ☐ Tumors, Cancer
- ☐ Endocrine or glandular Disorder
- ☐ Drug Allergies
- ☐ Radiation Treatment
- ☐ Asthma or Hay fever
- ☐ Sickle Cell Anemia
- ☐ T.B. or Pneumonia
- ☐ Hearing Problems

Dental: **Does your child or has ever had {please Check}**

1. Bleeding gums ____Yes ____No
2. Loose or sensitive teeth ____Yes ____No
3. Orthodontics {braces}____ Yes ____No
   When? _____
4. Do you think your child might need braces ____Yes ____No
5. Does your child need help with dental home care ____Yes ____No
6. Do any of your child's brother or sisters have dental problems ____Yes ____No
7. Does you child have sealants on his or her teeth ____Yes ____No
8. Has you child ever been hit in the mouth w/baseball, bicycle fall, ____Yes ____No

In one or two sentence, please tell us how we can help your child's dental needs:
_____
_____

Health History Verified: _____
Staff: _____
Dr: _____ ***Signature*** _____
{PARENT}

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 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: _____

Consent: I hereby grant permission to Implant and Sedation Dentistry of Charleston to administer local anesthetic and /or nitrous oxide sedation and employ such operative and technical procedures as may be necessary or advisable in the diagnosis and treatment of _____
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*!**