Clemson SC Dental Associates

PATIENT INFORMATION

Welcome to our office! *To assist us in serving you, please complete the following confidential form. The information provided is important to your dental health.*

Patient's name _____ Preferred name _____ Birth date_____

If minor, parents names _____ Home phone _____ Work phone _____

Mailing address _____ City _____State _____ Zip _____

Employer _____ Occupation _____

Spouse's name _____ Spouse's employer _____ ❑ Unmarried

Whom may we thank for referring you to our office? _____

How did you find our office ❑ Phonebook ❑ Website ❑ Facebook ❑ Other _____

BILLING, CREDIT, AND INSURANCE INFORMATION: ❑ Not covered by dental insurance

Your Social Security number: _____ Dental Insurance Co._____ Group number_____

Covered by spouse's insurance? ❑ yes ❑ no

Spouse's dental insurance company _____ Group number _____

Spouse's birthday _____ Social Security number _____

Patient Dental History

Reason for the visit _____

When was your last dental visit _____ What was done then_____

Have you had a complete Series of dental x-rays taken ❑ yes ❑ no When _____

Do your gums bleed while brushing or flossing?	❑ yes	❑ no
Are any of your teeth sensitive to hot or cold liquids/foods?	❑ yes	❑ no
Are any of your teeth sensitive to sweet or sour liquids/foods?	❑ yes	❑ no
Do you feel pain to any of your teeth?	❑ yes	❑ no
Have you had any head, neck or jaw injuries?	❑ yes	❑ no
Do you get migraines?	❑ yes	❑ no
Does food tend to get scaught between yout teeth?	❑ yes	❑ no
Have you had periodontal treatment (gum)?	❑ yes	❑ no
Do you wear a bite plate, night guard, or other appliance?	❑ yes	❑ no
Have you ever had orthodontic treatment?	❑ yes	❑ no
Do you wear dentures or partials?	❑ yes	❑ no

If you could change anything about your smile, what would you change? _____

_____

To the best of my knowledge, the questions on the form have been accurately answered. I understand that providing incorrect information can be dangerous to my (the patient's) health. It is m responsibility to inform the dental office of any changes.

Signature of patient (or parent) _____ Date _____

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 under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please 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 bisphosphonates? ◯ 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 get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

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

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

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

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 patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Clemson SC Dental Associates

Financial Policy

Thank you for choosing our office for your dental needs. We realize that every person's financial situation is different. Dental treatment is an excellent investment in an individual's medical and psychological care. For this reason, we have worked hard to provide a variety of payment options to help you receive the dental care you need and deserve that allows you to enjoy a healthy, beautiful smile with respect to your budget. We are always available to answer your questions or assist you in any way we can.

To maintain the practice operations and prevent potential misunderstandings, we ask patients to accept and adhere to the following financial arrangements regarding their dental treatment.

Optional Payment Terms:

1. **Full Pay Cash Discount (Non-Insurance)**: We offer a 5% accounting courtesy for all treatment paid in full (cash or check) at time of service.
2. **Major Service- Two Payment Option**: We offer a two-payment option for Crown, Bridge, and Denture treatment. We ask that you pay one-half of your co-payment at the first appointment and the second at the seat date appointment.
3. **Term Loan**: By arrangement with CareCredit, we offer our patients, upon approval, an interest-free term loan (up to 12 months) with no down payment, no annual fee, and no prepayment penalty. Please ask for an application.

Payments are expected at the time services are rendered. We accept cash, checks, debit cards, Visa/MasterCard and Discover.

In case of parent-separation, parent with legal custody is responsible for the bill of that child.

Interest at the rate of 1.5% monthly will be charged on any unpaid balances after 60 days.

If a payment is not received at least monthly, and paid off within 3 months the account is considered delinquent and will be turned over to a lawyer or collection agency.

I have read and understand the above financial policy.

_____ _____

Signature Date

Patients with Dental Insurance

We are happy to complete and file insurance as a courtesy for you.

The patient is responsible for providing the benefits and restrictions of their policy. The patient's estimated payment is due at the time of service. If the insurance payment is not received within 60 days, full payment is due from patient.
If patient has double-coverage we will be happy to assist, but the patient may be responsible for the filing of the secondary coverage as we do not always receive an explanation of benefits from the insurance company. If the account is paid in full, we will be glad to provide to you the information to file the second insurance.

I understand that I am financially responsible for all charges whether or not paid by insurance.

In order for us to file your insurance, it is necessary that you read and sign below.
To the extent permitted under applicable law, I authorize the release of any information relating to an insurance claim.

_____ _____

Signature Date

I hereby authorize payment of dental benefits, otherwise payable to me, directly to Clemson SC Dental Associates.

_____ _____

Signature Date

Clemson SC Dental Associates

Administrative Form

I authorize contact from this office **to confirm my appointments, treatment, & billing information** via:

____ Cell Phone Confirmation

____ Home Phone Confirmation

____ Work Phone Confirmation

____ Text Message to my Cell Phone

____ Email Confirmation

____ Any of the above

I authorize **information about my health** to be conveyed via:

____ Cell Phone Confirmation

____ Home Phone Confirmation

____ Work Phone Confirmation

____ Text Message to my Cell Phone

____ Email Confirmation

____ Any of the above

I approve being contacted about **special events, fundraising efforts, and new health information** on behalf of Clemson SC Dental Associates. via:

____ Phone message

____ Text Message to my Cell Phone

____ Email

____ Any of the above

____ None of the above (opt out)

_____ _____

Signature Date

Clemson SC Dental Associates

Dental Office Guidelines

We care about your smile and your health, and want our relationship with you to be positive. The information below explains how we can work together to accomplish this goal.

DENTIST/STAFF

1. Our office will make every effort to stay on schedule. Sometimes emergencies occur which require the dentist to interrupt his/her schedule. When this happens, our staff will keep you informed and assist you in any way possible. Please understand that there may be times when YOU have an emergency that will result in another patient having to wait.

2. We will explain the results of your dental examination and the available treatment options, if treatment is necessary.

3. As a reminder, we will make every effort to contact you prior to scheduled appointments. Please make sure we have a correct mailing address and telephone number on file.

PATIENT/PARENT/GUARDIAN

1. Your dental health depends on you by keeping your scheduled appointments and also helps us to serve you better. If you must cancel an appointment, please notify us at least 48 hours before your appointment to avoid a $25 cancellation fee. IF TWO APPOINTMENTS ARE MISSED WITHOUT PROPER NOTIFACTION, YOU WILL BE REQUIRED TO PREPAY FOR YOUR APPOINTMENTS. IF THREE APPOINTMENTS ARE MISSED WITHOUT PROPER NOTIFICATION, YOU WILL BE DISMISSED AS A PATIENT.

   *Failed prepaid appointments will be nonrefundable.

2. Please remember to bring any proof of dental benefits/insurance you may have.

3. One adult may accompany children who have an appointment.

4. Children under the age of 18 must come to their appointments with an adult.

As Agreed By:

_____ _____

Signature Date

Relationship to Patient _____