Welcome to Florence Dental Arts!

Patient Medical and Dental History Form

Please take a few minutes to carefully read over and answer the following questions to help us treat you safely.
If you have any questions, we will be glad to assist you.

Patient Name:_____Birthdate:_____ Phone Number: _____
Current Address: _____
_____

Dental History

Reason for today's visit:_____
Former Dentist:_____ City:_____ State:_____
Date of last dental visit:_____ Date of last dental X-rays:_____

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

Bad breath	□Yes	□No	Clicking or popping of jaw	□Yes	□No	Mouth Breathing	□Yes	□No
Bleeding gums	□Yes	□No	Blisters on mouth	□Yes	□No	Burning sensation on tongue	□Yes	□No
Chew on one side of mouth	□Yes	□No	History of tobacco use	□Yes	□No	Clicking or popping of jaw	□Yes	□No
Jaw pain or tiredness	□Yes	□No	Dry mouth	□Yes	□No	Fingernail biting	□Yes	□No
Food stuck between the teeth	□Yes	□No	Foreign objects	□Yes	□No	Grinding teeth	□Yes	□No
Gums swollen or tender	□Yes	□No	Lip or cheek biting	□Yes	□No	Loose or broken fillings	□Yes	□No

Is there anything that you would like to change about your teeth? _____
_____

Medical History

Physician's Name:_____ Date of last visit:_____

Please 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
Bacterial Endocartitis	□Yes	□No	what type?_____			Special Diet	□Yes	□No
Bleeding Abnormally			Hepatitis, type _____	□Yes	□No	Stroke	□Yes	□No
with extractions or surgery	□Yes	□No	Herpes	□Yes	□No	Swollen Feet or Ankles	□Yes	□No
Blood Disease	□Yes	□No	High Blood Pressure	□Yes	□No	Swollen Neck Glands	□Yes	□No
Cancer	□Yes	□No	Jaundice	□Yes	□No	Thyroid Problems	□Yes	□No
Chemical Dependancy	□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 System 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 have an allergy to □Aspirin □Barbituates (sleeping pills) □Codeine □Iodine □Latex
□Local Anesthetic □Penicillin □Sulfa □Other:_____
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

Please list any medications you are currently taking and what you are taking it for:_____
Pharmacy: _____ Phone:_____

Patient's Signature: _____ Date: _____

FLORENCE DENTAL ARTS

FAMILY & COSMETIC DENTISTRY

THOMAS R. CHERRY, JR., DMD

Patient Information

Date:_____

Patient Name:_____
First MI Last

Social Security #:_____

Sex: □ Male □ Female Age:_____

Birthdate:_____

Address:_____

City:_____

State: _____Zip Code:_____

Email:_____

Occupation:_____

Employer/ School:_____

Employer/School Address:_____

_____

□ Married □ Widowed □ Single □ Minor
□ Separated □ Divorced □ Partnered

Spouse's Name:_____

Spouse's Birthdate:_____

Spouse's Social Security #:_____

Spouse's Employer:_____

Whom may we thank for referring you?

_____

Who is responsible for this account?_____

Relationship to patient:_____

Insurance Company:_____

Group/Plan #:_____

Member ID #:_____

Subscriber's Name:_____

Birthdate:_____ SS#:_____

Relationship to Patient:_____

Is patient covered by secondary insurance? □Yes □No

Secondary Insurance Company:_____

Group #:_____ Member #:_____

Assignment and Release: I certify that I, and/or my dependent(s), have insurance coverage with_____ and assign directly to Dr. Thomas Cherry 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 my use my health care information and may disclose such information to the above-named insurance companies and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature of Patient or Guardian:_____

Pleast print name: _____

Date:_____ Relationship to Patient:_____

Phone Numbers

Home: (_____)_____

Work: (_____)_____Ext_____

Cell: (_____)_____

Spouse's Work: (_____)_____

How would you prefer we contact you?_____

_____

IN CASE OF EMERGENCY, PLEASE CONTACT:

Name:_____

Relationship:_____

Home:_____

Work:_____

Cell:_____

FLORENCE DENTAL ARTS

FAMILY & COSMETIC DENTISTRY

THOMAS R. CHERRY, JR., DMD

Terms of Payment

The following is a guide to the terms of payment we accept. We are committed to working with you to match a payment plan to your needs. Therefore, we offer different options to our patients which allows for payment to be convenient and flexible. We are available to answer any questions you may have.

Dental Insurance

Our office employs a dental insurance specialist for our patient's convenience, and we will gladly assist you with your dental insurance plan. To help us assist you in obtaining your maximum dental benefits, please come prepared with the following information: A current dental insurance card, the subscribers social security number, date of birth, and a copy of your driver's license (if applicable). Once your plan coverage has been verified, we will accept the assignment of benefits from your dental insurance provider. Most plans cover only a portion of the dental fee. As a courtesy to our patients, we will file your primary dental insurance for you, but we ask that you pay your deductible and the portion we estimate your plan will not cover at the time of service. If your insurance has not paid within 60 days of treatment, you will be billed for the unpaid balance, and payment in full will be expected at this time. We recommend you become directly involved in communication with your dental insurance company in order to expedite the payment.

Payment Options

- We accept Visa, Discover, and MasterCard, money order, cash or personal check. A fee of $35.00 will be assigned for all returned checks.
- A convenient interest free payment plan is available through our in-office financial partner CareCredit for those who qualify. (Please call us for further information)
- A pre-authorized payment plan on your credit card is an option for those who qualify.

Appointments

In order to allow the best possible care for our patients, we reserve a specific time just for you. We make every effort to see you as scheduled. We appreciate your promptness and your consideration in not changing your scheduled time. However, if you need to change your appointment, 24 hours' notice is expected. This gives us the opportunity to schedule another patient for treatment in your place. **A fee of $40.00 per appointment hour will incur without 24 hours' notice.**

Patient Records

If for any reason it becomes necessary for you to obtain a copy of your patient records, please note that we charge $20.00 record duplication fee. Please allow 7 to 10 days after completion of a records release authorization to receive your records.

Patient Agreement

- I understand that my insurance policy is an agreement between myself and the insurance company; therefore I am ultimately responsible for all the fees incurred for my dental treatment regardless of payment or denial of my insurance claims by my insurance company.
- I authorize insurance payment directly to Dr. Thomas Cherry, Jr.
- I authorize the release of necessary information to my insurance company to determine liability for payment and to obtain reimbursement for any claims.
- If this account is assigned to an attorney or collections agency, I agree to be responsible for nay attorney fees, collection fees, and court cost incurred.

_____ _____

Signature of Responsible Party Date

Privacy Policy

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION.

PLEASE REVIEW CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 1/1/2003 , and will remain in effect until we replace it.
We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made changes. Prior to making a significant change in our privacy practices, we will amend this Notice and make the new Notice available upon request.
You may request a copy of our Notice at any time. For more information about our privacy practices or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to obtain treatment information for services we provide to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: Other than our use of your health information for treatment and payment of healthcare operations, we will not share - without written authorization - your health information or disclose it to anyone for any purpose. If you provide an authorization to us, you may revoke it, in writing, at any time. Your revocations will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences in your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence, or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of an inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or obtain copies of your health information with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending a letter to the address at the end of this Notice. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates have disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities, for the last 6 years. If you request this accounting more than once in any 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your

request in writing. Your request must specify the alternative means or locations, and provide a satisfactory explanation of how payment will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing and must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web Site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you would like more information about our privacy practices or have questions or concerns, please contact us.
If you are concerned that we may have violated your privacy rights, disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use of disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may communicate with us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you chose to file a complaint with us or with U.S. Department of Health and Human Services.

Contact Officer: Thomas Cherry

Mail:
1527 Heritage Lane
Florence, SC 29505
United States

 Telephone: 843.665.6200

 Fax: 843.665.6201

 Email: florencedmd@gmail.com

Acknowledgement of Receipt of Notice of Privacy Practices

1,_____
, have received a copy of Florence Dental Arts' Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement was not obtained for the following reason:

- **Individual refused to sign**
- **Communication barriers prohibited obtaining the acknowledgement**
- **An emergency situation prevented us from obtaining acknowledgement**
- **Other (Please Specify)**

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