TIME 12:04 PM

DATE 3/8/2017

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

Emg. Contact

Prev. Dentist

Contact Number

Family Doctor

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Time 11:17 AM | Deaton Dental Associates Of Summerville | Date 7/11/2024

2024 UPDATED MEDICAL HX FORM

Patient Name: | Birth Date: | Date Created:

Are you under a physician's care now?	Yes No	If yes
Have you ever been hospitalized or had a major operation?	Yes No	If yes
When was the last time you were hospitalized and for what?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Are you taking any medications, pills, or drugs? Please provide a list or write out meds	Yes No	If yes
Are you taking a blood thinner or aspirin daily?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Do you drink soda,enegry drinks or sweet tea? How much per day?	Yes No	If yes
Do you use tobacco or vape?	Yes No	If yes
Do you use controlled substances?	Yes No	If yes
Do you need to pre-medicate for dental visits? If so why	Yes No	If yes

Women: Are you...

☐ Pregnant/ Due Date_____ ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

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/Dementia Yes No	Diabetes Yes No	Hepatitis A 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	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	Leukemia Yes No
Stomach/Intestinal Disease Yes No	Breathing Problems Yes No	Frequent Headaches Yes No	Liver Disease Yes No
Stroke Yes No	Bruise Easily 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	Yellow Jaundice Yes No
Parkinson's Yes No	Autism Yes No	Acid Reflux Yes No	Anorexia/Bulimia Yes No

Have you ever had any serious illness not listed above?	Yes No	If yes
If you have or have had Cancer what type?	Yes No	If yes

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:

X Date:_____

PATIENT NAME:_____ **DOB:** _____

DENTAL HISTORY

Whom may we thank for the referral; _____
Do you pre-medicate for dental visits?_____**If so, what do you normally take:**

_____

Purpose of initial visit_____

When was your last cleaning and examination?_____

When was your last x-rays taken? Bitewings_____ Full Mouth_____ Panorex_____

Are any of your teeth SENSITIVE to: hot___ cold___ sweets___ pressure___

Are you having pain or discomfort at this time?.....☐ yes ☐ no

Do you feel very nervous about having dental treatment?.....☐ yes ☐ no

Have you ever had a bad experience in the dental office?.....☐ yes ☐ no

Have you ever had any excessive bleeding requiring special treatment?.....☐ yes ☐ no

Are you aware of GRINDING or CLENCHING your teeth?.....☐ yes ☐ no

Have you experienced any pain or soreness in the muscles of face or around your ear?.☐ yes ☐ no

Do you have frequent HEADACHES or SHOULDER ACHES?.....☐ yes ☐ no

Do you have frequent EARACHE or NECK PAINS?.....☐ yes ☐ no

Do your gums bleed or hurt?.....☐ yes ☐ no

Have you ever had gum treatment or surgery?.....☐ yes ☐ no

Are you UNHAPPY with the appearance of your teeth?.....☐ yes ☐ no

Have you been diagnosed with sleep apnea?.....☐ yes ☐ no
Are you aware of or have you been told you snore?.....☐ yes ☐ no
Do you use a CPAP machine?.....☐ yes ☐ no

If you wear a removable partial or complete denture, please complete the following:
How long have you worn your **present** denture? _____
When did you receive your first partial or complete denture?_____
When were your teeth extracted?_____

Is there any other dental information that you feel we should know about?_____

_____

Patient/Guarantor_____ Date_____

Dental Associates Of Summerville, LLC

CONSENT FOR TREATMENT

1. I hereby authorize the doctor or designated staff member to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of (name of patient)_____'s dental needs.
2. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetics agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. 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.
5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that finance charge will be added to my account.

Patient's Signature_____Date_____
Parent / Responsible Party's Signature_____
Relationship to Patient _____

Regarding Insurance

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from the insurance companies and will credit any such collections to the patients account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. Patient is aware he or she is responsible for any services or amounts not covered under the terms their policy.

Dental Associates of Summerville

Acknowledgement of Receipt Of Notice of Privacy Practices

Patient Name & Address: _____

_____

_____

I have received a copy of the Notice of Privacy Practices for the above named practice.

_____ _____

Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ❑ An emergency existed & a signature was not possible at the time.
- ❑ The individual refused to sign.
- ❑ A copy was mailed with a request for a signature by return mail.
- ❑ Unable to communicate with the patient for the following reason:

  _____
- ❑ Other: _____

  _____

Prepared By _____

Signature _____

Date _____

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Communications between Patients and their Families, Friends, or Caregivers

This form allows Deaton Dental Associates of Summerville (Name of Practice) to communicate information about your care (e.g., appointments, labs, medication, treatment plans, billing information) to you and those you list on this form. Signing this form is optional, is not required to receive treatment, and does not expire until you end it in writing.

Patient Name: _____
(Last) (First) (Middle Initial)

Date of Birth: _____ (mm/dd/yyyy) **Main Contact Number:** (___) _____
☐ Home ☐ Cell* ☐ Work

Mailing Address: _____
(Street)

_____
(City) (State) (Zip)

COMMUNICATING WITH YOU

PHONE **DETAILED MESSAGES PERMITTED**

☐ Main Contact Number Above ☐ text (SMS)* ☐ voicemail/answering machine ☐ None

☐ Other: (___) _____ ☐ text (SMS)* ☐ voicemail/answering machine ☐ None
☐ Home ☐ Cell* ☐ Work

EMAIL*

☐ _____

☐ All information from this practice
☐ Appointment information only (request/confirm/cancel)
☐ Data breach notifications
☐ Billing/insurance information

COMMUNICATING WITH YOUR FAMILY, FRIENDS, OR CAREGIVERS

☐ This practice may communicate to the family members, friends, or caregivers listed below.

Spouse/Partner: _____ (First and Last Name)
Phone: (___) _____
Email:* _____

Other: _____ (First and Last Name)
Phone: (___) _____
Email:* _____
Relationship: _____

Check the box next to each type of information this practice may share.

☐ All information ☐ Prescriptions ☐ Appointments (request/confirm/cancel) ☐ Billing/Insurance

☐ Other: _____

Do not include:

☐ Mental health records ☐ Communicable diseases (e.g., HIV/AIDS) ☐ Alcohol/drug abuse treatment

* I understand that emails and texts are not always secure ways to communicate and could be intercepted and read by a third party. I am willing to accept this risk.
This practice is not responsible for the privacy or security of your health information once it is sent to you, or the recipient(s) listed above.

YOUR PHOTOS & MULTIMEDIA

	Photos/Images may be used/posted:
☐ Photo received from you or personal representative	☐ In office
☐ Photo taken by staff (e.g., pre/post procedure)	☐ On office's website
☐ Other:_____	☐ Other: _____

PATIENT RIGHTS & SIGNATURE

- You can end this authorization at any time in writing. See our Notice of Privacy Practices for exceptions. A termination will not apply to any releases of information that happen before we receive a written termination from you.
- The recipient of the information could use or release it in a way that federal or state laws do not protect. This practice is not responsible for the privacy or security of your health information after it is sent to those listed on this authorization.
- You can review or copy the information that will be used or released as described in this authorization.
- You do not have to sign this authorization to receive treatment from this practice.
- You understand that the information that will be used or released might include a communicable disease diagnosis such as HIV or a diagnosis related to mental health or substance abuse unless you exclude it above.
- All changes or updates to this form must be made in writing and signed by you (patient) or your personal representative. Minor edits (e.g., new phone number) can be made on this form, initialed, and dated instead of requiring a new form.

_____ _____

Patient/Personal Representative Signature **Date: mm/dd/yyyy**

Printed name and description of Personal Representative's authority (e.g., healthcare power of attorney)
(Attach documentation to support the personal representative's authority if not already on file with the practice)

_____

FOR OFFICE USE & REFERENCE ONLY

☐ This authorization has been terminated: _____
mm/dd/yyyy

The termination must be in writing and filed with the original authorization.

Date original signed authorization received: _____
mm/dd/yyyy

☐ Copy of original authorization provided to patient/personal representative (check if yes)

Notes: _____

_____

_____

It is recommended that the practice review this form with the patient or their personal representative periodically for changes (e.g., annually with insurance verification).