TIME 02:27 PM DATE 4/7/2020

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

Emergency Contact

Emergency Contact #

Previous Dentist

Referred By

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:

Medical History Revised 11/2016

Patient Name: (13336) Ken . Birth Date: Date Created: 4/7/2020

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, c

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
Have you ever had a serious head or neck injury?	Yes No	If yes
Are you taking any medications, pills, or drugs?	Yes No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Are you on a special diet?	Yes No	
Do you use tobacco?	Yes No	

Women: Are you...

Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic
Metal Latex Sulfa Drugs Local Anesthetics

Do you use controlled substances?	Yes No	If yes
Other?		If yes

General Single Questions

Do you snore or have you been told you snore? Yes No

General Single Questions

Have you been diagnosed with sleep apnea? Yes No

General Single Questions

Do you wear a C-PAP? have you been told you need a C-PAP? Yes No

General Single Questions

If there was a non-surgical way to stop snoring would you be interested? Yes No

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 Problems 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 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:_____

BROKEN RESERVATION & SHORT NOTICE CANCELLATION POLICY

YOU MUST CONFIRM YOUR RESERVATION!!! IF YOU DO NOT CONFIRM WITH IN 48 HOURS OF YOUR APPOINTMENT, WE RESERVE THE RIGHT TO OFFER THE TIME TO ANOTHER PATIENT.

Failure to give a 48 hour notice of a change to your appointment will result in the following:

- A fee of **$50 will be charged** to your account for missed or cancelled appointments occurring more than 1 time in a calendar year.
- **3rd violation to this policy in a calendar year will result in immediate dismissal from our office.**

Emergencies happen, we understand that. We will allow special consideration for extreme family emergencies (such as severe illness or death in the immediate family).

X_____

Guardian/Patient Signature Date

MEDICAID
BROKEN RESERVATION & SHORT NOTICE CANCELLATION POLICY

YOU MUST CONFIRM YOUR RESERVATION!!! IF YOU DO NOT CONFIRM WITH IN 48 HOURS OF YOUR APPOINTMENT, WE RESERVE THE RIGHT TO OFFER THE TIME TO ANOTHER PATIENT.

Failure to give a 48 hour notice of a change to your appointment will result in the following:

- **We will report your failed attendance to SC Medicaid---WHICH MAY CAUSE YOU TO LOOSE YOUR MEDICAID INSURACE!!!!**
- **2nd violation of this policy in a calendar year will result in immediate dismissal from our office.**

Emergencies happen, we understand that. We will allow special consideration for extreme family emergencies (such as severe illness or death in the immediate family).

X_____

Guardian/Patient Signature Date

Assignment of Benefits & Financial Responsibility Form

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits: I hereby assign all dental, medical, and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to **Confident Smiles of Laurens** (R. Nicholas Cost, Jr., DDS, PA)

I understand that I am responsible for any amount not covered by insurance or the agreed amount for services rendered for dental/medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any.

On behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I hereby affirm that any payment made to me by my Insurance Carrier will be immediately transferred to Confident Smiles of Laurens (R. Nicholas Cost, Jr., DDS, PA) upon receipt for services rendered. I further understand that fees are due and payable for the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement EOB or Check.

I understand that I may choose to pay via Cash, MasterCard, Visa, American Express, Discover or CareCredit. We offer financing through 3rd party entities and assist you in applying for them if you are interested. We do not offer in-house financing.

We offer a 5% courtesy savings adjustment for prepayment of your estimated copay (if you have insurance) or full amount due (if you are uninsured).

We require either 20% down payment or $20 down (whichever is greater) of your estimated copay (if you have insurance) or of the full amount due (if you are uninsured)in order to preserve the next appointment for you. The remaining amount is due the day of your appointment prior to being seen. That being said, we are not contracted with your insurance company; you are, therefore, any estimate we provide is subject to the terms and conditions of the plan your employer has chosen for you and is just that--AN ESTIMATE. Your signature below is your acknowledgement that you may owe more after your insurance pays and any amount due is your responsibility to be paid within 30 days of receiving a statement from our office. If we do not receive payment from your insurance carrier within 60 days, you will be responsible for payment of your treatment fees and collection of your benefits from your insurance carrier will need to be achieved by you.

We will charge your account a fee of $50 for missed or cancelled appointments occurring more than 1 time in a calendar year.

We will charge $50 for returned checks.

If you have any questions about the above information, please do not hesitate to ask.

A photocopy of this assignment is to be considered as valid as the original.

X _____

Patient/Responsible Party Signature **Date**

_____

Witness Signature **Date**

Authorization- Compound Treatment & Social Media

This authorization form permits Confident Smiles of Laurens, 318 W Farley Ave, Laurens SC 29360, to use or disclose protected health information listed in the Description section below to the Entity or Person listed in the Receiving Entity section for the following patient:

Name _____ Birth Date _____

Entity or person to receive information: VOICE Mail number: _____	Description of Information to be provided: ☐ Appointment information ☐ Financial information ☐ Family billing information ☐ Clinical information Please list _____
Entity or person to receive information: Unsecured email address: _____	Description of Information to be provided: ☐ Appointment information ☐ Financial information ☐ Family billing information ☐ Clinical information Please list _____
Entity or person to receive information: Text messages: #_____	Description of Information to be provided: ☐ Appointment information ☐ Financial information ☐ Clinical information Please list _____
Entity or person to receive information: Any Treating Facility is authorized to receive unencrypted email PHI	Description of Information to be provided: ☐ Unencrypted PHI for treatment with minimal identifiers.
Entity or person to receive information: Parent or Spouse- give name and relationship: Name _____ Relationship_____	Description of Information to be provided: ☐ Appointment information ☐ Financial information ☐ Family billing information ☐ Clinical information Please list _____
Entity or person to receive information: School or Employer: _____	Description of Information to be provided: ☐ Appointment information ☐ Return to work or school document
Entity or person to receive information: Other- give name and relationship: _____ _____	Description of Information to be provided: ☐ Appointment information ☐ Financial information ☐ Family billing information ☐ Clinical information Please list _____

General viewing and Social Media viewing	Description of Information to be provided: ☐ Photos- Office placement ☐ Photos- patient placement ☐ Contest information

Purpose
The purpose of this authorization is to meet the patient's request for information disclosures and uses.

Expiration date or event: This authorization shall be enforce until revoked by the patient or

_____

Verification method or code: This practice will verify the identity of any entity requesting protected health information. Verification information may include:_____

Rights of the Patient
I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

I understand that I have the right to revoke this authorization at any time by sending a written notification to the address listed at the top of this form I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

X _____ **Date** _____

Signature of Patient or Personal Representative (as defined by HIPAA)

Description of Personal Representative's Authority (attach necessary documentation)

_____

****

Office Use Only: Receiving Employee_____Date received_____

☐ Copy given to patient

Acknowledgement of Receipt of Notice of Privacy Practices For

Confident Smiles of Laurens
318 W Farley Ave
Laurens, SC 29360

I hereby acknowledge that I have received the Notice of Privacy Practices for the above office.

_____

Signature: Patient's Name / Personal Representative (as defined by HIPAA) Date

_____

Description of Personal Representation and please attach copy of documentation.

Documentation of "Good Faith" Attempt to get acknowledgement signature.

- ☐ Document presented to patient, but patient refused to sign acknowledgement.
- ☐ Patient presented with an emergency situation and there was no time to give the Notice or receive a signature. Attempt to get give the Notice, and get any acknowledgement will be handled as soon as possible.
- ☐ Documentation was presented to the patient but a communication failure prevented us from receiving the acknowledgement.
- ☐ The documentation was mailed to the patient but never returned to us.
- ☐ Other _____

_____

Employee preparing document Date

_____

Employee signature _____