PATIENT REGISTRATION AND HEALTH HISTORY

GREAT WHITE SMILES

Please complete the following confidential information

Date _____
Patient's Name _____
Address _____
City _____ State _____ Zip _____
Home Phone No. _____ Cell No. _____
Birthdate _____ Age _____ Sex ____M / F____
Marital Status:_____
Social Security No. _____
Occupation _____
Employer _____
Address _____
City _____ State _____ Zip _____
Work No. _____

If the patient is a student

Name of School _____
Grade _____

Person Responsible for the Account

Name _____
Relationship to Patient _____
Address _____
City _____ State _____ Zip _____
Home Phone No. _____ Cell No. _____
Birthdate _____ Age _____ Sex ____M / F____
Social Security No. _____
Occupation _____
Employer _____
Address _____
City _____ State _____ Zip _____
Work No. _____

DENTAL INSURANCE

Primary Insurance

Insurance Company_____
Subscriber No. _____
Group No. _____
Address _____
City _____ State _____ Zip _____
Telephone No._____
Employer _____
Date Employed _____

Secondary Insurance

Insurance Company_____
Subscriber No. _____
Group No. _____
Address _____
City _____ State _____ Zip _____
Telephone No._____
Employer _____
Date Employed _____

Getting to Know You

Is another member of your family or relative a patient at our office?

Name _____ Relationship _____
Referred to us by _____
Your former address _____
City _____ State _____ Zip _____
Person to contact for Emergency _____
Phone No. _____
Address _____
City _____ State _____ Zip _____
Closest relative not living with you _____
Phone No. _____
Address _____
City _____ State _____ Zip _____

1. Are you having pain or discomfort at this time? ..... YES NO
2. Have you been a patient in the hospital during the past two years? ..... YES NO
3. Have you been under the care of a medical doctor during the past two years? ..... YES NO

   Physician's Name_____ Phone No. _____

   Address _____
4. Have you taken any medication or drugs during the past two years? ..... YES NO
5. Are you now taking any medication, drugs or pills? ..... YES NO

   If yes, please list: _____
6. Are you aware of being allergic to or have you ever reacted adversely to any medication or substance? ..... YES NO

   If yes, please list: _____
7. Indicate which of the following you have had or have at present. Circle "yes" or "no" to each item.

Heart Failure	YES	NO	Artificial Joints (hip, knee, etc.)	YES	NO	Hepatitis B (serum)	YES	NO
Heart Disease or Attack	YES	NO	Kidney Trouble	YES	NO	Venereal Disease	YES	NO
Angina Pectoris	YES	NO	Ulcers	YES	NO	A.I.D.S.	YES	NO
Congenital Heart Disease	YES	NO	Diabetes	YES	NO	H.I.V. Positive	YES	NO
Heart Murmur	YES	NO	Thyroid Problems	YES	NO	Cold Sore/Fever Blisters	YES	NO
High Blood Pressure	YES	NO	Glaucoma	YES	NO	Blood Transfusion	YES	NO
Arteriosclerosis	YES	NO	Cosmetic Surgery	YES	NO	Hemophilia	YES	NO
Mitral Valve Prolapse	YES	NO	Emphysema	YES	NO	Anemia	YES	NO
Artificial Heart Valve	YES	NO	Chronic Cough	YES	NO	Sickle Cell Disease	YES	NO
Heart Pacemaker	YES	NO	Tuberculosis	YES	NO	Bruise Easily	YES	NO
Heart Surgery	YES	NO	Asthma	YES	NO	Liver Disease	YES	NO
Rheumatic Fever	YES	NO	Osteoporosis	YES	NO	Yellow Jaundice	YES	NO
Arthritis	YES	NO	Allergies or Hives	YES	NO	Epilepsy or Seizures	YES	NO
Rheumatism	YES	NO	Sinus Trouble	YES	NO	Fainting or Dizzy Spells	YES	NO
Cortisone Medicine	YES	NO	Radiation Therapy	YES	NO	Nervousness	YES	NO
Drug Addiction	YES	NO	Chemotherapy	YES	NO	Psychiatric Treatment	YES	NO
Stroke	YES	NO	Hepatitis A (infection)	YES	NO	Developmentally Disabled	YES	NO

8. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? ..... YES NO
9. Do your ankles swell during the day? ..... YES NO
10. Do you use more than two pillows to sleep? ..... YES NO
11. Have you lost or gained more than 10 pounds in the last year? ..... YES NO
12. Do you ever wake up from sleep and feel short of breath? ..... YES NO
13. Are you on a special diet? ..... YES NO
14. Has your medical doctor ever said you have a cancer or tumor? ..... YES NO
15. Do you have or have you had any disease, condition, or problem not listed? ..... YES NO

    If yes, please list: _____

FOR WOMEN ONLY:

Are you pregnant? ☐ Yes, what month? _____ ☐ No Are you nursing? ☐ Yes ☐ No Are you taking birth control pills? ☐ Yes ☐ No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

☞ **Patient Signature** _____ **Date** _____

CONSENT:

1. The undersigned hereby authorizes doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
2. ☞ I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with **(name of patient)** _____**.** I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. Lastly, I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1-1/2% finance charge (18% APR) may be added to my account.

☞ **Patient** _____ **Date** _____ **Witness**_____

Parent or Responsible Party _____ Relationship to Patient _____

INSURANCE VERIFICATION FORM

As a service to our patients, we will file your dental insurance. We are out-of-network with all insurance providers. However, **YOU** are responsible for **ALL** communication with your insurance company except for additional information required of this office pertaining to specific procedures. We are providing you with this form, which has the necessary questions for you to ask regarding your coverage so you will have a better understanding of your insurance coverage. Ultimately, you are responsible for all charges/balances/unpaid claims. Please complete this form and bring it to your appointment. Please understand that dental insurance is intended to cover some, but not all, of the cost of your dental care, and may include a deductible which must be paid by the patient at the time of service. **We cannot stress enough that insurance payment is not, and has never been, a guideline for quality care.** Thank you for your cooperation!

Patient Name _____

Policy Holder's Name _____Relationship to patient_____

Policy Holder's DOB_____/_____/_____ SSN _____-_____-_____

Policy Holder's Employer _____Phone#(_____)_____-_____

Group # _____Policy #_____Is it a calendar or fiscal year?_____

POLICY EFFECTIVE DATE:_____/_____/_____YEARLY MAXIMUM $_____

COVERAGE: Preventive_____% Basic_____% Major _____%

DEDUCTIBLE: Individual $_____Family $_____ Does it apply to preventive?_____

FREQUENCY: Prophy_____BWX_____FMX/Pano _____
(How often do they cover?)

Flouride Coverage: Yes or No Covered at _____% Age Limit _____

Are Periodontal Cleanings Covered ?_____ If yes, under Basic or Major ?_____

Are there waiting periods on **Basic/Major** services?_____

Missing Tooth Clause? Yes or No Replacement (crowns, bridges, dentures): 3 5 7 10 None

Is coverage provided for replacement of teeth extracted prior to Insurance Coverage? Yes or No

Are benefits paid to the provider? Yes or No

AUTHORIZATION:
I certify that I am covered by _____Insurance Company and I assign directly to Dr. Taylor all insurance benefits otherwise payable to me. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____ _____/_____/_____
Signature Date

GREAT WHITE SMILES

Dr. Eddie Taylor
1032-E Kinley Road
Irmo, SC 29063
(803)781-3232

Patient Consent Form

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created to provide a standard for certain health care providers to obtain their patients consent for use and disclosures of health information about the patient to carry out treatment, payment or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. We provide the minimum necessary information to only those we feel are in need of your health care operations. We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment or health care operations. These entities are most often not required to obtain patient consent. You may refuse to consent to the use of disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions from a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name_____**Signature**_____**Date**_____

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule". We strive to achieve the very highest standard of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate uses of PHI in accordance with the government rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.

GREAT WHITE SMILES

Dr. Eddie Taylor
1032-E Kinley Road
Irmo, South Carolina 29063

Notification Authorization

I hereby authorize the office and staff of Dr. Eddie Taylor to notify me of necessary medical information including, but not limited to, lab results, authorization and referral information, appointment and/or changes in my care through the following methods if I am not immediately accessible via telephone:

- ☐ **Cell Phone/Cell Phone Voice Mail #**
- ☐ **Home Answering Machine**
- ☐ **Spouse**
- ☐ **Other Family Member (Please Specify)**

I understand the information I am authorizing may be personal and confidential in nature. I further understand that I may revoke this authorization at any time by notifying the office staff.

_____ _____

Patient Signature **Date**