882 Cook Road, Orangeburg, SC 29118
(803) 536-9503| frontdesk@gardencitydentalsc.com

Patients Name: _____ M☐ F☐ (Check one) DOB ____/____/_____
Last Mi First

SSN _____-_____-_____ Nickname _____

Home Address _____
City State ZIP CODE

Home Phone (____)_____ Cell Phone (____)_____ Email _____

Check one: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

In Case of Emergency Notify _____ Phone (____)_____ Relationship _____

How did you hear about us? *(circle all that apply)*
Friend, Family, Co-worker, Insurance Website, Web Search, Phone Book, Postcard, Other _____

Account Information *(person who is responsible for this account)*
☐ Self ☐ Parent ☐ Guardian *(paperwork must be provided)* ☐ Other _____*(please explain)*

Name _____ Address _____ Phone (____)_____

Insurance Information (if no Insurance check NONE and proceed to next section)

☐ SELF ☐ Spouse ☐ NONE ☐ Other _____
Policy Holder _____ DOB ____/____/_____ SSN _____-_____-_____
Last Mi First

Policyholder's Employer_____ Dental Insurance Carrier_____
Member ID# _____ Group #_____ Customer Service # _____

GARDEN CITY DENTAL FINANCIAL POLICY

I hereby accept responsibility for the payment of this account. By signing below, I am aware that any balance as of 120 days from each service may be subject to referral to a collection agency. I also understand that any fees incurred in the collection of this account, including collection agency and/or attorney's fees, will be added to the balance and will be payable by the responsible party. Any financial arrangements differing from these listed should be discussed and agreed upon in writing by both parties before the patient receives treatment.

Signature **X**_____ Date _____
(Responsible party)

INSURANCE-RELEASE OF INFORMATION & ASSIGNMENT OF BENEFITS
In requesting examination and/or treatment, I authorize the release of all information (including "x-rays") necessary to process my claims. I authorize this office to affix my name to all insurance claims. I also authorize payment to be made directly to Modlin & Londry XIV DDS PLLC (d.b.a. Garden City Dental) by my ins carrier for professional services rendered.

I understand that payment from my insurance company cannot be guaranteed despite any oral representations or reassurances by Employees of this practice, and I agree that I am financially responsible for and agree to pay any charges not covered by insurance. Payment will be due on any outstanding balance by 90 days from the date of each service, regardless of the status of any insurance claims. In the event that your dental insurance company sends you payment for services rendered by our office, you agree to remit payment in full within 30 days of receipt of such funds. Failure to do so will result in your account being placed with our Collections Agency. I authorize this office to contact and exchange information with credit agencies regarding any credit extended to my account.

Signature **X**_____ Date _____
(Patient, or parent if minor)

**IF NO DENTAL INSURANCE

TO FILE YOU MAY SKIP THIS PAGE

ABOUT YOUR DENTAL INSURANCE COVERAGE

Dental insurance coverage is ever-changing. Our staff is here to help you understand your particular dental insurance coverage. For every patient or family, we contact the insurance company and gather information that helps us ***interpret*** coverage, using information provided by your dental insurer.

Although we do our best to gather detailed information about waiting periods, downgrades in treatment coverage, and restrictions of treatment, insurance companies may not disclose pertinent additional information that would help determine your out-of-pocket responsibility. Because of this, we can only provide ***estimates*** of what may be paid on your behalf by your insurance provider.

There are several ways in which you can assist us in providing you with the best estimates possible:

- Thoroughly read your dental policy and familiarize yourself with the details of coverage. Pay close attention to waiting periods, maximums and deductibles, alternate benefits and missing tooth clauses, other types of exclusion clauses, etc.
- Visit your insurance provider's website to determine if we are an in-network provider with your plan. If not, determine if your provider offers out-of-network coverage. We are happy to bill all dental insurance providers on your behalf, but it is the patient's responsibility to determine whether you are visiting an in or out-of-network provider.
- Inform us of any change or update with your coverage at least 48 hours in advance of any appointment to avoid paying for the full appointment fee out of pocket.
- Keep in mind that pretreatment or pre-authorization estimates from your dental provider can take 30-60+ days and are not a guarantee of coverage.

Patients should understand that the quality of the insurance is determined by the premium paid for the policy, and there are many levels of dental insurance. Many policies do not cover at or near 100% of preventative needs and the patient should research this ahead of the appointment. Due to our credentialing contracts, we are unable to make adjustments for payment deficiencies or payment denials by the insurance company. Patients are responsible for all amounts unpaid by their dental insurance provider for any reason, without exception.

It should be understood by each patient, insured, and Financially Responsible Party that by us assuming this role as your assistant in interpreting your dental insurance, the patient, insured, or Financially Responsible Party is the ultimate responsible party in this regard. We will do our best to inform you, but in the end, without exception, and regardless of how competently you feel we have assisted you in interpreting your coverage, any fees due to the office which is not paid by the insurance company are due from the Financially Responsible Party within 90 days of the services being rendered.

Is there anything you would like to note about your dental insurance? _____
_____.
_____
_____

_____ _____

Signature of Patient, Parent, or Legal Guardian, and Financially Responsible Party Date

GARDEN CITY DENTAL

PATIENT NAME: _____

Rate Health 1-10 _____

MEDICAL HISTORY

Do you have or have you ever had any of the following diseases, conditions, or medical procedures?
(First, read <u>all</u> conditions in the list, *then* circle either "<u>Yes</u>" answers or "<u>No</u>" answers to the left)

Any Troubles, Surgeries, or defects, with these major organs:

Y N **Heart**: Attack, Angina/Pain, Murmur / MVP or other defects, Rapid Beat / Arrhythmias, Congestive Failure, Pacemaker, Surgeries: Bypass, Valve Replacement _____

Y N **Lung**: Asthma, Emphysema, Short of Breath, Cancer, TB, COPD, Other _____

Y N **Liver**: Hepatitis (types A, B, C), Jaundice / Cirrhosis, Enlargement, Cancer, Surgeries, Damage due to Alcohol or Drugs

Y N **Kidney / Bladder**: Stones, Cancer, Surgeries: Transplant, Removal, Non-Functioning _____

Please summarize any other surgeries or further details from above: _____

_____

Do you have or have you had any of the following diseases, conditions, or medical procedures?

<u>No Blanks, and please circle the appropriate selection where more than one is listed.</u>

Y N Blood Pressure, High or Low or Borderline
Y N Clotting / Bleeding Problems / Vascular Problems
Y N Anemia: Iron, Pernicious (B-12), Sickle Cell
Y N Stroke: Major, TIA's (mini)
Y N Diabetes: Circle 1 2 - Are you a "brittle" diabetic?_____
Y N Other Endocrine (hormone) problems?
Y N Poor or Delayed Healing
Y N Thyroid: Hyper (overactive) or Hypo (underactive)
Y N Seizures/Epilepsy, controlled? Y or N
Y N Cancer/Tumors/Leukemia
Y N Chemotherapy
Y N Radiation Therapy (for cancer)
Y N Occupational Radiation Exposure
Y N Skin Disorders / Rashes / Shingles
Y N HIV+ / AIDS / ARC
Y N Any other Infectious Conditions? _____
Y N Tobacco: Circle: Cigarettes, Cigars or Oral; pks/day____yrs.____
Y N Stomach, GI, IBD, GERD, Ulcers, U. Colitis, Crohn's, Gluten, Allergy
Y N Cholesterol

Y N Fainting Spells
Y N Frequent Headaches / Migraines
Y N Head Injuries
Y N Learning: ADD / ADHD / Dyslexia
Y N Sleep Disorders / Apnea (CPAP used?_____)
Y N Venereal Disease
Y N Jaw Joint (TMJ) Disorders (Bite guard? _____)
Y N Jaw or Facial Surgery
Y N ENT: Circle: Eye, Ear, Nose, Throat, Sinus
Y N Do You Have Difficulty Swallowing?
Y N Nervousness / Depression
Y N Other Psychiatric Disorder (_____)
Y N Alcohol Abuse (treated? _____)
Y N Drug Abuse / IV Drug History
Y N Arthritis, Rheumatism; Back Pain, Neck Pain
Y N Artificial Bones / Joints Replaced? Date_____
Y N Glaucoma
Y N Multiple Sclerosis

Medicine & Drug Allergies

Y N Do you have a **Latex Allergy**?
Y N **Allergies to Any Medicines** (List. Include Antibiotics, Painkillers, and Local Anesthetics: _____
Y N Have you taken any Prescription Steroids for *<u>more than 2 weeks in the last 2 years</u>*? _____
Y N **BLOOD THINNERS**? Circle: Coumadin/Warfarin; Plavix; Pradaxa; Daily aspirin_____mg/ Other Medications:_____
Y N Osteoporosis Medicines? Circle: **alendronate (Fosamax), pamidronate (Aredia), risedronate (Actonel, Atelvia) Zoledronate, (Zometa, Reclast, Aclasta), etidronate (Didronel), raloxifene (Evista), ibandronate (Boniva)**

Women:

Y N Are you pregnant? How long? _____
Y N Are you Nursing?
Y N Are you taking Birth Control Pills?

Please List All Medications You Take:

_____
_____
_____

DENTAL HISTORY

PATIENT NAME: _____

-What is Your Main Dental Concern? _____

-Approximate Date & Reason for Last Dental Visit _____

-I usually brush _____ times per day and floss _____times per _____.

Y N Are you satisfied with your previous Dental Care?
Y N Are you aware of any Clenching or Teeth Grinding?
Y N Any Pain in your Jaw Muscles or around your Ears?
Y N Do your Jaws Click or Pop?
Y N Do you currently wear a Bite guard at Night?
How old is the Bite guard? _____yrs.
Y N Do your Gums Bleed? Whenever I brush____
Whenever I floss ____
Y N Past Orthodontic Treatment (braces)? Approx. Age _____
Y N Do you wear removable Partial or Complete Dentures?
When was it made_____ Last Reline _____

Y N Are you dissatisfied with the appearance of your smile?
Y N Do you have spaces or gaps between your teeth?
Y N Do you have old fillings or dental work that you perceive to be unattractive?
Y N Do you feel nervous about dental treatment?
Y N Have you ever had a bad experience in a dental office?
Y N Do you have Sensitive teeth?
Y N Does food trap between your teeth?

-Are your teeth (please circle the following that apply): Chipped, protruding, crowded or misshapen?
-If you answered yes to being nervous about dental treatment what can we do to alleviate your nervousness?

_____

-If you could change one thing about your smile, what would it be? _____
- How would you like your teeth to look in 15 years? _____

Authorization for Treatment

I authorize the doctor and staff to perform any necessary dental services needed after diagnosis and oral discussion. I agree that the information filled out on this form is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form. I understand it is my responsibility to inform this office of any changes to the information I have provided, including medications.

Print Patient Name _____

Signature _____ Date _____
Patient, Parent, or Legal Guardian

Doctor Signature _____ Date _____

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

Due to Federal Regulations concerning patient privacy, we are unable to discuss your medical condition, dental records or financials with anyone, including family members without your consent.

Disclosure of Protected Information

Please check ***one*** of the options below:

_____ Only discuss my health and financial information with me.

_____ Garden City Dental employees have my permission to discuss my medical condition and disclose dental records and/or financial matters with the individual listed below.

Name:_____ Phone Number_____ Relationship_____

Communication Preferences

Please check the applicable options below:

_____Garden City Dental employees may leave information regarding my account or appointments on my voicemail.

_____Garden City Dental employees may communicate with me regarding my account via email, at the physical address previously provided and/or the following address:_____

As a patient or legal guardian, it is your responsibility to let us know if any of the above information changes at any time.

_____ _____

Signature **Date**

Rights of the Patient

I understand that I have the right to revoke any HIPAA-related authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to Garden City Dental.

I understand that a revocation is not effective in cases where the information has already been 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.

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

This authorization shall be in force and effect until revoked by the patient or representative signing the authorization.

X_____ _____

Signature of Patient, Parent, or Legal Guardian **Date**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This form is posted in our waiting area and is available online on our website at www.gardencitydentalsc.com.
If requested, I have received a written copy of the Notice of Privacy Practices.

_____ _____

Signature of Patient, Parent, or Legal Guardian **Date**

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