INSURANCE INFORMATION

Today's Date: ___________ /___________ /___________

PATIENT INFORMATION

Patient Name: ______________________________ Preferred Name: ______________________________

SS #: ______________________________ Date of Birth: ______________________________

Address: ______________________________ Email : ______________________________

City : ______________________________ State: ______________ Zip: ______________

Home Phone: (___) ______________ Cell Phone: (___) ______________

Check Appropriate Box: ○ Minor ○ Single ○ Married ○ Divorced ○ Widowed ○ Separated

Patient's or Parent's Employer: ______________________________ Work Phone: (   ) ______________

Business Address: ______________________________

City : ______________________________ State: ______________ Zip: ______________

Spouse's or Parent's Name: ______________________________ Work Phone: (___) ______________

Spouse's or Parent's Employer: ______________________________

If Patient is a Student, Name of School/College: ______________ City: ______________ State: ______

Whom May We Thank for Referring You? ______________________________

Person to Contact in Case of Emergency: ______________ Phone: (___) ______________

Relation to Patient: ______________

RESPONSIBLE PARTY

Name of Person Responsible for Account: ______________ Relation to Patient: ______________

Address: ______________________________ Home Phone: (___) ______________

Drivers License #: ______________________________ SS #: ______________________________

Employer: ______________________________ Work Phone: (___) ______________

Currently a Patient in our Office: ○ Yes ○ No

INSURANCE INFORMATION

Name of Insured: ______________________________ Relation to Patient: ______________________________

Date of Birth: ______________________________ SS #: ______________________________

Employer: ______________________ Date Employed: ___________ Work Phone: (___) ______________

Employer Address: ______________________________

City : ______________________________ State: ______________ Zip: ______________

Insurance Company: ______________ Group #: ______________ Union or Local #: ______________

Business Address: ______________________________

City : ______________________________ State: ______________ Zip: ______________

How Much is Your Deductible?: ______________ How Much Have You Used?: ______ Max. Annual Benefit: ______

ADDITIONAL INSURANCE INFORMATION

Name of Insured:________________________________ Relation to Patient: _____________________________

Date of Birth: _________________________________ SS #:_____________________________________

Employer: ______________________________ Date Employed: ___________Work Phone: (   )____________

Employer Address: ____

City : ____ State: ________________ Zip: _____________

Insurance Company: _____________________ Group #: _______________ Union or Local #:______________

Business Address: ____

City : ____ State: ________________ Zip: _____________

How Much is Your Deductible?: ______________ How Much Have You Used?: _____ Max. Annual Benefit: ______

Are you under a physician's care now?	Yes	No	If yes, name: ____________
Have you ever been hospitalized or had a major operation?	Yes	No	If yes, describe: ____________
Have you ever had a serious head or neck injury?	Yes	No	If yes, describe: ____________
Are you taking any medications, pills, or drugs?	Yes	No	If yes, list all: ____________
Do you take, or have you taken, Phen-Fen or Redux?	Yes	No	
Have you ever taken Fosamax, Boniva, Actonel or any other medication containing bisphosphonates?	Yes	No	
Do you require antibiotic pre-medication for dental procedures?	Yes	No	
Do you use tobacco?	Yes	No	

Women: Are you … Pregnant Nursing Taking oral contraceptives

Are you allergic to any of the following? Penicillin Codeine Acrylic Metal Latex Sulfa Drugs Local Anesthetics

Other drug allergies?	Yes	No	If yes, list all: ____________
Do you use controlled substances?	Yes	No	If yes, list all: ____________

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes	No	Fainting Spells	Yes	No	Pain in Jaw Joints	Yes	No
Alzheimer's Disease	Yes	No	Frequent Cough	Yes	No	Parathyroid Disease	Yes	No
Anaphylaxis	Yes	No	Frequent Diarrhea	Yes	No	Radiation Treatments	Yes	No
Anemia	Yes	No	Frequent Headaches	Yes	No	Recent Weight Loss	Yes	No
Angina	Yes	No	Genital Herpes	Yes	No	Renal Dialysis	Yes	No
Arthritis/Gout	Yes	No	Glaucoma	Yes	No	Rheumatic Fever	Yes	No
Artificial Heart Valve	Yes	No	Hay Fever	Yes	No	Rheumatism	Yes	No
Artificial Joint	Yes	No	Heart Attack/Failure	Yes	No	Scarlet Fever	Yes	No
Asthma	Yes	No	Heart Murmur	Yes	No	Shingles	Yes	No
Blood Disease	Yes	No	Heart Pacemaker	Yes	No	Sickle Cell Disease	Yes	No
Blood Transfusion	Yes	No	Heart Trouble/Disease	Yes	No	Sinus Trouble	Yes	No
Breathing Problems	Yes	No	Hemophilia	Yes	No	Spina Bifida	Yes	No
Bruise Easily	Yes	No	Hepatitis A	Yes	No	Stomach/Intestinal Disease	Yes	No
Cancer	Yes	No	Hepatitis B or C	Yes	No	Stroke	Yes	No
Chemotherapy	Yes	No	Herpes	Yes	No	Swelling of Limbs	Yes	No
Chest Pains	Yes	No	High Blood Pressure	Yes	No	Thyroid Disease	Yes	No
Cold Sores/Fever Blisters	Yes	No	High Cholesterol	Yes	No	Tonsillitis	Yes	No
Congenital Heart Disorder	Yes	No	Hives or Rash	Yes	No	Tuberculosis	Yes	No
Convulsions	Yes	No	Hypoglycemia	Yes	No	Tumors or Growths	Yes	No
Cortisone Medicine	Yes	No	Irregular Heartbeat	Yes	No	Ulcers	Yes	No
Diabetes	Yes	No	Kidney Problems	Yes	No	Venereal Disease	Yes	No
Drug Addiction	Yes	No	Leukemia	Yes	No	Yellow Jaundice	Yes	No
Easily Winded	Yes	No	Liver Disease	Yes	No	Have you ever had any serious illness not listed above	Yes	No
Emphysema	Yes	No	Low Blood Pressure	Yes	No	If yes, describe: ____________		
Epilepsy or Seizures	Yes	No	Lung Disease	Yes	No			
Excessive Bleeding	Yes	No	Mitral Valve Prolapse	Yes	No			
Excessive Thirst	Yes	No	Osteoporosis	Yes	No			

Have you ever been diagnosed with a behavior disorder or issue? Yes No If yes, describe: ____________

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:____________

COSMETIC INFORMATION

Is there anything about your smile that you do not like?

____

Are you happy with the appearance (color, size, shape) of your teeth?

____

Are your teeth crowded or crooked? ____________________________

Are you missing any teeth? ____________________________

Are any teeth chipped? ____________________________

Is your bite comfortable when chewing, biting? ____________________________

Does food get trapped between your teeth when you eat? ____________________________

Do you have frequent headaches, neck pain and/or shoulder aches? ____________________________

Do you have any old fillings or dental treatment that you are unhappy with?

____

What would you like to change the most about the appearance of your teeth?

____

Are you interested in the options available for a more beautiful smile? ____________________________

Is there anything else that you would like us to know?

____

FINANCIAL POLICY

Thank you for choosing us as your aesthetic dental care provider. We are committed to your treatment being successful. The following is a statement of our Financial Policy, which we require you read and sign prior to treatment.

All patients must complete our Patient Information/Health History Form and HIPAA Form before seeing Dr. Nicholson or the hygienist.

- *Full payment is expected at the time of service unless you have made prior arrangements with our treatment coordinators.*
- *We will file your dental insurance for you after verification of benefits.*
- *We accept cash, checks, Visa, Mastercard, Discover, American Express, or third party financing through care credit.*
- *For all missed appointments without at least 24 hours prior notification, there will be a service charge to your account of $30.*

Dental Insurance

We are a fee-for-service dental provider. You are financially responsible for all services provided to you and/or your dependents regardless of any insurance company's arbitrary determination of usual and customary rates.

Workers' Compensation

To avoid any misunderstanding regarding workers' compensation, we wish our patients to know that all professional services are charged directly to the patient, and that patients are personally responsible for payment of fees. We will gladly prepare necessary forms or reports to help you obtain your benefits from insurance companies. We do not render our services on the basis that workers' compensation will pay all of our fees.

Minor Patients

All minor patients must be accompanied by an adult. This adult is responsible for payment of services performed on the minor at the time of service.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.

I have read, understand, and agree to this Financial Policy. I understand that should I default in my arrangement to pay my bill, I will assume responsibility for all costs of collection, including but not limited to a reasonable attorney's fee.

Patient Name (Printed): ____________________ Date: ____________

Signature of Patient or Responsible party: ____________________

DESIGNATED PARTY RELEASE

You may give Carolina General & Cosmetic Dentistry, PA written authorization to disclose your protected health information to anyone that you designate, such as a family member or personal representative. If you wish to authorize a person to receive your protected health information, please complete the form below. You may also use this form to give us consent to leave detailed information (results of x-rays, prescription refills, etc.) on your home answering machine, cell phone, e-mail or another party that you designate.

Patient Name: ___________________________________ Date of Birth:_________________________________

Today's Date: __________ /________ /__________ Chart ID #: ___________________(for office use only)

At my request, I authorize Carolina General & Cosmetic Dentistry, PA to disclose my protected health information to:

Name: ____ Phone #: ____

Name: ____ Phone #: ____

Name: ____ Phone #: ____

At my request, I also authorize **Carolina General & Cosmetic Dentistry, PA** to communicate my protected health information to me via the following methods:

☐ Leave detailed message on my HOME answering machine (phone #: ________________________)

☐ Leave detailed message on my CELL phone voice mail (phone #:____________________________)

☐ EMAIL detailed dental information (e-mail: ____)

Signature : ____ Date : ________________________

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For Cancellation Only

I understand that I may cancel this authorization at any time by signing this notice below. However, if I cancel this authorization, I also understand that the cancellation will ***not*** affect any action **Carolina General & Cosmetic Dentistry, PA** took in reliance on this authorization before receipt of written notice of cancellation.

Signature Authorizing Cancellation: ____

Date Authorization Cancelled: ________ /________ /________

HIPAA AUTHORIZATION FORM

I hereby authorize you to use or disclose the specific information described below, only for the purposes and parties described below.

Description of the specific information to be used or disclosed:

Name

Address

Social Security Number

Medical History

Person or entity requesting the information and authorized to make the requested use or disclosure:

____

Recipient of the information: ____

This information is being requested for the following purpose(s):

Treatment

Payment

Healthcare operations

Referrals to dental and/or medical specialists

This authorization shall remain in effect from the date signed below until 2050 (expiration date or event).

I understand that:

- *I may inspect or copy the protected health information to be used or disclosed*
- *I may revoke this authorization in writing by contacting your office at the address below, attention Privacy Officer.*
- *Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protect by HIPAA.*
- *I may refuse to sign this authorization and that you will not condition treatment or payment on me providing this authorization (expect to the extent that the authorization is for research-related treatment, in which case you may refuse to provide that research-related treatment).*

○ If this box is checked, I understand that you will receive compensation from a third party (insurance or finance company) for the use or disclosure of my information.

Patient Name: ______________________________ Signature: ______________________________

Relationship to Patient *(if signed by personal representative of Patient):* ____________________ Date:__________

383 S Pine St., Suite 3, Spartanburg, SC 29302