WELCOME!

WE WOULD LIKE TO GET TO KNOW YOU

Name _____ Date of Birth _____

Mailing Address_____Apt #_____

City _____State _____ Zip _____

Social Security #_____ Gender _____Marital Status _____ Spouse Name _____

Cell Phone _____ E-Mail _____

Occupation _____ Employer _____

Emergency contact _____ Relationship _____ Phone _____

Who may we thank for referring you to our office? _____

Dental Insurance Company _____

Subscriber ID # _____ Group # _____

Subscriber's Name _____ Date of Birth _____

Subscriber's Social Security # _____ Employer _____

If you have a multiple dental insurance plans please attach details

Are you okay with our office therapy dog, Stella, interacting with you? _____
Do you have any dental anxiety? _____
What can we do to make your dental experience a pleasant one? _____
_____
Have you ever been told to premedicate before a dental appointment? _____
When was your last dental visit? _____
What kind of treatment was performed at that time? _____
Have you ever had Scaling and Root Planing "deep cleaning"? _____
Do you have any missing teeth? _____
Do you have any sensitive teeth? _____
Does your jaw click, pop, or lock (TMJ/TMD)? _____
Do you use tobacco products? _____
Do you consume alcohol? _____
What would make your smile a 10? _____

S&C Dental Office Policy

Welcome to S&C Dental! We are here to provide our patients with the best possible dental care. As your provider, we recommend treatment that is in the best interest of your medical and dental health. Be aware that insurance companies select certain dental procedures that they may or may not cover regardless of your personal situation, health, and dental needs. The following is an overview of our office financial policy.

Insurance: Dental Insurance rarely pays for 100% of all dental services. ***As a courtesy***, we will bill your dental insurance for your care, providing you give us the needed information for claim submission. Your estimated co-pays are due at time of service and any balance unpaid after the claim settles is due within 14 days of receipt of statement. **Initials** _____

Payment from the insurance company is expected within thirty (30) days. If your insurance company has not responded within a sixty (60) days grace period from the date of service, the remaining balance in full is your responsibility. At the time of service, we will request from you an initial payment; this is an estimated portion of the charges which insurance may not cover, including all applicable deductibles and co-pays**.** **Initials** _____

Payment: Payment in full is required at the time of service, down payment for lengthy procedures may also be requested. For your convenience, we accept cash, checks, debit, and credit cards, including Visa, MasterCard and Discover. Our office also offers no interest and extended payment plans, upon approved credit, through CareCredit. **Initials** _____

Estimates: Before treatment, we will perform a diagnosis and provide you with an estimate of the charges involved. As treatment progresses, it is possible that additional circumstances may not be apparent at the initial exam. In this event, we will discuss options with you and proceed, as necessary. **Initials** _____

Aged Account: The total balance on your account, after claim settlement, is due upon receipt of statement. Failure to keep this account current may result in S&C Dental being unable to provide additional dental services. In the event of a default, I agree that any information collected can be used to collect on my account, and I agree to pay all costs incurred in the attempt to collect on this account, including late fees of 10% or $30 (whichever is greater), finance charges, service and/or collection agency fees, attorney's fees and court costs. **Initials** _____

Appointments: If you are unable to keep a scheduled appointment, we ask that you provide us with 48-hour notice as a courtesy. Notice of less than 48 hours may result in a minimum charge of $50.00. We understand emergencies arise; we are sensitive to those events. **Initials** _____

Assignment of Benefit: I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with my dental claims. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to S&C Dental. **Initials** _____

Copyright: Any comment posted online in any way relating to S&C Dental, doctors or employees will be the sole right and property of 26 Solutions PLLC dba S&C Dental and the copyright of the content of the comment, rating, or review is hereby assigned to 26 Solutions PLLC dba S&C Dental to utilize at our discretion in order to protect the practice and our patient's anonymity and privacy. **Initials** _____

Responsible party signature _____ **Date** _____

Name of Person Responsible for Account _____

Patient Name _____ **Relationship to Responsible Party** _____

DO YOU HAVE/HAVE YOU HAD ANY OF THE FOLLOWING? *Please circle and provide more information if known*

Anemia	Excessive Bleeding	Dialysis	Snoring
Arthritis	Fainting	Liver Disease	Stomach Problems
Artificial Joints	Gastric Reflux	Mental Disorder	Stents
Artificial Valves	Glaucoma	Anxiety	Stroke
Asthma	Head Injuries	Depression	Taking Blood Thinners
Blood Disease	Heart Attack	Osteoporosis	Taking/Taken Bisphosphonates
Blood Pressure-High	Heart Burn	Pacemaker	Taking Habit Forming Drugs
Blood Pressure-Low	Heart Disease	Respiratory Problems	Thyroid Disease
Cancer	Heart Murmur	Rheumatic Fever	Tuberculosis
Chemotherapy/Radiation	Hepatitis A, B, C	Rheumatism	Tumors
Diabetes	HIV/AIDS	Seizures	Ulcers
Dizziness	Jaundice	Sinus Problems/Sinusitis	Venereal Disease
Epilepsy	Kidney Disease	Sleep Apnea	

Conditions/syndromes/diagnosis not listed? Please explain _____

_____

_____

_____

_____

Are you under the care of a physician? Physician Name _____ Physician's Phone #: _____

ALLERGIES Are you allergic or reactive to:

Yes No Reaction

( ) ( ) Local anesthetic "Novocain"? _____

( ) ( ) Penicillin/Amoxicillin? _____

( ) ( ) Clindamycin? _____

( ) ( ) Erythromycin? _____

( ) ( ) Other Antibiotics? _____

( ) ( ) Latex? _____

ALL Other Allergies Please List:

_____

_____

_____

_____

WOMEN

	Yes No
Are/could you be pregnant?	( ) ( )
Est. Delivery Date_____	
Are you nursing?	( ) ( )
Are you on birth control?	( ) ( )

Women Note: *Antibiotics and some pain medications may alter the effectiveness of birth control pills. Consult your physician/ gynecologist for assistance regarding additional methods of birth control.*

CURRENT MEDICATIONS Please list all medication name(s), dosage, and purpose?

_____

_____

_____

_____

_____

_____

_____

_____

_____

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_____

Notice of Privacy Practices for Health Information (HIPPA)

How your Health Information may be used…

…To Provide Treatment

We will use your PHI inside our office to provide you with the best dental care possible! This may include office and clerical procedures used to streamline coordination between the Doctor, his Assistants, Hygienists, and business office staff. In addition, your treatment may require us to share your PHI with other entities such as referring Doctors, Clinical Laboratories, or your pharmacy.

…To Obtain Payment

We may include your PHI with paperwork sent to collect payment for the services you receive in our office, such as with insurance forms sent either through the mail or electronically. We will be sure to only work with companies with a similar commitment to the protection of your PHI.

…To Conduct Dental Care Operations

Your PHI may be used during performance reviews or training of our staff. It is possible that your PHI will be disclosed during audits by insurance companies or government agencies as a part of their quality assurance or compliance reviews. Your PHI may be reviewed in the process of certification, licensing, or credentialing.

…In Patient Reminders

Because we believe regular care is very important to your dental health, we will remind you of an appointment you've scheduled or that it is time to contact us and make an appointment. Additionally, we may contact you to follow up on your treatment or to inform you of treatment options that may be available for you or your family. These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best possible preventative, restorative, and cosmetic treatment that modern dentistry can provide. This may include postcards, folding postcards, letters, voicemail messages, and electronic reminders such as e-mail (unless you tell us that you do not want to receive these reminders).

…Abuse or Neglect

We will notify the proper government agency if we believe a patient is the victim of abuse, neglect, or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we are specifically required or authorized by law or with the patient's agreement.

...Public Health or National Security

We may be required to disclose PHI to federal officials or military authorities when it is necessary to complete an investigation related to public health or national security.

…For Law Enforcement

We may be required to disclose PHI to law enforcement officials for law enforcement purposes. An example would be if you were a victim of a crime, or in order to report a crime.

…Family, Friends, and Caregivers

With your permission, we may share your PHI with those you tell us will be helping you with your home hygiene, treatment, medication, or payment. If there is an emergency, and you are unable to tell us what you want, we will use our very best judgment in sharing your PHI, and only when it will be important to those participating in providing your care.

…To Coroners, Funeral Directors, and Medical Examiners

We may be required by law to provide PHI to coroners, funeral directors, or medical examiners in order to determine a cause of death or prepare for a funeral.

…Research

Advances in dental knowledge often involve learning from the careful study of the dental histories of prior patients. Formal review of dental histories as a part of a research study will happen only under the ethical guidance of an Institutional Review Board.

Your Rights as a Patient

You have the right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it. You have the right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations. You have the right to inspect and copy your PHI. You have the right to amend your PHI. You have the right to receive an accounting of disclosures of PHI. You have the right to obtain a paper copy of this notice from us upon request.

Please list any person(s) you give your permission to have protected information shared with upon request: _____

_____

I acknowledge that I have received a copy of the S&C Dental Notice of Privacy Practices, containing a complete description of the uses and disclosures of my health information. This is simply an acknowledgement of receipt and nothing more.

Patient/Guardian/Parent Signature _____ **Date** _____

Print Name _____ **Relationship to patient** _____

S&C DENTAL PHOTO CONSENT

I authorize the use and disclosure of my name, photographic/video images, and/or testimonial for marketing purposes by S&C Dental and all related parties. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPAA privacy regulations.

The photographic/video images, and/or testimonial will be used for: Social Media and/or Advertising.
In the examples of but limited to:

_____ I authorize social media posts I make about S&C Dental be shared

_____ I authorize S&C Dental and all related parties to post on their social media accounts

_____ I authorize my photo be displayed in the office

I understand that I may revoke this authorization at any time, but such revocation must be in writing and received by the practice via registered mail. Revocation affects disclosure moving forward and is not retroactive.

_____ _____

Patient or Parent/Guardian (Signature) Date

_____ _____

Printed Name Patient Name (if different)