Sea Glass
PERIODONTICS AND IMPLANTOLOGY

Date:

Patient Information

Patient Name: _____ **DOB:** _____ **SEX:** **Female** or **Male**
(MM/DD/YYYY)

SSN: _____ **Height:** _____ **Weight:** _____ **Marital Status:** _____

Address: _____

Email Address: _____ **Employer:** _____

Home #: ( ) _____- _____ **Cell #:** ( ) _____- _____ **Work #:** ( ) _____- _____
(OK to text? **Y** **or** **N)**

General Dentist: _____ **Referred By?** _____

Reason for referral? _____

Insurance Information

Subscriber Name: _____ **Relationship to Subscriber:** _____

Primary Insurance Company: _____ **Phone #:** ( ) _____- _____

Address: _____ **DOB of Subscriber:** _____

ID#: _____ **Group #:** _____ **SSN of Subscriber:** _____

Dual Coverage? **YES** or **NO** **Secondary Insurance Company:** _____

Secondary Subscriber Name: _____ **Relationship to Subscriber:** _____

Phone #: ( ) _____- _____ **Address:** _____

ID#: _____ **Group #:** _____ *SSN of Subscriber:* _____

Emergency Contact

Name: _____ **Relationship:** _____

Best contact # to reach them at? ( ) _____ - _____

Health History

Name of Physician(s): _____ **Phone #: ( ) _____ - _____**
Name of Physician(s): _____ **Phone #: ( ) _____ - _____**

1. **Are you under the care of any other physician(s)?** YES or NO
   If yes, please list: _____
2. **Have you ever been hospitalized for any surgical operation, illness, or childbirth?** YES or NO
   If yes, please list: _____
3. **Are you taking any medications or vitamins/supplements?** YES or NO
   If yes, please explain: _____
4. **Have you ever taken any of the following medications for Osteoporosis?** Fosamax, Boniva, Actonel, Bonefos, Didronel, Zometa, Other: _____
   If so, when? _____
5. **Are you currently taking any blood thinners?** (including Aspirin, Coumadin, Plavix) YES or NO
   If yes, what are you taking? _____
6. **Have you ever been instructed to pre-medicate with antibiotics before a dental appointment due to a joint replacement/heart condition?** YES or NO
   If yes, what type of joint replacement/heart condition? _____
7. **Are you allergic to/had any adverse reactions to any drugs/medications** (including Anesthesia)**?** YES or NO
   If yes, what? _____
8. **Are you allergic to latex or any rubber products?** YES or NO
9. **Are you allergic to milk, eggs, or any other food products?** YES or NO
   If yes, what? _____
10. **Are you currently using any tobacco products?** YES or NO
11. **Do you drink alcohol?** YES or NO
12. **Do you use recreational drugs?** YES or NO

Women Only

- **Are you pregnant or think you may be pregnant?** YES or NO
- **Are you nursing?** YES or NO
- **Are you taking birth control pills, hormones, or female contraceptives?** YES or NO

Preferred Pharmacy: _____ **Phone #:** ( ) _____- _____

Health History

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

Cardiovascular

High Blood Pressure

Heart Disease

Rheumatic Fever

Heart Attack

Heart Murmur

Mitral Valve Prolapse

Cardiac Pacemaker

Heart Surgery/Stents

Angina/Chest Pains

Heart Infection/Endocarditis

Respiratory

Asthma

Shortness of Breath

Emphysema

Tuberculosis

Chronic Obstructive Pulmonary Disease

Neurologic

Fainting/Seizures

Epilepsy/Convulsions

Stroke

Transient Ischemic Attacks (ISAs)

Fibromyalgia

Infectious Diseases/Immune Problems

Organ Transplant

AIDS/HIV Infection

Hepatitis: A B C

Infectious/Sexually Transmitted Disease

MRSA/VRSA

Endocrine

Diabetes

Thyroid/Parathyroid Problems

Liver Disease

Jaundice

Cancer/Blood Disorders

Cancer

Type/Year: _____

Radiation/Chemotherapy

Which area: _____

Anemia

Stomach/Intestinal Problems

Irritable Bowel Syndrome

Colitis, Diverticulitis

Crohn's Disease

Acid Reflux

Peptic Ulcer Disease

Other

Swollen Ankles

Kidney Disorders/Stones

Arthritis

Joint Replacement(s)

Frequently Tired

Hay Fever/Allergies

Glaucoma

Adverse Reactions to Anesthesia

Sleep Apnea

Other condition(s) not mentioned above:

_____

(Patient/Guardian Signature) **(Date)**

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HIPAA

Acknowledgment of Receipt of Notice of Privacy Policy

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA) that I have certain rights to privacy regarding my protected information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third party payers
- Conduct normal healthcare operations, such as quality assessments and dentists/physician certifications

I have acknowledged that I have received notice of the availability of your **Notice of Privacy Practices** containing a more complete description of the uses and disclosures of my health information. I understand that this office has the rights to change its **Notice of Privacy Practices** from time to time and that I may contact this office at any time at the address above to obtain a current copy of the **Notice of Privacy Practices.** I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____ **Signature :** _____

Relationship: _____ **Date:** _____
(If Parent or Legal Guardian)

Patient Representative Info

Patient's Representative: _____ **Name of person responsible for payment:** _____

DOB: _____ **Home #:** ( ) _____- _____ **Work #:** ( ) _____- _____ **Cell #:** ( ) _____- _____

Do you give us permission to contact your representative if needed regarding your care? YES or NO

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Dental Appointment Agreement and Cancellation Policy

Our goal is to strive to help our patients achieve and maintain the best oral health as possible for a lifetime. In order to achieve this goal, it is very important for our patients to make every effort to keep their scheduled appointments in our office. Broken appointments can result in unproductive time that our doctor and hygienists could use to treat other patients who are awaiting an appointment.

Our team understands that some situations arise and require our patients to reschedule or cancel their appointment. If you **no show**, **reschedule**, or **cancel** your appointment without **48 hours** notice, it is considered a *Broken Appointment* and a $75 fee will be applied to your account.

The following procedures require a deposit in order to reserve your time with either the dentist or the hygienist:

Sedation or Local Surgeries require a 20% deposit

Scaling and Root Planing require a $100 deposit

I understand the Dental Appointment Agreement and I agree to follow the terms of the *Broken Appointment* Policy.

_____

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

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Release of Records

I, _____ authorize **Diane Jenkins Periodontics** to release copies of any of my records with respect to any dental or medical care for treatment to _____.

(General Dentist)

I understand that the certain type of information to be disclosed to my General Dentist may include: a detailed report of examination findings, treatment needed, detailed prognosis, and copies of any other records (**x-rays, photographs)** that pertain to me.

I hereby release **Diane Jenkins Periodontics** from any legal responsibility or legal liability that may arise from the release of such information.

_____

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

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Our office is in the old Rafferty's building, south of Downtown Greenville. From I-385 we are closest to Exit 37, Roper Mountain Road.

Sea Glass Periodontics and Implantology
600 Congaree Road, Greenville, SC 29607

From Downtown Greenville: Take I-385 South to Exit 37, Roper Mountain Road. At the top of the ramp, turn RIGHT. Proceed to the FIRST stop light (Congaree Road) and turn RIGHT. Proceed about 1 mile and we will be on your left.

From I-85 North or South: Take I-385 South Exit 37, Roper Mountain Road. At the top of the ramp, turn LEFT. Proceed to the SECOND stop light (Congaree Road) and turn RIGHT. Proceed about 1 mile and we will be on your left.

From I-385 Coming from Simpsonville: Merge onto to I-385 North. Take Exit 37, Roper Mountain Road. At the top of the ramp turn LEFT. Proceed to the SECOND stop light (Congaree Road) and turn RIGHT. Proceed about 1 mile and we will be on your left.