Sea Glass
PERIODONTICS AND IMPLANTOLOGY

Date:

Patient Information

Patient Name: _____ **DOB:** _____
(MM/DD/YYYY)

SEX: Female or **Male** **SSN:** _____ **Marital Status:** _____

Address: _____

Email Address: _____ **Employer:** _____

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

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

Reason for referral? _____

Dental 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:** _____

DOB of Subscriber: _____ ***SSN of Subscriber:*** _____

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

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

Health History – Page 1

Patient Name: _____ **DOB:** _____

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

Height: _____ Weight: _____

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. **Is your A1C Regularly tested?**
   If yes, when _____ **Score?** _____
4. **Are you taking injectables/pills for weight loss or diabetes? (GLP-1, Ozempic, Mounjaro or Wegovy)** YES or NO
   If yes, please explain: _____
5. **Have you ever taken any of the following medications for Osteoporosis?** Fosamax, Boniva, Actonel, Bonefos, Didronel, Zometa, Other: _____
   If so, when? _____
6. **Are you currently taking any blood thinners?** (including Aspirin, Coumadin, Plavix) YES or NO
   If yes, what are you taking? _____
7. **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? _____
8. **Are you allergic to/had any adverse reactions to any drugs/medications** (including Anesthesia)**?** YES or NO
   If yes, what? _____
9. **Are you allergic to latex or any rubber products?** YES or NO
10. **Are you allergic to milk, eggs, or any other food products?** YES or NO
    If yes, what? _____
11. **Are you currently using any tobacco products?** YES or NO
12. **Do you drink alcohol?** YES or NO
13. **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

Emergency Contact: Name: _____ **Number:** _____
Relatioship to Patient: _____
Preferred Pharmacy: _____ **Street/City:** _____

Pharmacy Phone Number: _____

Health History – Page 2

PLEASE LIST ALL MEDICATIONS/SUPPLEMENTS/VITAMINS BELOW:

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Patient Name: _____ **DOB:** _____

Health History – Page 3

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-hour** notice, it is considered a *Broken Appointment* and a $75 fee will be applied to your account for each hour you were scheduled.

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, $500 minimum.

Scaling and Root Planing require a 20% deposit, $200 minimum.

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, LLC** doing business as Sea Glass Periodontics & Implantology 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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PERIODONTICS AND IMPLANTOLOGY

Financial Policy

Thank you for choosing Sea Glass Periodontics. We are committed to your treatment being successful and providing the highest standard of care for our patients. For this reason, it is our policy not to allow insurance companies to dictate to us the standard of care that we believe to be in our patient's best interest.

For those patients with dental insurance benefits, we are happy to accept assignment of benefits for your treatment up to your allowable yearly maximum. It is important for you to give us correct information and we will gladly send a claim after each visit. Insurance policies vary in benefits and all fees are the responsibility of the patient.

By South Carolina Law, your insurance company is required to respond to any claims submitted within 60 days. If your insurance company has not paid the outstanding portion of the bill within 60 days, the balance is expected to be paid in full by you at that time.

Please be aware:

- Some, or perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary by your insurance company.
- Some insurance carriers will deny receipt of your claim. We recommend that you follow up with your insurance carrier within the next 30 days and advise us if there is a problem.
- Some insurance carriers will request additional information such as dental records, x-rays, etc., which may delay payment. We respond to each request as quickly as time permits.

For patients without dental insurance benefits, payment is due in full the day of services unless other arrangements have been made with the Financial Coordinator. At any time, you may request a consultation with the Financial Coordinator to discuss the payment options available to our patients.

I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents. I have read, understand, and agree to this Financial Policy.

Signature: _____ Date: _____