

**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:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Have you ever been hospitalized for any surgical operation, illness, or childbirth?** YES or NO

**If yes, please list:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Are you taking any medications or vitamins/supplements?** YES or NO

**If yes, please explain:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Have you ever taken any of the following medications for Osteoporosis?** Fosamax, Boniva, Actonel, Bonefos, Didronel, Zometa, Other: \_\_\_\_\_\_\_\_\_\_\_\_

**If so, when?**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Are you currently taking any blood thinners?** (including Aspirin, Coumadin, Plavix) YES or NO

**If yes, what are you taking?**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **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?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Are you allergic to/had any adverse reactions to any drugs/medications** (including Anesthesia)**?** YES or NO

**If yes, what?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Are you allergic to latex or any rubber products?** YES or NO
2. **Are you allergic to milk, eggs, or any other food products?** YES or NO

**If yes, what?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Are you currently using any tobacco products?** YES or NO
2. **Do you drink alcohol?** YES or NO
3. **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 #:**( ) \_\_\_\_\_\_\_\_\_\_\_- \_\_\_\_\_\_\_\_\_\_\_

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

**Health History**

 **Cardiovascular Endocrine**

High Blood Pressure Diabetes

Heart Disease Thyroid/Parathyroid Problems

Rheumatic Fever Liver Disease

Heart Attack Jaundice

Heart Murmur **Cancer/Blood Disorders**

Mitral Valve Prolapse Cancer

Cardiac Pacemaker Type/Year: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Heart Surgery/Stents Radiation/Chemotherapy

Angina/Chest Pains Which area: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Heart Infection/Endocarditis Anemia

 **Respiratory Stomach/Intestinal Problems**

Asthma Irritable Bowel Syndrome

Shortness of Breath Colitis, Diverticulitis

Emphysema Crohn’s Disease

Tuberculosis Acid Reflux

Chronic Obstructive Pulmonary Disease Peptic Ulcer Disease

 **Neurologic Other**

Fainting/Seizures Swollen Ankles

Epilepsy/Convulsions Kidney Disorders/Stones

Stroke Arthritis

Transient Ischemic Attacks (ISAs) Joint Replacement(s)

Fibromyalgia Frequently Tired

 **Infectious Diseases/Immune Problems** Hay Fever/Allergies

Organ Transplant Glaucoma

AIDS/HIV Infection Adverse Reactions to Anesthesia

Hepatitis: A B C Sleep Apnea

Infectious/Sexually Transmitted Disease Other condition(s) not mentioned above:

MRSA/VRSA

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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



**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



**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**



**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**

******

**Our office is located next to GHS/Prisma Hospital on SC Hwy 14, south of Downtown Simpsonville. From I-385 we are closest to Exit 27, Fairview Road. You can always follow the blue “H” hospital signs for guidance.**

**From Downtown Greenville: Take I-385 South to Simpsonville, Exit 27, Fairview Road. At the top of the ramp, go LEFT. Proceed to the SECOND stop light (SC Hwy 14) and turn RIGHT. Proceed about ¼ mile and Hillcrest Memorial Hospital will be on your left. Turn LEFT at the THIRD hospital entrance (marked as Entrance “3” and a sign for the Emergency room entrance). This is Hospital Drive. Our office is the first building on the right.**

**From I-85 North or South:** Take I-385 South to Simpsonville, Exit 27, Fairview Road. At the top of the ramp, go LEFT. Proceed to the SECOND stop light (SC Hwy 14) and turn RIGHT. Proceed about ¼ mile and Hillcrest Memorial Hospital will be on your left. Turn LEFT at the THIRD hospital entrance (marked as Entrance “3” and a sign for the Emergency room entrance). This is Hospital Drive. Our office is the first building on the right.

**From I-385 Coming North to Simpsonville:** Take Exit 27, Fairview Road. At the top of the ramp go RIGHT. Proceed to the FIRST stop light (SC Hwy 14) and turn RIGHT. Proceed about ¼ mile and Hillcrest Memorial Hospital will be on your left. Turn LEFT at the THIRD hospital entrance (marked as Entrance “3” and a sign for the Emergency room entrance). This is Hospital Drive. Our office is the first building on the right.