LOWCOUNTRY
FAMILY DENTISTRY

Phone: (843) 651-6776
Fax: (843) 651-7487
675 Wachesaw Road, Suite C
Murrells Inlet, South Carolina 29576
www.lcfamilydentistry.com

PATIENT REGISTRATION

First Name: _____ Last Name: _____

How did you hear about our dental office?: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____

Email: _____

Date of Birth: _____ Social Security Number: _____

Emergency Contact (Name): _____ Phone: _____

INSURANCE INFORMATION

Name of Insurance Company: _____

Policy Holder (Name): _____

Relationship to Patient: Self Spouse Child Other

Policy Holder's Date of Birth: _____

Policy Holder's Social Security Number: _____

Policy Holder's Employer: _____

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What is the reason for your visit today ?_____

Date of Last Dental Visit _____ Last Dental Cleaning _____ Last Full Mouth X-rays _____

What was done at your last dental visit? _____

Previous Dentist's Name: _____

Address: _____ State: _____ Zip _____

Telephone: _____

How often do you have dental examinations _____

How often do you brush your teeth? _____ How often do you floss? _____

Have you ever used or are currently using topical fluoride? **Yes** **No**

What other dental aids do you use? (Interplak, toothpick, etc.) _____

Do you have any dental problems now? **Yes** **No**

If yes, please describe: _____

Are any of your teeth sensitive to:

Hot or cold? **Yes** **No**
Sweets? **Yes** **No**
Biting or Chewing? **Yes** **No**
Have you noticed any mouth odors or bad tastes? **Yes** **No**
Do you frequently get cold sores, blisters or any other oral lesions? **Yes** **No**
Do your gums bleed or hurt? **Yes** **No**
Have your parents experienced gum disease or tooth loss? **Yes** **No**
Have you noticed any loose teeth or change in your bite? **Yes** **No**
Does food tend to become caught in between your teeth? **Yes** **No**
If yes, where? _____

Do you:

Clench or grind your teeth while awake or asleep? **Yes** **No**
Bite your lips or checks regularly? **Yes** **No**
Hold foreign objects with your teeth? **Yes** **No**
(pencils, pipe, pins, nails, fingernails) **Yes** **No**
Mouth breathe while awake or asleep? **Yes** **No**
Have tired jaws, especially in the morning? **Yes** **No**
Snore or have any other sleeping disorders? **Yes** **No**
Smoke/chew tobacco or use other tobacco products? **Yes** **No**

Have you ever had:

Orthodontic treatment? **Yes** **No**
Oral Surgery? **Yes** **No**
Periodontal treatment? **Yes** **No**
Your teeth ground or the bite adjusted? **Yes** **No**
A bite plate or mouth guard? **Yes** **No**
A serious injury to the moth or head? **Yes** **No**
If so, please describe, including cause _____
_____

Have you experienced:

Clicking or popping of the jaw? **Yes** **No**
Pain? (joint, ear, side of face) **Yes** **No**
Difficulty in opening or closing the mouth? **Yes** **No**
Difficulty in chewing on either side of the mouth? **Yes** **No**
Headaches, neck aches or shoulder aches? **Yes** **No**
Sore Muscles (neck, shoulders)? **Yes** **No**
Are you satisfied with your teeth's appearance? **Yes** **No**
Would you like to keep all your teeth all of your life? **Yes** **No**

Do you feel nervous about having dental treatment? **Yes** **No**
If so, what is your biggest concern? _____
_____

Have you ever had an upsetting dental experience? **Yes** **No**
If yes, please describe _____
_____

Have you ever been told to take a pre-medication prior to dental treatment? **Yes** **No**

Is there anything else about having dental treatment that you would like us to know? **Yes** **No**

If yes, please describe _____
_____

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MEDICAL HISTORY

Patient Name: _____ Birth Date: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ( ) Yes ( ) No
If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ( ) Yes ( ) No
If yes, please explain: _____

Have you ever had a serious head or neck injury? ( ) Yes ( ) No
If yes, please explain: _____

Are you taking any medications, pills, or drugs? ( ) Yes ( ) No
If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ( ) Yes ( ) No
Are you on a special diet? ( ) Yes ( ) No
Do you use tobacco? ( ) Yes ( ) No
Do you use controlled substances? ( ) Yes ( ) No
Do you need to pre-medicate? ( ) Yes ( ) No
If yes, please explain: _____

Women: Are you Pregnant / Trying to get pregnant? ( ) Yes ( ) No
Taking oral contraceptives? ( ) Yes ( ) No
Nursing? ( ) Yes ( ) No
Are you allergic to any of the following?
( ) Aspirin ( ) Penicillin ( ) Codeine ( ) Acrylic ( ) Metal ( ) Latex ( ) Local Anesthetics ( ) Other

If yes, please explain: _____

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

AIDS/HIV Positive	( ) Yes ( ) No	Cortisone Medicine	( ) Yes ( ) No	Hemophilia	( ) Yes ( ) No	Renal Dialysis	( ) Yes ( ) No
Alzheimer's Disease	( ) Yes ( ) No	Diabetes	( ) Yes ( ) No	Hepatitis A	( ) Yes ( ) No	Rheumatic Fever	( ) Yes ( ) No
Anaphylaxis	( ) Yes ( ) No	Drug Addiction	( ) Yes ( ) No	Hepatitis B or C	( ) Yes ( ) No	Rheumatism	( ) Yes ( ) No
Anemia	( ) Yes ( ) No	Easily Winded	( ) Yes ( ) No	Herpes	( ) Yes ( ) No	Scarlet Fever	( ) Yes ( ) No
Angina	( ) Yes ( ) No	Emphysema	( ) Yes ( ) No	High Blood Pressure	( ) Yes ( ) No	Shingles	( ) Yes ( ) No
Arthritis/Gout	( ) Yes ( ) No	Epilepsy or Seizures	( ) Yes ( ) No	Hives or Rash	( ) Yes ( ) No	Sickle Cell Disease	( ) Yes ( ) No
Artificial Heart Valve	( ) Yes ( ) No	Excessive Bleeding	( ) Yes ( ) No	Hypoglycemia	( ) Yes ( ) No	Sinus Trouble	( ) Yes ( ) No
Artificial Joint	( ) Yes ( ) No	Excessive Thirst	( ) Yes ( ) No	Irregular Heartbeat	( ) Yes ( ) No	Spina Bifida	( ) Yes ( ) No
Asthma	( ) Yes ( ) No	Fainting Spells/Dizziness	( ) Yes ( ) No	Kidney Problems	( ) Yes ( ) No	Stomach Disease	( ) Yes ( ) No
Blood Disease	( ) Yes ( ) No	Frequent Cough	( ) Yes ( ) No	Leukemia	( ) Yes ( ) No	Stroke	( ) Yes ( ) No
Blood Transfusion	( ) Yes ( ) No	Frequent Diarrhea	( ) Yes ( ) No	Liver Disease	( ) Yes ( ) No	Swelling of Limbs	( ) Yes ( ) No
Breathing Problem	( ) Yes ( ) No	Frequent Headaches	( ) Yes ( ) No	Low Blood Pressure	( ) Yes ( ) No	Thyroid Disease	( ) Yes ( ) No
Bruise Easily	( ) Yes ( ) No	Genital Herpes	( ) Yes ( ) No	Lung Disease	( ) Yes ( ) No	Tonsillitis	( ) Yes ( ) No
Cancer	( ) Yes ( ) No	Glaucoma	( ) Yes ( ) No	Mitral Valve Prolapse	( ) Yes ( ) No	Tuberculosis	( ) Yes ( ) No
Chemotherapy	( ) Yes ( ) No	Hay Fever	( ) Yes ( ) No	Pain in Jaw Joints	( ) Yes ( ) No	Tumors or Growths	( ) Yes ( ) No
Chest Pains	( ) Yes ( ) No	Heart Attack/Failure	( ) Yes ( ) No	Parathyroid Disease	( ) Yes ( ) No	Ulcers	( ) Yes ( ) No
Cold Sores/Fever Blisters	( ) Yes ( ) No	Heart Murmur	( ) Yes ( ) No	Psychiatric Care	( ) Yes ( ) No	Venereal Disease	( ) Yes ( ) No
Congenital Heart Disorder	( ) Yes ( ) No	Heart Pace Maker	( ) Yes ( ) No	Radiation Treatments	( ) Yes ( ) No	Yellow Jaundice	( ) Yes ( ) No
Convulsions	( ) Yes ( ) No	Heart Trouble/Disease	( ) Yes ( ) No	Recent Weight Loss	( ) Yes ( ) No		

Have you ever had any serious illness not listed above? ( ) Yes ( ) No

If yes, please explain: _____

_____

Have you ever been told to take a pre-med prior to dental treatment? ( ) Yes ( ) No

If yes, please explain: _____

_____

Additional 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: _____

DATE _____

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AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient Name: _____

Patient Address: _____ City: _____ State: _____

Patient Phone Number: _____

I authorize the professional office of my dentist named above to release health information identifying me (including if applicable, information about HIV infection or AIDS, information about substance abuse treatment and information about mental health services) under the following terms and conditions:

1. Detailed description of the information to be released.
2. To whom may the information be released.
3. The purpose(s) for the release (if the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose, if desired by the individual).
4. Expiration date or event relating to the individual or purpose for the release.

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if choose not to sign this authorization

If you sign this authorization you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes state or federal law changes this possibility.

(For marketing authorizations, include as applicable: We will receive direct or indirect remuneration from a third party for disclosing your identifiable health information in accordance with this authorization.)

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Patient Signature: _____ Date: _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient: _____ Print Name: _____

Source of Authority: _____

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Lowcountry Family Dentistry Notice of Privacy Practices.

Patient Name: _____

Signature: _____ Date: _____

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PAYMENT IS DUE AT TIME OF SERVICE

We are committed to providing you with the best possible care. This information is designed to guide you through the rapidly changing world of dentistry and insurance plans. **Please read carefully and sign at the bottom of the page indicating your understanding and acceptance of our policies and procedures.** If you have dental insurance, we can provide you with a receipt for you to submit or as a courtesy we will submit your claim for you. Our receipt is suitable for your insurance company. **We will have you pay any deductibles and co-pays required at the time of service.**

PAYMENT IS DUE AT THE TIME OF SERVICE UNLESS PAYMENT ARRANGEMENTS HAVE BEEN MADE AND APPROVED IN ADVANCE.

YOU MUST REALIZE THAT:

1. Your insurance is a contract between you, your employer and the insurance company. We are not included in your contract.
2. Not all services are covered by all insurance policies. Some companies select certain services that they will not cover.
3. The "Usual and Customary Charges" that may be quoted by your insurance company are charges that have been determined and set by your insurance company. They do not necessarily reflect our fees.

We must emphasize that as a health care provider our relationship is with you, the patient, not the insurance company. While filing your insurance claims for our patients is a courtesy that was extended, **ALL CHARGES ARE YOUR RESPONSIBILITY FROM THE DATE SERVICE IS RENDERED.** We do realize that there are times that a temporary financial problem may affect your payment on your account. In that case PLEASE contact our financial advisor for assistance so that we may be able to set up payment options for you.

If you have any questions, feel free to ask us, we will be glad to help.

REGARDLESS OF ANY INSURANCE COVERAGE THAT I MAY HAVE, I AGREE THAT IT IS MY RESPONSIBILITY TO PAY MY BALANCE AND WILL PAY ANY BALANCE DUE.

WE CONFIRM ALL APPOINTMENTS 1 WEEK IN ADVANCE. WE ASK THAT YOU CALL BACK TO CONFIRM THAT YOU WILL BE IN FOR YOUR PRESCHEDULED APPOINTMENT. WE RESERVE THE RIGHT TO CHARGE $50.^{00} FOR EVERY 1/2 HOUR BROKEN APPOINTMENTS WITHOUT 24 HOUR NOTICE.

Signature: _____ Date: _____