Palmetto Dental Arts, PA
347 Red Cedar St
Bluffton, SC 29910
(843) 815-6500
palmettodental.com

Welcome!

So that we may provide you with the best possible care, please complete these forms.
All information is completely confidential.

Patient Registration

Date: ___________________

Patient Name: ________________________ ________________________ ____ ________________________
(last name) (first name) (initial) (preferred name)

Home Phone: ___________________________ Cell Phone: _______________________

Street Address: ____

City: _______________________________ State: ______ Zip: __________________

SSN: _________________________________ E-Mail Address: ___________________________________

Sex: Male Female Age: _______ Birth Date: ________________ Marital Status: __________

Employed by: _________________________________ Occupation: ____________________________

Business Address: _________________________________ Work Phone: ____________________________

Person responsible for account: _____________________________ Relationship: ____________________________

In case of emergency, who should be notified? ________________________ Phone: _______________________

How did you hear of Palmetto Dental Arts, P.A.? ____

This office requires payment at the time of service. However, for your convenience, we will file your insurance for the reimbursement check to be sent directly to you.

Do you have dental insurance? Yes No

Subscriber's Name: _________________________ SSN: __________________ DOB: ____________

Name of insurance carrier: _________________________________ Group Number: ______________

Address and phone number: ____

Employer who sponsors insurance plan: ____

I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of the signature on all insurance submissions.

____ ___________________________
Responsible Party Signature Date

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Dental Inquiry

Patient Name: ____

Welcome to Palmetto Dental Arts. This might be the most important dental visit you will ever have. We feel that helping you determine your present and future dental needs is the most important service we offer. Although there are issues you have probably never thought of in detail, please answer the following to your best ability...Thank you!

- What is your primary concern for this visit and what did you want to accomplish?

  ____

- Have you ever had any unpleasant experiences associated with previous dental visits?

  ____

- Have you ever been treated for gum disease?

  ____

- What are your expectations of this office?

  ____

Treatment Recommendations or Treatment Options

We prefer to give you options based on how you would like to treat your dental health. We are here to make recommendations on how to achieve your goals.

The following questions help us determine what is important to you…please rate on the following scale from 1 to 10, with 10 being the most important. (please check one)

How healthy would you like your mouth to be?

1 2 3 4 5 6 7 8 9 10

How preventive (or proactive) would you like to be regarding your dental health?

1 2 3 4 5 6 7 8 9 10

How important are dental cosmetics to you?

1 2 3 4 5 6 7 8 9 10

Anything else you would like to mention? ____

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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	

Women: Are you
Pregnant/Trying to get pregnant? Nursing
Taking oral contraceptives?

Are you allergic to any of the following?

Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other If yes, please explain: ____

Aids	Chest Pains	Frequent Headaches	Irregular Heartbeat	Scarlet Fever
Alzheimer's Disease	Cold Sores/Fever Blisters	Genital Herpes	Kidney Problems	Shingles
Anaphylaxis	Congenital Heart Disorder	Glaucoma	Leukemia	Sickle Cell Disease
Anemia	Convulsions	Hay Fever	Liver Disease	Sinus Trouble
Angina	Cortisone Medicine	Hearth Attack/Failure	Low Blood Pressure	Spina Bifida
Arthritis/Gout	Diabetes	Heart Murmur	Lung Disease	Stomach/Intestinal Disease
Artificial Heart Valve	Drug Addiction	Heart Pace Maker	Mitral Valve Prolapse	Stroke
Artificial Joint	Easily Winded	Heart Trouble/Disease	Pain in Jaw Points	Swelling of Limbs
Asthma	Emphysema	Hemophilia	Parathyroid Disease	Thyroid Disease
Blood Disease	Epilepsy or Seizures	Hepatitis A	Psychiatric Care	Tonsillitis
Blood Transfusion	Excessive Bleeding	Hepatitis B or C	Radiations Treatments	Tuberculosis
Breathing Problem	Excessive Thirst	Herpes	Recent Weight Loss	Tumors or Growths
Bruise Easily	Fainting Spells/Dizziness	High Blood Pressure	Renal Dialysis	Ulcers
Cancer	Frequent Cough	Hives or Rash	Rheumatic Fever	Venereal Disease
Chemotherapy	Frequent Diarrhea	Hypoglycemia	Rheumatism	Yellow Jaundice

Have you ever had any serious illness not listed above? Yes No If yes, please explain: ______________________

Comments: ____

____

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____

____

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 patients) 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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HIPAA Notice of Privacy Practices

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347 Red Cedar Street Bldg 400
Bluffton, SC 29910
843-815-6500

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected Health Information” is information about you, including demographic information that may identify you that relates to your past, present or future physical or mental health or condition and related health care services

1. Uses and Disclosures of Protected Health Information
Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your dentist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operation of the dentist’s practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a dentist to whom you have been referred to ensure that the dentist has the necessary information to diagnose or to treat you.

Payment: Your protected health information will be used, as need to obtain payment for your health care services

Healthcare Operations: We may use or disclosed, as-needed, your protected health information in order to support the business activities of your dentist’s practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your dentist. We may also call you by name in the waiting room when your dentist is ready to see you. We may use of disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers’ Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance,

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Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or opportunity to Object unless required by law.

You may revoke this authorization, any time, in writing, except to the extent that your dentist or the dentist's practice has taken an action in reliance on the use of disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment of healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friend that may be involved in your care or for your notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restrictions requested and to whom you want the restriction to apply.

Your dental is not required to agree to as restriction that you may request. If the dentist believes it is in your best interest permit to use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your dentist amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of notice. You then have the right to object of withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and human Service if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.
This notice was published and becomes effective on/or **April 14, 2003.**

______________________________ ______________________________
Signature Date

____
Witness