Welcome

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Patient # _____

SS#/SIN _____

Date _____

Patient Information (CONFIDENTIAL)

Name _____ Birthdate _____ Home Phone _____

Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Email _____ Cell Phone _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If Student, Name of School/College _____ City _____ State/Prov. _____ ☐ Full Time ☐ Part Time

Patient or Parent/Guardian's Employer _____ Work Phone _____

Business Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Email _____ Cell Phone _____

Driver's License# _____ Birthdate _____ Financial Institution _____

Employer _____ Work Phone _____ SS#/SIN _____

Is this person currently a patient in our office? ☐ Yes ☐ No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

☐ Cash ☐ Personal Check Credit Card ☐ VISA ☐ MasterCard ☐ I wish to discuss the office's payment policy.

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City _____ State/Prov. _____ Zip/P.C. _____

Insurance Company _____ Group # _____ Policy/ID # _____

Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City _____ State/Prov. _____ Zip/P.C. _____

Insurance Company _____ Group # _____ Policy/ID # _____

Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

Over Please

Time 11:29 AM

Spartanburg Family Dentistry, PC

Date 1/30/2019

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

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	
Have you ever been hospitalized or had a major operation?	Yes No	If yes	
Have you ever had a serious head or neck injury?	Yes No	If yes	
Are you taking any medications, pills, or drugs?	Yes No	If yes	
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes	
Are you on a special diet?	Yes No		
Do you use tobacco?	Yes No		
Do you use controlled substances?	Yes No	If yes	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

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

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

Have you ever had any serious illness not listed above? Yes No If yes

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:

X_____ Date:_____

Spartanburg Family Dentistry, PC

Financial Policy

We cannot thank you enough for allowing Spartanburg Family Dentistry to take care of your dental needs. For those patients who have financial assistance from dental insurance, the full co-payment is due at time of service.

We accept cash, personal check or most major credit cards (Visa, Mastercard, or Discover) as methods of payments. We also offer CareCredit for those times when financial assistance is needed. Please speak to one of our friendly staff members to receive additional information regarding this interest-free financing or any of our payment methods.

Emergency Patients:
For emergency patients who are not patients of record, we will happily file any insurance claims, as long as we can verify your insurance coverage and remaining benefit level. If we are unable to verify these benefits, we will require payment in full.

Minors with two separated or divorced parents:
When two parents are each responsible for one half of the cost of the children's dental care, the parent who brings in the child is responsible for paying the full co-payment or full fee. They will also be responsible for collecting payment from the other parent.

NSF/ Returned Checks:
There is a $25.00 fee for processing a returned or NSF check. We reserve the right to reject check payments once a returned or NSF check occurs.

Short Notice Cancellations, Broken Appointments or Disconnected Numbers:
We, at Spartanburg Family Dentistry, PC value and respect your time. Your appointment time is a reserved time for you and only you. Each time a patient does not keep their appointment; other patients who do keep their appointments are penalized. Frequent cancellations by other patients may also restrict your ability to get the appointment time you need or desire.

In order to insure mutual respect for your time and ours, our office does have a **$25** missed appointment fee for all no shows and/or short notice cancellations (less than 48 hrs notice). To help avoid any missed appointment fees we kindly request a minimum of 48 hours' notice for any reschedules or cancellations.

We require a working primary phone number for appointment confirmation purposes. If the phone number we have on file for you is disconnected, leaving us no alternative number, we will cancel your appointment and reserve the right to not reschedule your appointment.

Deposits:
For longer procedures, many times a scheduling deposit is required. The deposit can vary based on the length of appointment or complexity of procedure you require. We will notify you if a deposit is needed.

INSURANCE:
Most insurance companies are now "deciding" which type of restorative material or treatment the patient should receive, regardless of the clinical diagnosis. While we strive to do everything possible to maximize the insurance benefits, I am aware that Spartanburg Family Dentistry, PC will diagnose the type of restorative material or treatment that is needed due to their Standard of Care, not what the insurance company decides. This will mean for some patients, based on the insurance company's benefit plan, composite resin (tooth colored) fillings on posterior teeth will only be reimbursed at the amalgam (metal) filling rate, with the remainder of the fee due from the patient.

Dental insurance reimbursement has increased very little from the 1970's. Today's dental insurance carriers will typically cover routine maintenance and small fixes, but seldom will provide significant benefit for large or complex problems.

I understand that insurance plans are payment assistance plans; they are not designed to cover the entire costs of treatment.

I understand that my dental insurance carrier may pay less than the bill for services. If the insurance claim(s) is not paid in 60 days, the balance will become my responsibility. By signing this form, I have authorized assignment of benefits directly to Spartanburg Family Dentistry.

I am also aware that the office reserves the right to charge 1.5% interest for any balance over 90 days old, as well as, any and all additional charges that might occur if the account is turned over for collection and/or attorney services are required.

Signed_____ Date_____

Spartanburg Family Dentistry, PC

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name:_____

Address:_____

Telephone: (____) _____-_____

SECTION B: TO THE PATIENT- PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practice before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time.

Signature _____

I _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Signature_____Date_____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient _____

REVOCATION OF CONSENT

I revoke my Consent to your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. I understand that revocation of my Consent will not affect any action you took in reliance of my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature_____Date_____

INCLUDE COMPLETED CONSENT IN THE PATIENT'S CHART

Spartanburg Family Dentistry
Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you may obtain access to this information.

Please review it carefully

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally are kept properly confidential. This act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal information.

Spartanburg Family Dentistry, PC makes every effort to ensure your health information is private. We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

ROUTINE USES AND DISCLOSURES OF YOUR HEALTH RECORD

Treatment: We may use medical information about you to provide, coordinate and manage your treatment or services. An example of this would include teeth cleaning services. Various units may share information about you to coordinate your needs such as lab work and prescriptions. Your record may be sent to a doctor to whom you have been referred. You may plan for a friend or relative to pick you up after a procedure. A doctor or employee may believe it is in your best interest to tell your friend or relative what drug you must take that night and what will speed your recovery at home.

Payment: We use and release health information so that treatment and services you receive may be billed to and payment collected from you, an insurance company, or a third party. We also may call your dental insurance for preapproval of a service. We may give dental plan details about your treatment in order for reimbursement to us or you. If someone else is responsible for you payment, we will contact that person.

Health Care Operations: We may use and release your record to support our business functions (for example, administrative, legal, financial activities). These uses and disclosures are imperative to operate the practice, support treatment and payment, and help patients receive the highest degree of excellence in dentistry. Activities may include measuring quality, reviewing employee performance and training.

Here is how your dental records may be used for business operations:

- We may call, text message or email you to remind you about or confirm an appointment, give you information regarding treatment alternatives or other health related benefits and services that may be of interest to you.
- We may use health information to review our treatment and services.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer.

- The right to reasonable requests to receive confidential communications of protected health information, including those related to disclosures to family members, other relatives, close personal friends or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to inspect and copy your protected health information.

- The right to amend your protected health information.
- ·The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

Business Associates

- Business associates of Spartanburg Family Dentistry, PC provide some services related to business operations. We have a written contract that requires associates to protect your record in the course of performing their job. Ex: Attorneys, Cleaning services, Schedule Confirmation Services, Billing Services.

SPECIAL USES AND DISCLOSURES OF YOUR HEALTH RECORD

Emergencies: We may use or release your health information during emergencies.

Communication Barriers: We may use or release your health information if we try to get your consent but cannot because of major communication barriers and the doctor or staff decides that you intend to consent to use or release of such information.

Worker's Compensation: We may release information about you to comply with worker's compensation laws or similar programs.

Legal Proceedings: We may release health information about you for the following reasons: court or administrative order, subpoena or other legal process.

Legal Requirements: We will give out medical information about you when required to do so by federal, state or local law.

Public Health Risks: We may release information about you to local, state or federal public health agencies (such as the Food and Drug Administration and the Department of Health and Environmental Control) for reasons such as:

To prevent or control disease, injury, or disability

To report adverse events, such as drug reactions

To notify a person who may have been exposed to a disease

To alert a government agent if we believe a patient is the victim of abuse, neglect, or domestic violence

Military, Veterans and National Security: if you are a member of the armed forces, we may release information about you as required by military authorities.

Law Enforcement: We may release your health information to a law enforcement official: In response to a court order, subpoena, warrant summons, or similar legal process. In response to criminal conduct at this facility. In an emergency to report a crime: the location of a crime or the identity, description or location of the person who committed the crime.

Amend: Should you believe that information we have about you is incorrect or incomplete, you may ask us to modify or add the information. You have the right to request a change or addition as long as the record is kept by Spartanburg Family Dentistry. We may deny your request if it is not in writing or does not include a reason to support the request. We may also deny a request to

modify medical record in these cases:

- The current information is accurate and complete.
- It is not part of the medical information kept by Spartanburg Family Dentistry, PC
- The record was not created by us.

If we deny this request you have the right to file a statement of disagreement. We may then prepare a rebuttal and provide you with a copy.

Accounting of Disclosures: You have the right to request an "accounting of disclosures," a list of disclosures made about you other than treatment, payment or business operations. Request this list by writing to Spartanburg Family Dentistry, 271 South Pine Street, Spartanburg, SC 29302. Your request may state a period of time, which may not be longer than six years and may not include a date before August 1, 2014

The first list you request within a 12 month period will be free. Additional lists may involve a charge. We will notify you of the cost, and you may cancel or adjust your request before any fees are incurred.

Request Restrictions: You have the right to request that we limit information we use or give out about you for treatment, payment, or business operations. You also have the right to request a limit on what we release to someone involved in your care or payment for your care, such as a family member. For example, you could ask that we not use or give out information about a treatment that you had to your family.

We are not required to agree to your request! If we do agree, we will comply with your request unless the material is needed for emergency treatment. To request restrictions, submit a Restriction of Information agreement form to Spartanburg Family Dentistry, 271 South Pine Street, Spartanburg, SC 29302. Please state (1) what you want to limit (2) if you want to limit use, release, or both (3) to whom the limits should apply, for example disclosures to your family.

Request Confidential Communications: You have the right to request that we interact with you about medical conditions and treatment in a certain way or place. For example, you can ask that we contact you only by mail or only at work.

To request confidential communications, submit a Restriction of Information Agreement Form to Spartanburg Family Dentistry, 271 South Pine Street, Spartanburg, SC 29302. We will try to meet all reasonable requests. You must state how or where you wish to be contacted.

Paper Copy of This Notice: You have the right to a paper copy of this Notice at any time. Please contact Spartanburg Family Dentistry, PC at 864-585-5246.

Complaints: Should you believe that your privacy has been violated, you may file a complaint with Spartanburg Family Dentistry, PC. To file a complaint, call the Practice Administrator at (864) 585-5246.

Other Uses: Other uses and disclosures of medical information covered by this Notice or relevant laws will be made only with your written consent. If you allow us to use or release health information about you, you may cancel that consent, in writing, at any time. If you revoke it, we will no longer use or release information for the reasons covered by your written consent. Revocation of consent may impair reimbursement from insurance companies for your treatment. Note: We cannot take back disclosures already made with your consent.

spartanburg family DENTISTRY

Appointment Policy

Effective date: January 1, 2019

- If you are 15 minutes late for your appointment, you will be considered a "Late Arrival." We will either work you into the schedule or reschedule your appointment for another day.

- If you are 30 minutes late for your appointment, you will be considered a "No Show" and a charge of $25 will be applied to your account.

- Cancellations made same day of your appointment are considered "No Show" appointments. A charge of $25 will be applied to your account.

- If you "No Show" for 3 scheduled appointments, unfortunately you will be dismissed from our practice.

- All cancellations can be done by either contacting our office at 864-585-5246 or by notifying us via Demandforce.

Patient Name:_____

Date:_____ Signature:_____

spartanburg family DENTISTRY

We are compassionate professionals, delivering personalized dental excellence, while striving to exceed the expectations of our family of patients

LIMITED DENTAL WARRANTIES

Our goal at Spartanburg Family Dentistry is not only to correct any current dental issues, but to help educate you on how to prevent future problems, thereby saving you both time and unnecessary expense. The long-term success of the dental treatments we provide are dependent upon the quality of your at-home oral hygiene, along with your periodic professional exams, cleanings, x-rays and fluoride treatments. Your individual dental needs will aid us in the determination of the frequency of your dental maintenance visits. With that in mind, we offer the following limited dental warranties provided you maintain prescribed periodic exams, cleanings and x-rays:

DENTAL SEALANTS

Sealants are plastic coatings placed on the chewing surfaces of the teeth to help prevent decay in the pits and grooves of the teeth. Floss and fluoride use will help prevent decay between the teeth. We will repair or replace sealants for a period of two years after initial placement.

ROOT CANALS

A root canal is performed to preserve the structure of the tooth while removing infection. A root canal is recommended if a tooth's pulp becomes diseased, inflamed or otherwise abscessed. If you lose your tooth within three years due to failure of the root canal, we will apply the patient's portion of the root canal fee as a credit towards future services.

TOOTH COLORED FILLINGS

Tooth-colored fillings are a more cosmetic alternative to traditional amalgam fillings many patients are familiar with. They are natural looking and provide an attractive restoration that will last for many years.

If a dental filling is the recommended treatment and it fails/breaks under normal use, we will replace/repair it for a period of one year after initial placement. If the tooth breaks in this one year period and now requires a crown, we will credit the patient cost of the filling towards the patient cost of the crown.

If Dr. Summers proposed a crown for a particular tooth and you elect the treatment option of a large filling, this warranty does not apply.

CROWNS, BRIDGES AND PORCELAIN VENEERS

These procedures are warranted for a full three years. We will replace/repair them at no charge during this three year period if they break or are lost with *normal* use. This does not include incidents causing breakage of normal, healthy teeth.

DENTURES AND PARTIAL DENTURES

We will adjust dentures and partials for a maximum three year period. Full upper and lower denture patients must be seen once every six months for a recall exam to evaluate the health of your oral soft tissues and of your dentures.

Patients with some of their own natural teeth must be seen at the recommended recall appointments or this warranty does not apply.

NOTE: We are confident in the quality of the treatment prescribed for you. The primary key to your long-term success is maintaining proper at-home oral hygiene. The second key to success is maintaining regular professional recall appointments which include an examination, cleaning, necessary x-rays and fluoride treatments. The interval between these recall appointments will vary depending on each patient's individual dental needs typically scheduled every three, four or six months. This warranty does not cover accidents that cause damage to the teeth or dental prosthesis.

FAILURE TO SCHEDULE AND KEEP YOUR REGULAR RECALL APPOINTMENTS WITH

OUR OFFICE WILL VOID ALL WARRANTIES.

Patient Name (Print) _____ **Date** _____

Patient Signature _____ **Date** _____

spartanburg family DENTISTRY

Smile Evaluation Form

Are you happy with the appearance of your teeth/gums/smile? ☐ Yes ☐ No

Would you like to discuss enhancing the appearance of your smile? ☐ Yes ☐ No

What don't you like about your smile?

_____

_____

Would you like to discuss how to make your teeth WHITE? ☐ Yes ☐ No