TIME 09:37 AM DATE 5/13/2015

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

Referred By:

Last Dental Visit

Percentages Updated:

INS EFFECTIVE DATE:

Last Dentist

Chief Complaint

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Time 2:33 PM

Julian H. Campbell, DMD, PC

Date 2/19/2015

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	

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 use controlled substances?	○ Yes ○ No	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 ○ 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:_____

PALMETTO SMILES OF CHARLESTON

3188 W. MONTAGUE AVE, NORTH CHARLESTON, SC 29418

843-554-3300

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVATE PRACTICES

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have a certain right to privacy regarding my protected health information. I understand that the information can and will be used to:

*Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who m ay be involved in that treatment directly and indirectly.

*Obtain payment from third-party payers and disclose any pertinent information

*Conduct normal healthcare operations, such as quality assessment and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practice from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I hereby authorize you to use or disclose the specific information described below, only for the purposes and parties also described below: (CIRCLE ONE)

YES or NO may be notified by telephone of pending office visits and/or test(s)

YES or NO office any call you at home with lab and/or other test results

YES or No pharmacy refills can be called or faxed to your pharmacy

YES or NO may speak to referring or treating doctors on my behalf

I, _____, do give permission to disclose any and all information pertaining to my dental care to the below named family member(s) or friend(s).

Name: _____ Contact Number:_____

Name: _____ Contact Number:_____

This authorization shall remain in effect from date signed below unless I decide to cancel this authorization by informing this office in writing at the address above. I may refuse to sign this authorization and you will not continue my treatment.

Patient Name: _____

Patient or Guardian's Signature:_____ Date:_____

PATIENT APPOINTMENT AGREEMENT FOR PALMETTO SMILES OF CHARLESTON

We make every effort to value your time and we schedule your appointment time just for you.

We truly appreciate your courtesy of giving us 48 hours' notice if you have a conflict with your appointment and need to schedule a different day or time. We are committed to your oral health and keeping your scheduled appointments allows us to be partners in your dental care.

We will not charge for your first missed appointment. However, if you miss an appointment a second time you may be required to make a deposit when scheduling the next appointment and you will have a $50.00 no show/no call fee applied to your account. If you keep the appointment the payment will be applied towards treatment. However, if you fail to keep the appointment a second time, the payment will be applied towards lost production time.

It is our philosophy to continue to put our patients first and to make your experience a positive one. Thank you for allowing us to share our missed appointment policy with you and please let us know if you have any questions.

Appointment Agreement

- I acknowledge an appointment is a reservation
- I agree to provide a minimum of 48 hours' notice if I need to change my appointment for any reason. There will be a charge of $50.00 if a 48-hour notice has not been given.

_____

Patient Signature

_____

Date

PALMETTO SMILES OF CHARLESTON DENTAL HEALTH HISTORY

LAST NAME: _____ FIRST NAME: _____

DATE OF BIRTH: _____

DO YOU HAVE ANY CONCERNS ABOUT PREVIOUS DENTAL CARE OR FOR THIS DENTAL VISIT?

_____

ON A SCALE OF 1 TO 10 (10 BEING THE HIGHEST) HOW IMPORTANT IS IT FOR YOU TO KEEP YOUR TEETH THE REST OF YOUR LIFE?

_____

ARE YOU HAPPY WITH YOUR SMILE? YES OR NO

IF NO PLEASE EXPLAIN: _____

DO YOU SNORE? YES OR NO

DO YOU FEEL FATIGUED DURING THE DAY? YES OR NO

DO YOU WAKE UP FEELING LIKE YOU HAVEN'T SLEPT? YES OR NO

HAVE YOU BEEN TOLD YOU STOP BREATHING AT NIGHT? YES OR NO

DO YOU GASP FOR AIR OR CHOKE WHILE SLEEPING? YES OR NO

DO YOU USE A CPAP MACHINE? YES OR NO

DO YOUR GUMS BLEED? YES OR NO

ARE YOUR TEETH LOOSE? YES OR NO

HAVE YOU EVER BEEN TOLD THAT YOU HAVE BAD BREATH? YES OR NO

ARE YOUR TEETH SENSITVE TO: SWEETS COLD HEAT PRESSURE

DO YOU LIKE THE COLOR OF YOUR TEETH? YES OR NO

DO YOU FEEL YOUR TEETH ARE STARTING TO GET LONGER? YES OR NO

DO YOU GET FOOD STUCK BETWEEN YOUR TEETH EASILY? YES OR NO

DO YOU EVER EXPERIENCE TOOTH PAIN THAT IS RELIEVED BY BITING DOWN ON THE AFFECTED AREA? YES OR NO

WHAT WOULD YOU CHANGE ABOUT THE CONDITION OF YOUR MOUTH? _____

I understand the need for these questions to be answered truthfully. To the best of my knowledge, the answers that I have given are accurate. I also understand that it is very important to report any changes or updates in my medical status. I give permission to obtain from my physician any additional information regarding my medical history needed to provide me with the best treatment possible.

Patient Signature: _____ Date: _____

Guardian Name: _____ Guardian Signature: _____