PATIENT INFORMATION

Welcome to our office! To assist us in serving you, please complete the following confidential form. The information provided is important to your dental health.

Full Name: _____ Preferred Name: _____ DOB: _____ SSN: _____

If minor, parent/guardian name: _____ Parent/Guardian SSN: _____

Home Phone: _____ Cell phone: _____ Work Phone: _____

Email: _____ Preferred Method of Contact: _____

Mailing address _____ City _____ State _____ Zip _____

Employer _____ Occupation _____

Marital Status: ❑ Married ❑ Single ❑ Widowed Spouse's Name: _____

Emergency Contact: _____ Phone Number: _____ Relationship: _____

Whom may we thank for referring you to our office? _____

BILLING, CREDIT, AND INSURANCE INFORMATION: ❑ Not covered by dental insurance

Dental Insurance Company: _____ Claims Address: _____

Subscriber's Name: _____ DOB: _____

Policy ID# or SS#: _____ Group Number: _____ Insurance Co. Phone #: _____

Do you have a Secondary Insurance? ❑ yes ❑ no

Name of Company: _____ Claims Address _____

Subscriber's Name: _____ DOB: _____

Policy ID# or SS#: _____ Group number _____ Insurance Co. Phone # _____

DENTAL HEALTH HISTORY

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

(Please check any that apply)

- ❑ Fear/apprehension about dental treatment
- ❑ Problems with previous dental treatment
- ❑ Abnormal bleeding after extraction or dental treatment
- ❑ Gag easily
- ❑ Bad breath
- ❑ Periodontal treatment (deep cleaning, grafting)
- ❑ Wear dentures/Partials
- ❑ Food catching between teeth
- ❑ Difficulty chewing food
- ❑ Chew only on one side of mouth
- ❑ Avoid brushing part of mouth due to pain
- ❑ Bleeding Gums
- ❑ Swollen or Tender gums
- ❑ Teeth Whitening
- ❑ Frequent sores in or around the mouth
- ❑ Sores or growths in your mouth
- ❑ Sensitivity to sweets
- ❑ Sensitivity to hot
- ❑ Sensitivity to cold
- ❑ Pain with biting
- ❑ Fluoride treatments
- ❑ Orthodontic treatment (history of braces or currently in braces)
- ❑ Grinding teeth
- ❑ Clicking/Popping of Jaw
- ❑ Pain in Jaw
- ❑ Wake up with pain/soreness of jaw
- ❑ Wear a night guard/occlusal splint
- ❑ History of Trauma to the Teeth/Jaw

How often do you brush your teeth: _____

How often do you floss your teeth: _____

Name of Previous Dentist: _____

Date of Last Dental Visit: _____

Date of Last Dental X-rays: _____

Reason for leaving previous dentist: _____

_____

Reason for todays visit: _____

_____

_____

Are you dissatisfied with the appearance of your teeth? ❑ Yes ❑ No

Do you prefer to save your teeth? ❑ Yes ❑ No

Rate your smile on a scale 1-10: _____

Do you want complete dental care? ❑ Yes ❑ No

LIVE OAK DENTAL

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

Medical Health History

Name of your Physician: _____ Phone Number: _____ Date of last medical exam: _____

Have you had any serious illnesses or operations? Please describe: _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (phentermine), Pondimin (fenfluramine), and Redux (dexfenfluramine.) ❑ Yes ❑ No

(Women) Are you pregnant ❑ Yes ❑ No Nursing ❑ Yes ❑ No Taking hormones or contraceptives ❑ Yes ❑ No

Have you ever needed antibiotic prophylaxis prior to a dental procedure? ❑ Yes ❑ No

Do you smoke or use chewing tobacco? ❑ Yes ❑ No If yes #of packs/cans per week: _____ Number of years: _____

Do you drink alcohol? ❑ Yes ❑ No If yes # of drinks per day: _____ Do you use recreational drugs? ❑ Yes ❑ No

Do you have or have you had any of the following?
(Please check any that apply)

- ❑ Heart ailment or angina
- ❑ Allergies or Hives
- ❑ Anemia
- ❑ Arthritis, Rheumatism
- ❑ Artificial Heart Valves
- ❑ Artificial Joints
- ❑ Asthma
- ❑ Back Problems
- ❑ Blood Disease, hemophilia
- ❑ Blood Transfusion (Date: _____)
- ❑ Cancer (Type: _____)
- ❑ Chemotherapy
- ❑ Chronic Pain
- ❑ Circulatory Problems
- ❑ Cortisone Treatments
- ❑ Cough, Persistent
- ❑ Cough up Blood
- ❑ Diabetes
- ❑ Drug addiction
- ❑ Depression/Anxiety
- ❑ Epilepsy (Date of last seizure: _____)
- ❑ Fainting
- ❑ Glaucoma
- ❑ Heart Murmur
- ❑ Heart Problems
- ❑ Herpes or Cold Sores
- ❑ High Blood Pressure
- ❑ HIV/AIDS
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Migraine Headaches
- ❑ Mitral Valve Prolapse
- ❑ Osteoporosis
- ❑ Pacemaker
- ❑ Radiation treatment (Location: _____)
- ❑ Respiratory Disease
- ❑ Rheumatic Fever or Rheumatic Heart Disease
- ❑ Scarlet Fever
- ❑ Shortness of Breath
- ❑ Sinus Issues
- ❑ Skin Rash
- ❑ Sleep Apnea
- ❑ Stroke
- ❑ Swelling of Feet of Ankles
- ❑ Thyroid Problems
- ❑ Tonsilitis
- ❑ Tuberculosis or other lung disease
- ❑ Ulcers

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Latex materials
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics ("Novocain")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other: _____

Are you taking any of the following medications?

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners)
- ❑ Antibiotics
- ❑ Antidepressants or tranquilizers
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medicine

Please list all current medications: _____

Pharmacy Name: _____ Pharmacy Address and Phone #: _____

Signature: To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Date

Live Oak Dental
912 Holly Street
Holly Hill, S.C. 29059

Your Financial Responsibility

Patient Name:_____

We will file your initial insurance as a courtesy to you. Insurance contracts are between the patient and the patient's insurance company; therefore **charges not covered by your insurance are fully your responsibility.** Insurance claims which are denied, rejected or not paid in full will be your responsibility. Upon receipt of your statement, your account will be considered delinquent if over 30 days. Please pay promptly to avoid your account being turned over to collections.

I understand I am responsible for all services rendered. I hereby agree that in the event of default in payment of any amount due and if this account is placed in the hands of a collections agency or attorney, I will pay additional charge equal to the cost of the collections agency fee, attorney's fee and court cost incurred and permitted by laws covering these transactions.

Your insurance company will be notified to verify covered procedures, **all insurance quotes are estimates**. You will be responsible for payment the day of service for treatment that is not covered by your insurance company.

We will allow 1/2 of your patient share on the initial visit for impressions for complete/partial dentures, crowns and bridges only. The other half will be collected the day of delivery. If you are unable to follow these guidelines, your appoint will be rescheduled until your funds are available.

We offer a payment plan called CareCredit that allows you to start your treatment immediately with flexible financing options. For more information about applying fro CareCredit and our financial policy with CareCredit please ask.

$35.00 cancellation fee may be applied to missed or canceled appointments without a 48 hours in advance notice

I fully understand that I am responsible for the total fee regardless of what my insurance carrier pays. I also understand that payment will be due at the time of the procedure/ procedures.

X_____ Date:_____

Patient/Parent/Guardian Signature