# Carolina Forest Cosmetic Dentistry

WELCOME TO OUR PRACTICE! WE LOOK FORWARD TO PROVIDING YOU WITH THE HIGHEST QUALITY DENTAL CARE.

## PATIENT INFORMATION

NAME _____
ADDRESS _____
CITY _____ STATE _____ ZIP_____
SEX: M F AGE _____ BIRTH DATE _____MARITAL STATUS: S M D W
SSN:_____ HOME PHONE _____
MOBILE_____ E-MAIL _____
NOTIFY IN CASE OF EMERGENCY _____
PHONE NUMBER _____
WHO MAY WE THANK FOR REFERRING YOU!
_____

## INSURANCE INFORMATION

POLICY HOLDER _____
RELATION TO PATIENT _____
D.O.B. _____ SSN _____
ADDRESS (IF DIFFERENT THAN PATIENT)
_____
CITY _____ STATE _____ ZIP _____
PHONE _____ WORK _____
EMPLOYER _____
INSURANCE CO. _____

## AUTHORIZATION

I AUTHORIZE MY DENTIST TO RELEASE NECESSARY INFORMATION TO SECURE PAYMENT OF BENEFITS. I UNDERSTAND THAT AFTER 30 DAYS, I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. A REBILLING FEE OF 18% YEARLY, 1.5% MONTHLY, WILL BE CHARGED TO MY ACCOUNT IF ACCOUNT IS NOT PAID IN FULL BY STATEMENT DUE DATE.

WE REALIZE EMERGENCIES CAN OCCUR. SHOULD AN UNFORESEEN SITUATION PREVENT YOU FROM MAKING A PREARRANGED APPOINTMENT, PLEASE CONTACT OUR OFFICE TO AVOID THE POSSIBILITY OF A MISUNDERSTANDING (AND A $75.00 PER HALF-HOUR CANCELLATION FEE).

SIGNATURE _____DATE _____

How did you hear about us? _____
What was the reason for today's visit? _____
Do you love your smile? _____
Is there anything you would like to change? _____
Why did you leave your last dentist? _____
Do you like the color of your teeth? _____

Indicate which of the following you have had, or have at present. Circle "Yes" or "No" to each item.

| | | | | | |
|---|---|---|---|---|---|
| Heart Concerns | Y | N | Diabetes | Y | N |
| Congenital Heart Disease | Y | N | Headaches | Y | N |
| Heart Murmur | Y | N | Jaw Pain | Y | N |
| High Blood Pressure | Y | N | Jaw Popping | Y | N |
| Mitral Valve Prolapse | Y | N | Limited opening | Y | N |
| Artificial Heart Valve | Y | N | Congested Ears | Y | N |
| Pacemaker | Y | N | Dizziness | Y | N |
| Stroke | Y | N | Ringing Ears | Y | N |
| Asthma | Y | N | Loose Teeth | Y | N |
| Liver Disease/jaundice | Y | N | Posture Problems | Y | N |
| Latex Sensitivity | Y | N | Clenching | Y | N |
| Artificial Joints | Y | N | Grinding | Y | N |
| Kidney Trouble | Y | N | Facial Pain | Y | N |
| Radiation/Chemotherapy | Y | N | Sensitive Teeth | Y | N |
| Epilepsy/Seizures | Y | N | Neck Pain | Y | N |
| AIDS/HIV | Y | N | Bell's Palsy | Y | N |
| Sickle Cell Disease | Y | N | Difficulty Swallowing | Y | N |
| Hepatitis | Y | N | Trigeminal Neuralgia | Y | N |
| Neurological Disorder | Y | N | Tingling in Arms/Fingers | Y | N |
| Psychiatric/Psychological | Y | N | Insomnia/Frequent waking | Y | N |
| Have you had braces? | Y | N | Do you see a Chiropractor? | Y | N |
| Does floss shred when you use it? | Y | N | Do your gums bleed? | Y | N |
| Do you smoke or chew tobacco? | Y | N | Does your breath concern you? | Y | N |
| Have you ever taken "Fem/Phen?" | Y | N | Does food pack/catch between your teeth? | Y | N |

Allergies:_____
_____

Any medications: _____
Do you take or have you ever taken Bisphosphonates (Fosamax, Actenol, Aredia, and Zometa, Etc.?)
Do you have any disease, condition or problem not listed?
_____
_____
Women: Are you Pregnant? Y N Nursing? Y N Taking Birth Control? Y N

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider who may release such information to you. I will notify the doctor of any change in my health or medication.

Signature_____Date_____

# Carolina Forest Cosmetic Dentistry

We place a high emphasis on helping you determine your present and future dental needs. Here are some things we are going to be talking about at your first visit. These are issues you may have never thought of. Please check what expresses how you feel about the following questions:

☐Are you having any areas of concern? _____

☐Tell us in your opinion what you think the present state of health of you mouth is:

_____

☐How healthy do you want us to get your mouth? (please circle)

"Don't really care" Average The best it can be

☐Tell us about your good dental experiences…

_____

And bad ones… _____

☐What caused you to leave your last dentist? _____

☐What would you like to change about your smile?_____

☐What would it take for you to trust us to be your dentist?

_____

☐Do you have any family or friends that already come to our office? _____

☐What do you already know about our office and what are your expectations?

_____

☐Has fear ever been an issue for you in a dental office?

_____

☐Has time ever been a factor in getting your dental work done?

_____

☐Has the cost of dental treatment been a concern for you?

_____

☐What can we do to help you with this? _____

☐We have the unique ability to look at your mouth from 3 different perspectives. What combination of these would you like us to use for you?

As a **general** dentist As a **cosmetic** dentist As a **functional** dentist

☐At what point do you want us to initiate treatment?

When my tooth hurts or breaks When something is worsening When something isn't ideal

☐What quality of dentistry do you want us to recommend?

"Just patch it" Average Ideal/the best

☐Is there any additional information you would like us to know?

_____

_____

_____

220 Middleburg Drive Myrtle Beach, SC 29579 Phone: 843.903.3111 Fax: 843.903.3110 www.SmileCF.com

# Carolina Forest Cosmetic Dentistry's Financial Policy

Thank you for choosing our office for your dental needs. We realize that every person's financial situation is different. For this reason, we have worked hard to provide a variety of payment options to help you receive the dental care you need and deserve that allows you to enjoy a healthy, beautiful smile with respect to your budget. Dental treatment is an excellent investment in an individual's medical and psychological care. We are always available to answer your questions or assist you in any way we can.

To maintain the practice operations and prevent potential misunderstandings, we ask patients to accept and adhere to the following financial arrangements regarding their dental treatment.

**Optional Payment Terms:**

1. **Full Pay Cash Discount**: We offer a 5% accounting courtesy for all treatment that is paid in full for the next scheduled appointment. We will still file your insurance and payment will go directly to you the patient.
2. **Term Loan**: By arrangement with Care Credit, we offer our patients, upon approval, an interest-free term loan (up to 6 months) with no down payment, no annual fee, and no prepayment penalty. Please ask for an application.

**Payments are expected at the time services are rendered. We accept cash, debit cards, and all major credit cards.**

**Broken appointments:** A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at least 48 hours notice to avoid a $75.00/hour cancellation fee (emergencies are an exception).

**Finance Charge:** Payment is due at time of service. If we have not received your payment within 30 days, a service charge will be assessed at a rate of 18% APR on all balances past the specified due date. After 90 days your account will be turned over to collection status.

Please initial that you have read and understand this page. _____

# NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**PLEASE REVIEW IT CAREFULLY.**
**THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

**OUR LEGAL DUTY**
We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2008, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

**USES AND DISCLOSURES OF HEALTH INFORMATION**
We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

**Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**To Your Family and Friends:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

**Persons Involved In Care:** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

**Marketing Health-Related Services:** We will not use your health information for marketing communications without your written authorization.

**Required by Law:** We may use or disclose your health information when we are required to do so by law.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters.)

**PATIENT RIGHTS**

**Access:** You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice.)

**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2008. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

**Restrictions:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

**Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

**Amendment:** You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

**Electronic Notice:** If you receive this Notice on our Web site or by electronic mail(e-mail), you are entitled to receive this Notice in written form.

**QUESTIONS AND COMPLAINTS**

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, You may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.


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|---|---|
| Contact Officer: | Dr. Dustin Holladay |
| Telephone: | 843-903-3111 |
| Fax: | 843-903-3110 |
| E-Mail: | Doctorholladay@hotmail.com |
| Address: | 220 Middleburg Dr<br>Myrtle Beach, SC 29579 |

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You May Refuse To Sign This Acknowledgement

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

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please specifiy)