PATIENT INFORMATION

Patient Name: _____ Date: _____
M/F Married/Single/Child (please circle appropriate one)
Social Security#: _____ Birth date: _____
Phone: H_____ W_____ C_____
Email address: _____
Address: _____ City_____ State_____Zip_____
Emergency contact Name: _____ Phone: _____
Would you like to be reminded of your appointment by: Text _ Email_ Phone_ All_
WHOM MAY WE THANK FOR REFERRING YOU TO OUR PRACTICE?_____
We would like to have your authorization to use your photo's for our office advertisement: Yes/No

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Responsible Party Information

Name: _____Male/Female _____
Social Security #: _____ M/S/C/ other _____
Phone#: H_____W_____C_____
Address: _____

Employment Information

The following is for: The patient _____ the person responsible for payment and insured _____
Employer Name:_____Occupation: _____
Address: _____ Phone#: _____

Insurance Information

Primary Insurance

Name of insured: _____ Is insured a patient? Yes/No _____
Insured's Birth Date: _____ ID#: _____ GR#: _____
Insured's Employer Name: _____
Patient's relationship to insured: Self __ Spouse ___ Child ___ Other _____
Primary Insurance Plan Name: _____Phone#:_____
Address: _____City_____State_____Zip_____

Secondary Insurance (if applicable)

Name of Insured: _____ Is insured a patient? Yes/No _____
Insured's Birth Date: _____ID#: _____ GR#: _____
Insured's Employer Name: _____
Patient's relationship to insured: Self __ Spouse __ Child __ Other __
Secondary Insurance Plan Name: _____ Phone#: _____
Address: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse To Sign This Acknowledgement****

I, _____, have received a copy of the Carolina Forest Cosmetic Dentistry Notice of Privacy Practices.

_____ (Please print name)
_____ (Signature)
_____ (Date)

Whom may we share your information with: _____
Relationship: _____

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

Personal Representative's Name: _____

Relationship to Patient: _____

For Program 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)

FINANCIAL MENU

We consider our relationship with you to be of primary importance and will always make our recommendations based on what we believe is the very best treatment for you regardless of your insurance coverage or financial arrangements. For your comfort and convenience, we offer a wide range of financial options.

Broken appointment

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.oo/hour cancellation fee.**_____ (We schedule 1 patient at a time, if you do not show we have no one to see. This is the reason we are ready to see you on time everyday).

Pre-Payment in Full

A pre-payment Bookkeeping Courtesy of 5%will be given for direct payment in full by **CASH (NOT CHECK)** prior to treatment._____

Pre-Authorized Credit Card Agreement

With your permission and signature, we will charge your MasterCard, Visa, Discover with an agreed amount each month. This allows you to make monthly payments without applying for additional credit for future treatment._____

Care Credit

Interest free payment plan with low payments for **6 months**. With good credit we can get fast approval by phone. _____

INSURANCE

°It is our pleasure to assist you in maximizing your insurance benefit by completing your claim form. If your carrier is up to date (in over 70% of the cases), the claims will be transmitted via computer modem before the end of the treatment day. As a courtesy, in addition to filling the claim, **we will initially ask you for your ESTIMATED co-payment.** _____

° Please understand that this is ***only an estimate,*** and is based upon the information available to us. Once your carrier has paid the claim, any difference will be due upon receipt of our statement._____

°If your insurance company postpones payment for more than ***60 days,*** we ask that you make the remaining payment while we work together to get the insurance company to pay you their obligation. After 60 day grace period, the remaining balance is subject to 18% APR._____

°**The range of benefits depends solely on what your employer wishes to purchase.** Some plans cover as little as 30% or as much as 100% of dental services, with most falling in the 40% to 80% range. Many plans base the amount of benefit on a schedule of fees arbitrarily developed by insurance companies. For this reason, you may receive a lower percentage that the reimbursement level indicated in your dental plan._____

MEDICAL HISTORY

Patents Name: _____ Date: _____

DO YOU HAVE or HAVE YOU EVER HAD: **YES/NO** **YES/NO**

Hospitalization for?_____ ◯ Asthma_____ ◯
Liver Disease/jaundice____ ◯ Hepatitis A/B/C___ ◯
AIDS/HIV_____ ◯ Heart concerns _____ ◯
HPV_____ ◯ Heart Attack _ yr_____ ◯
Latex sensitivity_____ ◯ Heart Valve repair/replaced __ ◯
Artificial Joints- type __ yr placed_____ ◯ Pacemaker - yr placed_____ ◯ Kidney Trouble _____ ◯ Diabetes Type I/II_____ ◯
Cancer – Type _____ ◯ Stroke ___yr_____ ◯
Radiation/Chemotherapy- yr_____ ◯ Congenital Heart Disease/Heart Murmur ◯
Epilepsy/Seizures____last seizure_____ ◯ High Blood Pressure/Low Blood Pressure ◯
Sickle Cell Disease_____ ◯ Mitral Valve prolapse ◯
Tuberculosis _____ ◯ High Cholesterol _____ ◯
Thyroid disease _____ ◯ Lupus _____ ◯
Rheumatoid Arthritis _____ ◯ Neurological Disorder_____ ◯
Psychiatric/Psychological_____ ◯
Have you taken Bisphosphonates for osteoporosis/osteopenia? _____◯◯
Are you a smoker, previously smoked, or tobacco use?_____◯◯
FEMALES – Birth control _____ Pregnant_____ Nursing_____

Allergies

Aspirin_____ Penicillin ___ Erythromycin___
Tetracycline___ Sulfa_____ Local anesthetic _____
Fluoride _____ metals (nickel, gold, silver, _____)
Latex_____ other _____

Medications

(List all medications, supplements, and or vitamins taken within the last two years)

Drug	**Purpose**	**Drug**	**Purpose**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Signature_____ Date:_____

Patients Name:_____ Date:_____

Dental Information

Please answer YES or NO TO THE FOLLOWING:

	Y/N		Y/N
●Are any teeth sensitive to hot, cold?	◯	●Do you have problems with your jaw joint?	◯
●Are your teeth becoming more crooked, crowded, or overlapped?	◯	● Are your teeth developing spaces or becoming more loose?	◯
●Do you clench your teeth in the daytime or make them sore?	◯	●Do you have any problems with sleep (i.e. restlessness), wake up with a headache?	◯
●Have you ever whitened (bleached) your teeth?	◯	●Have you felt uncomfortable or self conscious about the appearance of your teeth?	◯
●Have you been disappointed with the appearance of previous dental work?	◯	● Did you have braces, orthodontic treatment or had you bite adjusted?	◯

●Are you having any areas of concern?_____

● What do you think the present state of health of your mouth is? Great Good Not ideal

●How healthy do you want your mouth? Perfect Good OK

●Tell us about your dental experiences..._____

●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?_____

●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? **YES** **NO**

●We have the unique ability to look at your mouth from 2 different perspectives. What combination of these would you like us to use for you?

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

●At what time do you want us to initiate treatment?

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

WRITE A REVIEW FOR CAROLINA FOREST COSMETIC DENTISTRY!

We would appreciate your online feedback. To make it easy, we've put together this handout that details the steps needed to leave a review on the most popular review sites.

If you have a concern with your experience at Carolina Forest Cosmetic Dentistry, please call our office at 843-903-3111 or by email at: info@smilecf.com.

Thank you!!

YELP – Visit yelp.com and find our business using the search bar at the very top of the page. Narrow results by using: **our exact business name and city**. Click on our business page, and click the "Write a review" button. This button is located underneath the business' address, telephone number and website. Select a rating for your overall experience at our office. Use the scale they give you (the ratings range between 1 star and 5 stars). The submission will not let the review be posted without a rating. Then you are finished!

GOOGLE – To write a Google review you will need a free Google account. To post a review, Google the name: **Carolina Forest Cosmetic Dentistry**. On the right side of the page you will see reviews that have already been written. Click the "Write a review" button under clinic's name. Log in to your Google account and type your review into the field provided. Just click the "publish" button and you're finished!

FACEBOOK – Log into your Facebook account and enter our office name: **CarolinaForest CosmeticDentistry**. When in our page you can hit the star for the rating and then write the review. Once done, hit save and you are finished!