Date: _____

Patient Name: _____

Address _____ City: _____ State: _____ Zip: _____

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

Birth Date: _____ Age: _____ Sex: _____

Social Security #: _____ Marital Status: _____

Occupation: _____ Employer: _____

Answer all questions by checking either yes or no. Answers to the following questions are for our records only and will be considered confidential.

	Yes	No	
Are you under a physician's care now?	❑	❑	If Yes, please explain: _____
Have you ever been hospitalized or had a major operation?	❑	❑	If Yes, please explain: _____
Have you ever had a serious head or neck injury?	❑	❑	If Yes, please explain: _____
Are you taking any medications, pills, or drugs?	❑	❑	If Yes, please explain: _____
Are you in pain?	❑	❑	_____
When was your last dental appointment?	❑	❑	_____
Do you use tobacco?	❑	❑	_____
Do you use controlled substances?	❑	❑	_____

Are you allergic to any of the following?

❑ Aspirin ❑ Penicillin ❑ Codeine ❑ Acrylic ❑ Metal ❑ Latex ❑ Local Anesthetics

❑ Other If yes, please explain: _____

Women: Are you

Pregnant/ Trying to get pregnant? ❑ Yes ❑ No Taking oral contraceptives? ❑ Yes ❑ No Nursing? ❑ Yes ❑ No

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

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

	Yes	No
Does food lodge between your teeth?	❑	❑
Are your teeth sensitive to heat, cold or sweets?	❑	❑
Do your jaws "click" or "pop" when you open your mouth?	❑	❑
Are you dissatisfied with the appearance of your teeth?	❑	❑
Do you have difficulty in chewing your food?	❑	❑
Do you breathe through your mouth?	❑	❑
Have you had a toothache recently?	❑	❑
Do you have bleeding gums?	❑	❑
Do you think any of your teeth are moving or drifting?	❑	❑
Do you grind or clench your teeth together?	❑	❑

	Yes	No
Have you ever received treatment for periodontal disease?	❑	❑
Have you ever had a deep cleaning?	❑	❑
Do you have any teeth missing that have not been replaced by bridgework, partial or full dentures?	❑	❑
Do your teeth need cleaning?	❑	❑
Do your jaws feel tired in the morning or at the end of the day?	❑	❑

In your own words describe your present dental health

_____

_____

_____

My present general health is: Excellent, Fair, Poor

Patient or legal guardian _____ Date: _____

Date_____

Primary
Insurance Company:_____

Employer:_____

Employee:_____

Date of Birth:_____

Social Security #:_____

Group #:_____

Coverage: Family_____ **Self**_____**Child**____

If child Parent's name_____

Work Phone:_____

Secondary
Insurance Company:_____

Employer:_____

Employee:_____

DOB:_____

Social Security #:_____

Group#:_____

Coverage: Family_____**Self**_____**Child**_____

Work Phone:_____

Please be advised that our office will file your insurance as a courtesy to you the patient, but obtaining payment from the insurace company is actually a matter between the patient and the insurance company and the balance is therefore the responsibility of the patient. If insurance does not pay what is estimated it becomes the full responsibilty of the patient to pay the account in full.

You will be expected to pay in full at the time services are rendered. Methods of payment are Master Card, VISA, Cash, Check, and Care Credit Finance Company. If you have any questions about any of the payment options, please call 285-1571.

We work by appointment only. If you arrive more than ten (10) minutes late for your scheduled appointment time, you may be asked to reschedule your appointment for the later date. There is a $20.00 fee for broken appointments without a 24 hour notice. After 2 broken appointments without 24 hours notice, no further appointments will be scheduled.

A parent or guardian must accompany children under the age of 18.

Patient Signature _____

Meeting Street Dentistry

Financial and Office Policies

Thank you for choosing Meeting Street Dentistry as your dental healthcare provider. We are committed to providing the highest quality dental care. In order to accomplish high quality of care at a reasonable cost to our patients, we must require that **ALL** patients pay their deductibles and non-covered services at the time of service. Thank you for your understanding and cooperation.

Insured Patients
All patients must provide the receptionist with current dental insurance information at least 24 hours prior to your appointment in order for insurance benefits to be obtained in a timely manner. We will gladly file your claims, but please remember that you are ultimately responsible for **ALL** charges.

We will **estimate** to the best of our ability the amount you are responsible for paying at the time of service. These estimates are **not guarantees** that the insurance company will pay the remaining balance. You are responsible for paying your portion for serves **at the time services are rendered.**

Deductibles and Other Non-Covered Services
We ask that **ALL** deductibles and any non-covered expenses be paid **when checking in at the front desk.**

Uninsured Patients
If you do not have insurance coverage payment in full is required at the time of service unless arrangements have been made prior to your appointment.

Missed Appointments
When you miss an appointment, you deny valuable time to another patient in need of dental care. We realize unexpected circumstances may arise. When possible, please call **48 hours in advance** to cancel or reschedule your appointment. **If a patient "no shows" for an appointment there will be a $30.00 broken appointment fee added to your account. After the second missed appointment, no other appointment will be scheduled for the patient.** We will provide emergency care for 30 days following the dismissal.

Returned Checks
Checks returned due to insufficient funds will be subject to an additional fee of

$30.00. The amount of the returned check plus the $30.00 insufficient fund fee must be paid in **cash or money order** within 10 days of receipt of written notification from our office.

Collection Procedures

After 90 days any past due balances will be turned over to our collection agency. The account will be adjusted to include any fees incurred during this process.

> *You agree to reimburse Meeting Street Dentistry the fees charged by any collection agency, which will be added to the account at the time it is placed with the agency. This fee may be based on a percentage at the maximum of 50% of the debt including reasonable attorneys' fees and all reasonable costs and expenses incurred in such collection efforts.*

Minor Patients

If the Patient is a minor **(anyone under the age of 18)**, a parent or guardian must be present in our office during **ALL** dental appointments. The adult accompanying a minor is responsible for the payment that is due at the time of service. Please be sure that whomever is bringing the minor is prepared to render any payment that is necessary. If a parent or guardian cannot be present at the time of the appointment, we will gladly reschedule the visit to another day.

Thank you again for choosing Meeting Street Dentistry. If you have any questions concerning the above financial and office policies, please contact our office for a full explanation.

We accept cash, check, Visa, Master Card, Discover, American Express, and debit.

I HAVE READ AND AGREE TO THESE FINANCIAL/OFFICE POLICIES. I UNDERSTAND AND TAKE FULL RESPONSIBILITY FOR INSURANCE AND PAYMENTS AS STATED ABOVE.

_____ _____

Patient(s) Name (please print) Date

_____ _____

Responsible Party Signature Date

_____ _____

Responsible Party SS# Date of Birth

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGMENT

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 acknowledgment of receipt of our Privacy Practice, but acknowledgment could not be obtained because:

_____ Individual refused to sign

_____ Communication barriers prohibited acknowledgment

_____ An emergency situation prevented us from obtaining acknowledgment

_____ Other (Please Specify)

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____

Date Of Birth_____SS#_____

SECTION B: TO THE PATIENT -- PLEASE READ THE FOLLOWIN G STATEMENT 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 use and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practice and described in our Notice of Privacy Practice. If we change our privacy, we will issue a revised Notice of Privacy Practice, which contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practice,
including any revisions of our notice at any time by contacting

Meeting Street Dentistry, LLC
1440 West Meeting Street
P.O. Box 869
Lancaster, SC 29721
(803)285-1571

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contact information listed above. Please understand that revocation of this consent will not affect an action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

Signature:

I, _____, have had full opportunity to read and consider the consents of this consent form and your Notice of Privacy Practice. 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 the consent is signed by a personal representative on behalf of the patient, complete the following:
Personal representative Signature: _____
Relationship to patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT