Lowcountry Dental Center

Patient Information **Today's Date:_____**

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-mail address: _____
Best phone to reach you (circle one): Home Work Cell

Social Security#: _____ Birthdate: _____

Sex: M F Marital status: Single Married Divorced Widowed

Patient/Parent Employer: _____

Spouse Name: _____

Spouse Social Security#_____Birthdate: _____

Spouse Employer _____

Who referred you to our office: ____ Friend/Family* _____ Newspaper _____ Yellow Pages ____ Other

*Please specify so we can thank them:_____

Insurance Information

Primary Insurance: _____

Policyholder's Name: _____

Relationship to policyholder: _____

Group# _____ Phone#_____

Assignment and Release:
Dr. Snyder does not participate with any insurance companies in accepting reduced fees. The responsibility of the insurance is to you and it is your responsibility to see that you are reimbursed properly. As a courtesy to our valued patients, we will file claims for your primary. Fees for services provided to insured patients are our usual and customary fees charged to all patients for similar services. Your insurance company may base its allowance on their own fixed fee schedule. The amount of the fee paid may therefore be different than the percentage listed in your benefit booklet.

I understand that the responsibility for payment for services and products provided in this office for myself or my dependents is mine, payable at the time services are rendered unless written financial arrangements have been made prior to start of treatment. In the event of default, I promise to pay any collection costs and attorney fees as may be required to effect collection. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of responsible party:

_____ Date:_____

Tell us more:

Why have you made this dental appointment?_____

_____

Why did you leave the office of your previous dentist?

_____

Please check one box in each section:

My mouth is: _____ Very Comfortable

_____ Moderately Comfortable

_____ Uncomfortable

Choose one:
_____I think the appearance of my smile is excellent
_____I am satisfied with the appearance of my smile
_____I would like to change my smile
_____I am unconcerned about the appearance of my mouth

Choose one:
_____I will do whatever I must to keep my teeth
_____I want to keep my teeth but only within a certain budget of time and money
_____I am indifferent about keeping my teeth

Choose one:
_____I have always done the dental treatment that was recommended to me
_____I usually do what dental treatment was recommended to me
_____I have not done what dental treatment was recommended to me
_____I have not had dental treatment recommended to me

Choose one:
_____I put dental care for myself and family high on my priority list
_____I put dental care low on my list
_____I have never considered where I put dental care

I think my present state of dental health is: _____ Excellent
_____Good
_____Fair

Obstacles I see to having excellent dental care for myself. If you select more than one of the following, please number them in order of significance with #1 being that which is most significant for you at this time:

_____I see no obstacles
_____Time away from work or other obligations
_____Fear of pain, surgery or injections
_____Fear due to past dental experiences
_____The cost of the treatment
_____Other Please explain: _____

Lowcountry Dental Center
Medical History

Patient Name: _____ Date: _____

Preferred Pharmacy: _____ Phone#:_____

Physician's Name: _____ Phone#:_____

Medications (please include any pre-medication):

Allergies:

Yes	No		Yes	No	
		Aspirin			Latex
		Codeine			Metals (ex. Nickel, Stainless Steel)
		Dental Anesthetics			Penicillin
		Erythromycin			Tetracycline
		Jewelry			Other:

Do you smoke or use tobacco? Yes No

If female, please answer the following:

Are you taking Birth Control Pills? Yes No

Are you pregnant? Yes No if yes, # of weeks: _____

Are you nursing? Yes No

Conditions:

Y	N		Y	N		Y	N	
☐	☐	Abnormal Bleeding	☐	☐	Frequent Headaches	☐	☐	Radiation Therapy
☐	☐	Alcohol Abuse	☐	☐	Glaucoma	☐	☐	Seizures
☐	☐	Allergies	☐	☐	HIV+ AIDS	☐	☐	Shingles
☐	☐	Anemia	☐	☐	Heart Attack	☐	☐	Sickle Cell Disease
☐	☐	Angina Pectoris	☐	☐	Heart Condition	☐	☐	Sinus Problems
☐	☐	Arthritis	☐	☐	Heart Murmur	☐	☐	Stroke
☐	☐	Artificial Bones/Joints	☐	☐	Heart Surgery	☐	☐	Thyroid Problems
☐	☐	Artificial Heart Valve	☐	☐	Hemophilia	☐	☐	Tuberculosis
☐	☐	Asthma	☐	☐	Hepatitis A	☐	☐	Ulcers
☐	☐	Blood Transfusion	☐	☐	Hepatitis B			
☐	☐	Cancer – Chemotherapy	☐	☐	Herpes			
		Cancer type:_____	☐	☐	High Blood Pressure			
☐	☐	Colitis	☐	☐	Kidney Problems			
☐	☐	Congenital Heart Defect	☐	☐	Liver Disease			
☐	☐	Diabetes	☐	☐	Low Blood Pressure			
☐	☐	Difficulty Breathing	☐	☐	Migraines			
☐	☐	Drug Abuse	☐	☐	Mitral Valve Prolapse			
☐	☐	Emphysema	☐	☐	Osteoporosis			
☐	☐	Epilepsy	☐	☐	Pace Maker			
☐	☐	Fainting Spells	☐	☐	Pain in Jaw Joints			
☐	☐	Fever Blisters	☐	☐	Psychiatric Problems			

Other conditions not listed that we should know about:

I certify that the information listed here is accurate to the best of my knowledge (please sign below):

LOWCOUNTRY DENTAL CENTER, INC.

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

_____

_____

_____

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).

LOWCOUNTRY DENTAL CENTER
PATIENT CONSENT FOR COMMUNICATION

Patient Name: _____

I give my permission for Lowcountry Dental Center to contact me regarding my appointments and care in the following manner(s):
Please check off all that apply and circle your preferred method of communication.

_____ **Home Phone _____**

_____ **Work Phone** _____
Provide number here

_____ **Cell Phone** _____
Provide number here

_____ **Text Message via the cell phone indicated above**

_____ **E-mail:** _____
Provide appropriate e-mail address here-PRINT CLEARLY

I understand that in communicating with me in the above manner, Lowcountry Dental Center may leave a message when I am unavailable. I also understand that e-mails are sent via our secured, non-encrypted email server. I understand that there is some level of risk that third parties might be able to read unencrypted emails. It is my responsibility to provide updates to this contact information in a timely manner.

_____ _____
Signature of Patient/Guardian Date