

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):

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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	
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy
<input type="checkbox"/>	<input type="checkbox"/>	Alcohol Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	HIV+ AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Shingles
<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease
<input type="checkbox"/>	<input type="checkbox"/>	Angina Pectoris	<input type="checkbox"/>	<input type="checkbox"/>	Heart Condition	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	Artificial Bones/Joints	<input type="checkbox"/>	<input type="checkbox"/>	Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems
<input type="checkbox"/>	<input type="checkbox"/>	Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers
<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B	Other conditions not listed that we should know about:		
<input type="checkbox"/>	<input type="checkbox"/>	Cancer – Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Herpes			
		Cancer type: _____	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure			
<input type="checkbox"/>	<input type="checkbox"/>	Colitis	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems			
<input type="checkbox"/>	<input type="checkbox"/>	Congenital Heart Defect	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease			
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure			
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Breathing	<input type="checkbox"/>	<input type="checkbox"/>	Migraines			
<input type="checkbox"/>	<input type="checkbox"/>	Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse			
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis			
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Pace Maker			
<input type="checkbox"/>	<input type="checkbox"/>	Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>	Pain in Jaw Joints			
<input type="checkbox"/>	<input type="checkbox"/>	Fever Blisters	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Problems			

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)