REEDY RIVER DENTISTRY

J. HUNTER HICKLIN, DMD

Bringing natural smiles to Greenville

# DENTAL HISTORY

Name:

How did you hear about us?

Reason for Appointment?

Have you had regular preventive dental care in the past?

When was your last cleaning appointment?

Previous Dentist?

Have you had xrays in the past year?

Are you satisfied with appearance of your teeth?

If you could change anything about your smile, what would it be?

Have you ever had orthodontic (braces) treatment?

Have you had any or all of your wisdom teeth removed?

Do you wear a removable partial or denture? Year made?

If so, are you satisfied?

Have you ever had any injuries to your mouth?

Have you ever been told you have gum disease?

Do your gums bleed when you brush or floss?

Do you have any sore or sensitive teeth?

Do you have any pain or clicking in the jaw joint?

Do you clench or grind your teeth?

Have you ever had a negative dental experience?

Do you drink soft drinks, sports drinks, or any sweetened beverage regularly?

What and how many per day?

Do you have any other concerns we should know about?

864 272 3091
1803-A Augusta St. Greenville, SC
ReedyRiverDentistry.com

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# HIPAA

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of privacy practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or healthcare operations (TPO) and for other purpose that are permitted or required by law. It also describes your right to access and control your protected health information. "Protected health information" is information about you including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

Use and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside our office that are involved in your care and treatment for the purpose of providing health care services to you to, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

**Treatment**

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care for you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment**

Your protected health information will be used as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations**

We may use or disclose, asneeded,
your protected health information in order to support the business activities of
your physician's practice. These activities include, but are not limited to quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients in our office. In addition, we may use a signin
sheet at the registration desk where you will be asked to sign your
name and indicate your physician. We may also call you by name in the waiting room when your physician is ready is ready to see you, we may use or disclose your protected health information, to contact you of your appointment. We may use or disclose your protected health information in the following situations without your authorization. These situations include: Required by law, Public Health issues as required by law, Communicable Diseases: Health oversight: Abuse or Neglect: Food and Drug Administration requirements: legal proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation;
Research: Criminal Activity: Military Activity and National Security: Workers Compensation: Inmates Required Uses and Disclosures: Under the law we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with requirements of section 164.500

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Other permitted and required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to object unless required by law.
You may revoke this authorization, at any time, in writing, except to the extent that your physician or physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with the respect to your protected health information
You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following: Psychotherapy notes; information compiled in reasonable anticipation of, or use in a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operation. You may also request that any part of your protected health information not to be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us. Upon request, even if you agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We have the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 23, 2003.

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature below is acknowledgement that you have received this notice of our Privacy Practices:

Print Name

Signature

Date

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# PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

## Responsible Party ( if someone other than the patient )

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

## Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

### Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

### Section 3

Referred By

Previous Dentist

Emergency Contact

Emergency Contact #

## Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

## Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Reedy River Dentistry

# Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication

| | | |
|---|---|---|
| Are you under a physician's care now? | Yes No | If yes |
| Have you ever been hospitalized or had a major operation? | Yes No | If yes |
| Have you ever had a serious head or neck injury? | Yes No | If yes |
| Are you taking any medications, pills, or drugs? | Yes No | If yes |
| Do you take, or have you taken, Phen-Fen or Redux? | Yes No | If yes |
| Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? | Yes No | If yes |
| Are you on a special diet? | Yes No | |
| Do you use tobacco? | Yes No | |

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

Do you use controlled substances? Yes No If yes

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

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

Have you ever had any serious illness not listed Yes No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____

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# PATIENT PAYMENT POLICY

*Thank you for choosing Reedy River Dentistry for your dental needs. We appreciate the opportunity to care for you and your family's dental needs. The following information is provided to avoid any confusions regarding payment for dental services. Please sign below that you have read and agree to the policy.*

**Payment Policy**

- At date of service you are required to pay your estimated amount due. After insurance has paid you are responsible for any remaining balance.
- Payment for service is due in full provided there is no insurance.
- We accept Cash, Check, Visa, Mastercard. Any returned check is subject to a $20.00 return check fee.
- If a patient is younger than 18 years of age, we do require a parent or guardian to be responsible for the account, and to be in accordance with the request shown above.
- If your account is overdue for longer than 90 days, it may be referred to a collection agency.

**Insurance**

As a courtesy, we file insurance. It is your responsibility to notify us of any changes to your insurance coverage. This is your insurance policy and we require that you know your benefits regarding maximums, waiting periods, benefits year, and deductibles. Please know that any information required from your insurance company regarding the treatment done will be provided by us as it is requested.

Print Patient Name

Responsible Party Signature

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