PARKSIDE
DENTAL

Patient Registration

Patient's Name _____ **Preferred Name**_____ **Single ☐ Married ☐ Child ☐**

Social Security Number (if adult)_____ **Date of Birth**_____

Address_____ **City**_____**State**_____ **Zip**_____

Home Phone_____ **Cell Phone**_____ **E-Mail**_____

Name of Spouse or Parent's Name (if minor)_____

Patient (or Guardian) Employed by_____ **Phone**_____

Who holds financial responsibility for this patient?:_____**Social**_____

Address and phone # if different from Patient:_____

_____

In case of an Emergency, who should be notified_____ **Phone**_____

Do you have dental insurance that may cover any part of our professional services_____ **Yes ☐ No☐**

If so, primary policy holders name_____**Relationship to Patient**_____

Name of primary company_____ **Phone #** _____**ID#**_____

Social Security # of Policy Holder (if not above)_____ **Date of Birth of Policy Holder**_____

Policy Holder Employed By (if covered by spouse insurance)_____

Do you have secondary dental insurance _____**Yes ☐ No■**

If so, primary policy holders name_____**Relationship to Patient**_____

If so, name of secondary company_____ **Phone #**_____ **ID#**_____

Social Security # of Policy Holder (if not above)_____ **Date of Birth of Policy Holder**_____

Policy Holder Employed By (if covered by spouse insurance)_____

How did you hear about us?

☐Current Patient-whom may we thank? _____

☐ Internet/Facebook ☐ Insurance ☐Other_____

AUTHORIZATION TO RELEASE HEALTH INFORMATION

I authorize Parkside Dental, LLC to release health information including but not limited to: HIV, AIDS, information about substance abuse treatment, mental health services, pre-medication information, under the following terms 1) obtain insurance benefit information 2) refer you to a specialist 3) speak with a specialist 4) phone in prescriptions. You are under no obligation to authorize disclosure. If you sign this authorization, you may revoke it at any time with written notice.
I UNDERSTAND THE AUTHORIZATION TO RELEASE HEALTH INFORMATION. I AM SIGNING THIS VOLUNTARILY. I AUTHORIZE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED.

Signature of Responsible Party_____ **Date**_____

PARKSIDE DENTAL

Medical and Dental History Form

Patient Name _____ **Date** _____
Last *First* *Middle* **Date of Birth** _____

Do you have any of the following diseases or problems: (Check next to the box that fits your description)

- ☐ Active Tuberculosis
- ☐ Persistent cough greater than a 3 week duration
- ☐ Cough that produces blood
- ☐ Been exposed to anyone with tuberculosis

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information

What is the reason for your dental visit today?

☐ Routine care (cleaning and exam) ☐ Emergency (tooth pain) ☐ Consultation ☐ Other, explain: _____

How do you feel about your smile? _____

_____

☐ *Yes* ☐ *No* Do your gums bleed when you brush or floss?
☐ *Yes* ☐ *No* Are your teeth sensitive to cold, hot, sweets, or pressure?
☐ *Yes* ☐ *No* Is your mouth dry?
☐ *Yes* ☐ *No* Have you had any periodontal (gum) treatments?
☐ *Yes* ☐ *No* Have you ever had orthodontic (braces) treatment?
☐ *Yes* ☐ *No* Have you had any problems associated with previous dental treatment?
☐ *Yes* ☐ *No* Is your home water supply fluoridated?
☐ *Yes* ☐ *No* Do you drink bottled or filtered water?
If yes, how often? *Circle one*: DAILY / WEEKLY / OCCASIONALLY
☐ *Yes* ☐ *No* Are you currently experiencing dental pain or discomfort?
☐ *Yes* ☐ *No* Do you have earaches or neck pains?

☐ *Yes* ☐ *No* Do you have any clicking, popping or discomfort in the jaw?
☐ *Yes* ☐ *No* Do you brux or grind your teeth?
☐ *Yes* ☐ *No* Do you have sores or ulcers in your mouth?
☐ *Yes* ☐ *No* Do you wear dentures or partials?
☐ *Yes* ☐ *No* Do you participate in active recreational activities?
☐ *Yes* ☐ *No* Have you ever had a serious injury to your head or mouth?
Date of your last dental exam: _____
What was done at that time? _____
_____
Date of last dental x-rays: _____

Medical Information

☐ *Yes* ☐ *No* Are you now under the care of a physician?

Physician Information

Name _____

Address _____

Phone number _____

☐ *Yes* ☐ *No* ☐ *Don't know* Are you in good health?
☐ *Yes* ☐ *No* ☐ *Don't know* Has there been any change in your general health within the past year?
If yes, what condition is being treated? _____
_____
Date of last physical exam: _____

☐ *Yes* ☐ *No* Have you had a serious illness, operation or been hospitalized in the past 5 years?
If yes, what was the illness or problem? _____
_____
☐ *Yes* ☐ *No* Are you taking or have you recently taken any prescription or over the counter medicine(s)?
If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:
_____
_____
_____
_____
_____

☐ *Yes* ☐ *No* Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement
Date: _____
If yes, have you had any complications? _____
☐ *Yes* ☐ *No* Are you taking or scheduled to begin taking an **antiresorptive agent** (like Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease?
☐ *Yes* ☐ *No* Since 2001, were you treated or are you presently scheduled to begin treatment with an **antiresorptive agent** (like Aredia®, Zometa®, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?

☐ *Yes* ☐ *No* Do you use controlled substances (drugs?
☐ *Yes* ☐ *No* Do you use tobacco (smoking, snuff, chew, bidis)?
If so, how interested are you in stopping?
Circle one: VERY / SOMEWHAT / NOT INTERESTED
☐ *Yes* ☐ *No* Do you drink alcoholic beverages

WOMEN ONLY Are you:
☐ *Yes* ☐ *No* ☐ *Don't know* Pregnant
Number of weeks: _____
☐ *Yes* ☐ *No* Taking birth control pills or hormonal replacement?
☐ *Yes* ☐ *No* Nursing?

Allergies

Allergies. Are you allergic to or have you had a reaction to (To all yes responses, specify type of reaction):

- ☐ Local anesthetics _____
- ☐ Aspirin _____
- ☐ Penicillin or other antibiotics _____
- ☐ Barbiturates, sedatives, or sleeping pills _____
- ☐ Sulfa drugs_____
- ☐ Codeine or other narcotics _____
- ☐ Metals _____
- ☐ Latex (rubber) _____
- ☐ Iodine _____
- ☐ Hay fever/seasonal _____
- ☐ Animals _____
- ☐ Food _____
- ☐ Other: _____

Heart Conditions

- ☐ Artificial (prosthetic) heart valve
- ☐ Previous infective endocarditis
- ☐ Damaged valves in transplanted heart
- ☐ Congenital heart disease (CHD)
- ☐ Unrepaired, cyanotic CHD
- ☐ Repaired (completely) in last 6 months
- ☐ Repaired CHD with residual defects

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

(*Check next to the box that fits your description*)

- ☐ Cardiovascular disease
- ☐ Angina
- ☐ Arteriosclerosis
- ☐ Congestive heart failure
- ☐ Damaged heart valves
- ☐ Heart attack
- ☐ Heart murmur
- ☐ Low blood pressure
- ☐ High blood pressure
- ☐ Other congenital heart defects
- ☐ Mitral valve prolapse
- ☐ Pacemaker
- ☐ Rheumatic fever
- ☐ Rheumatic heart disease
- ☐ Abnormal bleeding
- ☐ Anemia
- ☐ Blood transfusion
  If yes, date:_____
- ☐ Hemophilia
- ☐ AIDS or HIV infection
- ☐ Arthritis
- ☐ Autoimmune disease
- ☐ Rheumatoid arthritis
- ☐ Systemic lupus erythematosus
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Sinus trouble
- ☐ Tuberculosis
- ☐ Cancer/Chemotherapy/Radiation treatment
- ☐ Chest pain upon exertion
- ☐ Chronic pain
- ☐ Diabetes Type I or II
- ☐ Eating disorder
- ☐ Malnutrition
- ☐ Gastrointestinal disease
- ☐ G.E. Reflux/persistent heartburn
- ☐ Ulcers
- ☐ Thyroid problems
- ☐ Stroke
- ☐ Glaucoma
- ☐ Hepatitis, jaundice or liver disease
- ☐ Epilepsy
- ☐ Fainting spells or seizures
- ☐ Neurological disorders
  If yes, specify:_____
- ☐ Sleep disorder
- ☐ Do you snore
- ☐ Mental health disorders
  If yes, specify:_____
- ☐ Recurrent Infections
  Type of infection: _____
- ☐ Kidney problems
- ☐ Night sweats
- ☐ Osteoporosis
- ☐ Persistent swollen glands
- ☐ in neck
- ☐ Severe headaches/
- ☐ migraines
- ☐ Severe or rapid weight loss
- ☐ Sexually transmitted disease
- ☐ Excessive urination

☐ *Yes* ☐ *No* ☐ *Don't know* Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?
Name and phone number of physician or dentist making recommendation:
_____
_____

☐ *Yes* ☐ *No* ☐ *Don't know* Do you have any disease, condition, or problem not listed above that you think I should know about?
Please explain:
_____
_____

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

_____ Date _____
Patient signature/legally authorized representative.

_____ Relationship _____
Printed name if signed on behalf of the patient

_____ Date _____
Dentist signature

PARKSIDE
DENTAL

Financial Policy

PLEASE READ ALL INFORMATION CONCERNING INSURANCE BENEFITS AND PAYMENT

1. Our office will file your insurance as a courtesy to you. However, your insurance policy is a contract between you, your employer, and the insurance company. Our office is not a party to this contract and it must be your responsibility to know your plan detail.
2. Our office will assist you the insured or beneficiary with the filing of your claim but it is **YOUR** responsibility to know your plan limitations and what the insurance will pay and not pay
3. If you have a change of address, telephone number, a new employer, or any other information needed to help find a claim, please inform us so we can update your records. **Any delays in filing a claim due to lack of information provided to us may result in a denial of that claim and full payment responsibility will then be upon the patient.**
4. Deductibles, co-payments or charges for non-covered services are due at the time of service. **Be prepared at all visits to make payment on your account.**
5. All estimates of payments are just that, an estimate. As each insurance plan is different, we can never be exact as to what they may pay for each procedure. If they pay more than expected and your account is overpaid, you will receive a refund.
6. Your dental treatment plan is tailored to meet your specific treatment needs. Treatment is not based on what your insurance will pay or not pay.
7. We will file your insurance at the time of service and expect payment in a timely manner. After 45 days, if we have not received payment from your insurance company, the account will then become self-pay and you will be responsible for the entire balance.
8. Our office staff will gladly assist you during the above mentioned time period, after which it will become your responsibility to pursue payment from the insurance company. All balances on your account will be due at that time.
9. Our office accepts cash, check, major credit cards, and Care Credit. For self-pay patients, your balance is due when services are received. If needed, please make financial arrangements prior to scheduling your treatment.
10. **NO SHOW, MISSED OR MULTIPLE CANCELLED APPOINTMENTS:** When an appointment is scheduled with the doctor or hygienist, this time has been reserved especially for you. We respectfully ask for 48 hours' notice if you need to reschedule so that we may use this time for another patient. Last minute cancellations or no shows will be charged a $35.00 fee and is payable before any other appointments can be scheduled for you or any family members.

I have read and have full understanding of the financial policy of Parkside Dental LLC.

Signature:_____ Date:_____

PARKSIDE
DENTAL

Informed Consent

Patient: _____ Date: _____

I authorize the performance of dental treatment upon (self or name of patient) _____ as necessary be the office of Parkside Dental LLC. This treatment may include but may not be limited to the following:

1. Comprehensive patient exams, diagnostic examinations, dental cleanings with the hygienist, diagnostic radiographs (X-Rays), recall appointments, examination of teeth and oral cavity by the dentist, administration of dental anesthetics as necessary to complete treatment procedures, root canal therapy, restorations such as fillings (traditional alloy and cosmetic), inlays, onlays, crowns, bridges, removable appliances, any necessary extractions of non-restorable teeth, periodontal surgery, biopsy, replacement of missing teeth, or other restorative therapy. Initial_____
2. Consent for dental radiographs (X-Rays). Our office follows the standard of care when recommending a patient to have dental radiographs. That is, we will take a Full Mouth Series or Panorex at the new patient examination unless the patient has current radiographs form another office taken within the last year. NOTE: these radiographs must be on file in our office at the time of your visit. We will routinely take radiographs every 12 to 18 months as determined by the doctor and hygienist at the time of your recall examination and cleaning. Any deviation to this 12 to 18 month protocol is beyond the standard of care and puts you the patient's health at risk and our office at the risk for liability. We will not assume this risk, as we want to deliver the best healthcare possible. Initial_____
3. Please refer to our financial policy regarding insurance, payment, and scheduling protocols that we follow at our office. I am aware that this office is HIPPA compliant. Initial_____
4. Consent for Minors or Dependents: I hereby authorize Parkside Dental LLC to provide the necessary treatments for the patient listed below. The above general consent also applies to the listed minor/dependent as to procedure and protocols followed. Patient Name:_____ Signature of Parent/Guardian_____Date_____
5. I am aware and understand that not all of the above procedures mentioned may be necessary for my treatment. I am aware and understand that I will be made informed before any treatment is performed.
6. Occasionally Parkside Dental will take photos of our patients to display, use on our social media sites, or in printed material to promote our practice. I do not expect compensation, financial or otherwise, for the use of these photos. Please initial one of the following statements:

   _____I agree to allow my photo or my child's photo to be displayed by Parkside Dental LLC
   _____I do not allow my photo or my child's photo to be displayed by Parkside Dental LLC

Patient Signature_____Date_____

PARKSIDE
DENTAL

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (MM/DD/YR), and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.___ for each page, $___ per hour for staff time to copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Bailey Moneyhun

Telephone: 864-457-3901

E-Mail: lparksidedental@gmail.com

Address: 502 E Rutherford St. Landrum, SC 29356

PARKSIDE
DENTAL

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

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)

_____

_____

_____