BEAUFORT CENTER FOR DENTISTRY

1264 Ribaut Road, Ste. 401, Beaufort, SC 29902
Phone: (843) 524-7950 Fax: (843) 525-1151

Thank you for choosing Beaufort Center for Dentistry! We strive to provide you with the best dental care. To help us meet your needs, please fill out this form completely in ink. Your answers are for our records only and will be kept strictly confidential. If you have any questions or need assistance, please do not hesitate to ask a team member!

New Patient Registration Form

Prefix:____ First Name:_____ Middle Name:_____ Last Name_____ Suffix:___
Preferred Name:_____ Date of Birth: _____ SSN:_____
Driver's License Number: _____ Sex: ☐ Male ☐ Female
Marital Status: ☐ Single ☐ Married ☐ Partnership ☐ Separated ☐ Divorced ☐ Widowed

Mailing Address: _____
City_____ State _____ Zip_____
Home Phone: _____ Mobile Phone: _____
Employer: _____ Occupation: _____
Work Phone: _____
Email Address: _____ ☐ Consent for Digital Communications
Preferred Contact Method for Appointment Confirmation: ☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ Text ☐ Email
How did you learn about our practice? ☐ Google ☐ Facebook ☐ Yelp ☐ Mailer ☐ Word of Mouth/Friend
If you were referred by a friend, whom may we thank? _____

Responsible Party:
Are you the Responsible Party? ☐ Yes ☐ No ***If no, please fill out the information below.***
First Name: _____ Middle Name: _____ Last Name: _____
Preferred Name:_____ Date of Birth: _____ SSN:_____
Mailing Address: _____
City_____ State _____ Zip_____
Home Phone: _____ Cell Phone: _____
Email Address: _____
Relationship to patient:_____

Insurance Information:
Name of Insured: _____
Name of Insurance Carrier: _____ Member ID#:_____
Relationship to Insured: _____ Group#:_____
Insured SSN: _____ Insured Date of Birth: _____
Insured Employer: _____

Do you have secondary coverage? *If yes, please fill out the information below.*

Secondary Insurance Information:
Name of Insured: _____
Name of Insurance Carrier: _____ Member ID#:_____
Relationship to Insured: _____ Group#:_____
Insured SSN: _____ Insured Date of Birth: _____
Employer: _____

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Although dental personnel primarily treat the area in and around your mouth, your oral health and overall health are connected. Health problems that you may have, or medication that you may be taking, could have an impact on our approach to your dental treatment. Thank you for answering the following questions as completely and accurately as possible.

Medical History

Prefix:____ First Name:_____ Middle Name:_____ Last Name_____ Suffix: ___
Emergency Contact Name: _____Phone:_____
Preferred Pharmacy:_____ Pharmacy Number: _____

Are you under a physician's care now? ☐ Yes ☐ No
If yes, please include:
Physician's Name: _____
Physician's Phone Number:_____
Date of Last Physical:_____
Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No
If yes, please explain:_____
Have you ever had a serious head or neck injury? ☐ Yes ☐ No
If yes, please explain:_____
Are you taking any medication, pills, or prescription drugs? ☐ Yes ☐ No
If yes, please include:_____
Frequency:_____
Have you ever reacted adversely to any medications or injections? ☐ Yes ☐ No
Are you on a special diet? ☐ Yes ☐ No
Do you use tobacco? ☐ Yes ☐ No
If yes, ☐ smoking ☐ smokeless
Do you use controlled substances? ☐ Yes ☐ No

Women: Are you ☐ Pregnant or Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?
Are you allergic to any of the following? ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Sulfa ☐ Acrylic ☐ Metal ☐ Latex
☐ Oxycodone ☐ Local Anesthetics ☐ Other (Please specify)_____

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

☐ AIDS/HIV Positive	☐ Chest Pains	☐ Frequent Headaches	☐ Irregular Heartbeat
☐ Scarlet Fever	☐ Alzheimer's Disease	☐ Cold Sores/Fever Blisters	☐ Genital Herpes
☐ Kidney Problems	☐ Shingles	☐ Anaphylaxis	☐ Congenital Heart Disorder
☐ Glaucoma	☐ Leukemia	☐ Sickle Cell Disease	☐ Anemia
☐ Convulsions	☐ Hay Fever	☐ Liver Disease	☐ Sinus Trouble
☐ Angina	☐ Cortisone Medicine	☐ Heart Attack/Failure	☐ Low Blood Pressure
☐ Spina Bifida	☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur*
☐ Lung Disease	☐ Intestinal Disease	☐ Artificial Heart Valve*	☐ Drug Addiction
☐ Heart Pace Maker*	☐ Mitral Valve Prolapse*	☐ Stroke	☐ Artificial Joint*

☐ Easily Winded	☐ Heart Trouble/Disease	☐ Pain in Jaw Joints	☐ Swelling of Limbs
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Parathyroid Disease
☐ Thyroid Disease	☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A
☐ Psychiatric Care	☐ Tonsillitis	☐ Blood Transfusion	☐ Excessive Bleeding
☐ Hepatitis B or C	☐ Radiation Treatments	☐ Tuberculosis	☐ Breathing Problems
☐ Excessive Thirst	☐ Herpes	☐ Recent Weight Loss	☐ Tumors or Growths
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ High Blood Pressure	☐ Renal Dialysis
☐ Ulcers	☐ Cancer	☐ Frequent Cough	☐ Hives or Rash
☐ Rheumatic Fever*	☐ Venereal Disease	☐ Chemotherapy	☐ Frequent Diarrhea
☐ Hypoglycemia	☐ Rheumatism	☐ Yellow Jaundice	

Dental History

Please check any of the following that apply to you.

☐ Sensitivity (hot, cold, sweets, pressure)
☐ Tooth pain or discomfort when chewing
☐ Headaches, earaches, neck pain
☐ Grinding or clenching teeth
☐ Bleeding, swollen or irritated gums
☐ Loose, chipped or shifting teeth
☐ Teeth or fillings breaking
☐ Bad breath or bad taste in your mouth

Are you interested in having whiter teeth?
☐ Yes ☐ No ☐ I'd like to learn more!

If you could improve/enhance your smile, what would you be most interested in?
☐ Make my smile brighter
☐ Straighten my teeth
☐ Close spaces/gaps in my teeth
☐ Replace old fillings with "tooth colored" fillings
☐ Repair chipped teeth
☐ Replace missing teeth
☐ I would like a total smile makeover!

To the best of my knowledge, the questions answered on this form are complete and correct. I understand that it is my responsibility to inform the dental office of any changes in my medical status, or my minor's medical status. I understand that providing inaccurate or misleading information could be dangerous to my health.

Patient or Guardian Printed Name *Date*

Patient or Guardian Signature *Relationship to Patient*

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At Beaufort Center for Dentistry, we provide each patient with the best possible dental care. We understand that everyone's financial situation is different. For this reason, we have worked hard to provide a variety of payment options to help you receive the quality care needed to enjoy a healthy and confident smile.

Financial Policy

PAYMENT IN FULL
Full payment is required at the time of service from all patients that do not have insurance coverage.

DENTAL INSURANCE
We are happy to file the forms necessary to see that you receive the full benefits of your coverage. We cannot guarantee any estimated coverage. By signing this form, you understand and acknowledge the following as it relates to your insurance:

- I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.
- I authorize the dentist to release all information necessary to secure payment of benefits. I understand that I am financially responsible for all charges whether paid by insurance. Payment and/or insurance copays are due at the time of treatment unless prior arrangement have been made.

Because the insurance policy is an agreement between you and the insurance company, we ask that patients be directly responsible for all charges. If for any reason your insurance company has not paid their portion within 60 days from the start of treatment, you are responsible for payment at that time.

PAYMENT OPTIONS

- CASH OR CHECK: Checks returned for insufficient funds will be subject to a $35.00 service fee to cover bank fees incurred as a result.
- CREDIT CARDS: For your convenience, we accept payment by all major credit cards.
- PAYMENT PLANS: To make our services accessible to as many patients as possible, we accept third-party payment plans through CareCredit. These plans are like a credit card that is just for health and dental expenses, and patients can divide the cost of their care into equal monthly payments and pay very little to no interest.

PAST DUE BALANCES
A past due balance is any amount owed from a prior visit where insurance is not pending, or an insurance payment has not been received within 60 days. Any delinquent accounts are required to be paid in full before incurring any new charges. All future charges will need to be paid at the time services are rendered. Severely delinquent accounts will be assigned to a collection agency and a charge of 35% of the outstanding balance will be assessed to your account to cover the collection fees.

You have the right to a paper copy of this notice. You may ask us to give you a paper copy of the Notice at any time (even if you have agreed to receive the Notice electronically).

_____ _____
Patient or Guardian Printed Name *Date*

_____ _____
Patient or Guardian Signature *Relationship to Patient*

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Notice of Privacy Practices Acknowledgement

You may refuse to sign this.

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. These rights are more fully described in Beaufort Center for Dentistry's Notice of Privacy Practices. We are permitted to review our Notice of Privacy Practices at any time. We will provide you with a copy of the revised Notice of Privacy Practices upon your request.

By signing below, you are acknowledging that you understand and have reviewed a copy of Beaufort Center for Dentistry's Notice of Privacy Practices.

_____ _____

Patient or Guardian Printed Name *Date*

_____ _____

Patient or Guardian Signature *Relationship to Patient*

FOR OFFICE USE ONLY

An attempt to obtain written acknowledgement of Receipt of our Notice of Privacy Practices was attempted, however acknowledgement could not be obtained because:

☐ Individual refused to sign
☐ Communication barriers prohibited obtaining the acknowledgement
☐ Other. Please provide details below.

_____

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