Patient Information

Today's Date_____

Patient Name_____ **Preferred Name**_____

Parent Name (if minor)_____ **Married, Single, Other (please circle)**

Birth Date _____ **Preferred Phone #**_____

Social Security # _____ Secondary Phone #_____

Mailing Address_____ **Work Phone#** _____

City, State, Zip Code _____ **Email**_____

Emergency Contact Name_____ **Phone #**_____

Other Family Members Seen in office: Name_____

Employer_____ **General Dentist** _____

Pharmacy/Phone number_____

Insurance Information: ____provide card _____not covered by dental insurance

Dental Insurance Co. _____**Group #**_____ **ID#**_____

Insurance address_____

Insurance phone #_____

Covered by spouse/parent insurance –please provide subscriber info below
Name:_____**SSN**_____

Insured birthday_____ **Employer**_____

Dental Insurance _____**Group#**_____ **ID #**_____

Insurance company address:_____

Insurance phone #_____

Payment is due day of service

HEALTH HISTORY

Patient Name: _____ Date of Birth: _____ Today's Date: _____
Emergency Contact Name _____ Phone# _____
Family Physician: _____ Date of Last Visit: _____
Do you have a current medical problem or condition? If so, Condition: _____

1. Have you been hospitalized or have you had a serious illness or surgery within the last 5 years?
   If so, list with dates: _____
   _____
2. Do you have heart trouble or any form of cardiovascular disease? ☐ YES ☐ NO
3. Check (✓) past and present known conditions:

☐ Heart Surgery (Date _____)	☐ Angina/chest pains (Frequency _____)	☐ High Blood Pressure
☐ Prosthetic Heart Valve (Date _____)	☐ Heart Attack (Date _____)	☐ Stroke (Date _____)
☐ Bypass (Date _____)	☐ Heart Murmur	☐ Low Blood Pressure
☐ Angioplasty (Date _____)	☐ Mitral Valve Defect	☐ Atherosclerosis
☐ Pacemaker (Date _____)	☐ Congenital Heart Failure	☐ Other _____

4. Are you currently on blood thinning medication? ☐ YES ☐ NO List _____
5. Does a medical condition require you to take antibiotic premedication prior to dental procedures? ☐ YES ☐ NO
6. Do you now or have you ever taken medication for osteoporosis or bone cancer? ☐ YES ☐ NO List _____
7. Do you or have you ever had any of the following conditions? Check (✓) all that apply:

☐ Tuberculosis (Date _____)	☐ Epilepsy/Seizures	☐ Hepatitis (Type _____, Date _____)
☐ Liver Disease/ Jaundice	☐ Persistent Cough	☐ Fainting or Dizzy Spells
☐ Kidney Disease	☐ Emphysema/Asthma	☐ Arthritis
☐ Diabetes	☐ Glaucoma	☐ Chronic Head, Back, or Neck
☐ High Cholesterol	☐ Venereal disease	☐ Artificial Joint, limb, or implant (hip/knee)
☐ Sinus trouble/Hay Fever	☐ HIV AIDS or ARC	☐ Nervousness
☐ Hypo/Hyperthyroidism	☐ Psychiatric Treatment	☐ Cancer (Type) _____
☐ Stomach or intestinal ulcers	☐ Herpes	☐ Chemo/Radiation (Date _____)
☐ Prolonged Bleeding	☐ Drug Addiction	☐ Venereal disease (Gonorrhea, Syphilis)
☐ Anemia	☐ Cortisone Medicine	☐ Alcohol/Drug use
☐ Bruise Easily	☐ Blood transfusion	☐ Hearing or Vision Impaired
☐ Tobacco history → since age _____	Type(s) _____	☐ Other _____

Are you **ALLERGIC** to or have you had unusual reactions to any drugs/medications? ☐ YES ☐ NO
Explain:

8. **LATEX ALLERGY** ☐ YES ☐ NO
9. Have you had surgery, radiation or other treatments for a tumor or growth to head or neck? ☐ YES ☐ NO
   For women only:
10. Are you pregnant? ☐ YES ☐ NO how far along? _____ Are you currently on birth control pills? ☐ YES ☐ NO
11. **Please list any *current* medications (or provide list):**

I understand that the information that I have provided today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my personal or medical information.

Signature: _____ Date: _____

Anderson Periodontic Associates

Mark R. Baker, D.M.D

Thank you for choosing Anderson Periodontic Associates. We are dedicated to providing exemplary periodontal treatment and dental care.

In an effort to keep healthcare cost down while maintaining the highest level of quality and exceptional care, we have the following protocols in place:

Appointment Policy: All patients are seen by appointment only. Your scheduled appointment time is your confirmation. We go to great lengths to provide courtesy reminders for the appointments. We don't want you to forget about your appointment, but once you've scheduled with us, the responsibility is still yours to keep the appointment. Please be advised that we require at least 48 hours or **Two business days**' notice whenever an appointment needs to be changed. One of the reasons that we consistently run on time in our office is that we do NOT double book or over book our schedule. This allows us to give you the personalized high quality attention that you deserve. **You will be billed for NO SHOW appointments or appointments cancelled less than two business days' notice.** Please, remember we do not take cancellations after business hours.

Financial Policy: Payment is due in full at the time service is rendered. We accept checks, cash, debit, and credit cards (Visa , MasterCard and CareCredit). Our office does not accept dental insurance as a form of payment, but please read information below regarding dental insurance. For surgical procedures, a deposit will be required to schedule the appointment. Our cancellation policy will be reviewed at the time of your treatment consultation. There will be a $40 fee charged for each returned check due to insufficient funds.

Dental Insurance: Anderson Periodontic Associates is not a participating provider with any dental insurance plan and does not accept the amount dental insurance companies arbitrarily determine that is usual and customary. A dental claim will be sent on your behalf after each visit, directing the insurance to send the payment directly to you. By South Carolina law, your insurance has 30 days to respond to any claims submitted. May times, insurance companies request additional information such as dental records, x-rays, or narratives which can delay payment. Our office responds as soon as possible to those claims.

Medical Insurance: Our office is not equipped to file medical insurance, nor do we accept any medical insurance programs including medical or health insurance and Medicaid.

Medicare: Neither Anderson Periodontic Associates nor our Doctor(s) or Hygienist(s) are Medicare providers. We are not able to submit claims to Medicare or receive payment. You, as our patient, are not authorized to submit Medicare for any services rendered. This may affect your supplemental benefits as well.

Hippa: Please see our separate notification of privacy policy. This will describe how your personal information is protected by our office.

Patients under the age of 18 years must be accompanied by a parent or guardian.

By signing below, I acknowledge I have read, understand and agree to the above information provided by Anderson Periodontic Associates.

Patient Signature _____

Patient Name Printed _____ **Date** _____

Patient Consent Form

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name:_____ Signature: _____Date:_____

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule". We strive to achieve the highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that and event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients