New Patient Paperwork

Patient Information:

Patient Name: _____ DOB: _____
Home Address: _____
City: _____ State: _____ Zip Code: _____
Home #: _____ Cell #: _____
E-Mail: _____@_____._____
Would you like to receive text messages and/or emails as appointment reminders? Yes or No

Health Information:

Are you under a physician's care now? Yes or No
Have you ever been hospitalized or had a major operation? Yes or No
Have you ever had a serious head or neck injury? Yes or No
Are you taking any medications (prescriptions or over the counter)? Yes or No
Do you take, or have you taken, Phen-Fen or Redux? Yes or No
Have you taken Fosamax, Boniva, Actonel or any other medications?
containing bisphosphonates? Yes or No
Are you on a special diet? Yes or No
Do you use tobacco? Yes or No
Do you use controlled substances? Yes or No
Are you intolerant to any substances? If yes, _____ Yes or No
If yes to **ANY** of the above please explain:
_____

Are you allergic to any of the following?
Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa Drugs Other: _____
Women: Are you pregnant? Yes/No Are you nursing? Yes/No Taking contraceptives? Yes/No
Do you have any of the following? If so, **please circle**. If not, **please cross through them**.

AIDS/HIV Positive	Cortisone Medicine	Hepatitis A	Recent Weight Loss
Alzheimer's Disease	Diabetes	Hepatitis B or C	Recent Weight Gain
Anaphylaxis	Drug Addiction	Herpes	Renal Dialysis
Anemia	Easily Winded	High Blood Pressure	Rheumatic Fever
Angina	Emphysema	High Cholesterol	Rheumatism
Arthritis/Gout	Epilepsy or Seizures	Hives or Rash	Scarlet Fever
Artificial Heart Valve	Excessive Bleeding	Hypoglycemia	Shingles
Artificial Joint	Fainting Spells/Dizziness	Irregular Heartbeat	Sickle Cell Disease
Asthma	Frequent Cough	Kidney Problems	Sinus Trouble
Blood Disease	Frequent Diarrhea	Leukemia	Spina Bifida
Blood Transfusion	Frequent Headaches	Liver Disease	Stomach/Intestinal Disease
Breathing Problem	Genital Herpes	Low Blood Pressure	Stroke
Bruise Easily	Glaucoma	Lung Disease	Swelling of Limbs
Cancer	Hay Fever	Mitral Valve Prolapsed	Thyroid Disease
Chemotherapy	Heart Attack/Failure	Osteoporosis	Tonsillitis
Chest Pains	Heart Murmur	Pain in Jaw Joints	Tuberculosis
Cold Sores/Fever Blisters	Heart Pacemaker	Parathyroid Disease	Tumors or Growths
Congenital Heart Disorder	Heart Trouble/Disease	Psychiatric Care	Ulcers
Convulsions	Hemophilia	Radiation Treatment	Venereal Disease

If you answered **YES** to **ANY** of the above please explain: _____
_____

Insurance:

Employer: _____ Insurance Co.: _____
Subscriber Name: _____ Subscribers DOB: _____
Group #: _____ Subscriber ID/SS#: _____
*Please note that in an effort to be fully compliant with HIPPA and OSHA we will require a photo ID for the policy holder.
Patient (Guardian) Signature: _____ Date: _____

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

_____ _____

Please ***print*** name of Patient Please ***sign*** for Patient / Guardian of Patient

_____ _____

Legal Representative / Guardian Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents: _____

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

☐ First Name Only ☐ Proper Sir Name ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA- List phone #'s and Email associated with ways to contact you:

☐ Cell Phone Confirmation#_____ ☐ Text Message to my Cell Phone
☐ Home Phone Confirmation#_____
☐ Work Phone Confirmation#_____
☐ Email Confirmation/Address: _____
☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation ☐ Text Message to my Cell Phone
☐ Home Phone Confirmation ☐ Email Confirmation
☐ Work Phone Confirmation ☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

☐ Phone Message ☐ **Any of the Above**
☐ Text Message ☐ **None of the above** (opt out)
☐ Email

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment ____
I could not communicate with the patient ____
The patient refused to sign ____
The patient was unable to sign because ____
Other (please describe) ____

_____
Signature of Privacy Officer

Date: _____

Re: Records Transfer

To Whom It May Concern:

I, _____, authorize the office of:
(patient/guardian's name)

_____
_____
_____

to transfer records and x-rays for: _____ _____
(patient name) (patient DOB)

to:
Smiles By Design (Dr. BriAnna Schraw)
1096 Assembly Drive, Ste. #216
Fort Mill, SC 29708

Sincerely,

_____ _____
(Signature of Patient or Guardian) (Date Signed)

Note: For digital radiographs, please email: office@drschraw.com

New Patients: Many insurance companies have limitations on how frequently they will cover x-rays. Please note at your first visit with us, x-rays will be taken if we have not received them from your previous dentist. *

Smiles by Design
Dr. BriAnna Schraw, DMD PA
1096 Assembly Drive #216 Fort Mill, SC 29708
803-548-4899

Our goal is to provide and maintain an open line of communication between the office and our patients. We believe that informing you in advance of our office policies allows for a good flow of communication and enables us to achieve our goal and serve you better. *Please read each section carefully and initial, indicating you understand and agree to adhere to the policies.* If you have any questions, please do not hesitate to ask a member of our team.

Insurance:

- It is your responsibility to keep us updated with your correct insurance information. If the insurance company you designate is incorrect, you will be responsible for payment of the visit and to submit the charges to the correct plan for reimbursement.
- If we are unable to verify your insurance you will be responsible for the full fees on the date services are rendered. We will provide you with the necessary form to file on your own.
- Insurance companies reserve the right to "downgrade" services to an alternate treatment option. In the event this happens, it is the patient's responsibility to pay the difference.
- You have authorizes your insurance company to pay my dental benefits directly to my dental office.
- It is not our offices responsibility to check your insurance benefits.
- It is your responsibility to know your own Dental plan.

Co-Payments & Deductibles:

- Co-Payment estimates and deductibles are due at the time services are rendered. If you do not have your estimated portion, you will be asked to reschedule your appointment and may be responsible for a broken appointment fee.

Self-Pay:

- If you wish to be self-pay we will extend a 10% discount on all services rendered. This will not be extended on products or lab fees.
- We offer a special for your annual cleanings, exams and x-rays if you do not carry a private insurance plan. Please ask us about it.

Non-Covered Services:

- Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover. Patients are responsible for all non-covered services.
- Regardless of your insurance company, non-covered services will be the responsibility of the patient or guardian.

Accounts:

- Accounts with an outstanding balance may incur finance charges. This is a fee insurance will not cover.

- If account is not paid in a timely manner or payment arrangement is not made or honored, the account will be sent to our collections attorney where attorneys fees and court cost will be applied to the account. Fees may be up to $500.
- For scheduled appointments, prior balances must be paid before your next visit.

Appointments:

- Confirmation calls, text and emails are sent as a courtesy. We also ask for a 48 hour notice for appointments that need to be rescheduled or canceled. Due to the demand for certain appointment times we reserve the right to cancel your appointment if we do not hear back from you to confirm your appointment.
- Our business hours are Monday thru Thursday 7am till 3pm. Please call during business hours to cancel any appointments.
- **There is a $50 fee assessed for appointments not canceled within the 48 hour notice and for no shows.**

Records:

- Record transfers require the proper HIPAA forms be completed and 48 hour notice to send the records.
- We do request accounts be in good standing prior to completing the records release.

ID Requirements:

- To remain in compliance with HIPAA and the "Red Flag" Laws we do require a photo ID for all individuals and for the parent(s)/guardian(s) of all minors.

Treatment:

- Treatment plans are individually tailored, and are not based on your dental insurance benefits or lack of benefits.
- The undersigned hereby authorizes Smiles by Design to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by the provider to make a thorough diagnosis of the patient's dental needs. I also authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated.
- You understand a minor, anyone under the age of 18, must be accompanied by a parent/guardian for ALL dental visits.

By signing below I agree I have read, understand and agree to the above terms and conditions.

Patient Name: _____ Date: _____

Signature: _____ Date: _____

Witness: _____ Date: _____