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: __________

Authorization for Release of Information – Compound Release

Name of Patient____Date of Birth _______________

____ is authorized to release protected health information about the above-named patient in the following manner and/or to selected persons.

Check each person/entity approved to receive information.	Check type of information that can be given to person/entity on the left in the same section.
☐ Voice Mail	☐ x-rays ☐ Other___________________________
☐ Other person (s) (provide name and phone number)	☐ Financial ☐ Dental
☐ Email communication-Provide email address* _______________________________ *For email communication to occur, please accept the disclosure below:	☐ Financial ☐ Dental ☐ Appointment reminders ☐ Breach notification
☐ Text communication – Provide number * _______________________________ *For text communication to occur, accept the disclosure below:	☐ Appointment reminder ☐ Other: _______________________________
☐ For **email and/or text communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.	
☐ Photo of patient received by patient or legal guardian ☐ Photo taken by staff (Example: pre/post procedure) ☐ Other	☐ May be posted in office ☐ May be posted on website ☐ Other______________________________

Patient Rights:

- I have the right to revoke this authorization at any time by contacting our office.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

____ Date ____________________

Signature of Patient or Personal Representative

*Description of Personal Representative's Authority (attach necessary documentation)

Authorization to Release Health Information

Patient Information:

Name of Patient____Date of Birth ___________

Address____

City, State, Zip____Phone _________________

____ **may release the following information:**

(Name of the entity)

☐ Dental XRays ☐ Financial records

o Other as listed

Entity or person who will receive the information:

Name____

Address____

City, State, Zip____Phone _________________

o **Send the information electronically. Email address:** ___________________________________

o For **email communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to move forward to allow email communications to occur.

This authorization shall be in effect until the information has been forwarded as requested or until the course of treatment is complete.

Patient Rights:

- I have the right to revoke this authorization at any time by contacting our office.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I may refuse to sign this authorization and that my treatment will not be conditioned on signing.

____ Date ________________________

Signature of Patient or Personal Representative

____

Description of Personal Representative's Authority (attach necessary documentation)

Revised Jan 2018

Smiles by Design-1096 Assembly Drive, Suite 216-Fort Mill, SC 29708

Office (803)548-4899 Fax(803)548-6414 Email to: Mandi@drschraw.com

Smiles by Design-1096 Assembly Drive, Suite 216-Fort Mill, SC 29708

Acknowledgement of Receipt Of Notice of Privacy Practices

Patient Name & Address: ____

____

____

I have received a copy of the Notice of Privacy Practices for the above named practice.

___________________________________ ________________________

Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ❑ An emergency existed & a signature was not possible at the time.
- ❑ The individual refused to sign.
- ❑ A copy was mailed with a request for a signature by return mail.
- ❑ Unable to communicate with the patient for the following reason: ____
- ❑ Other: ____ ____

Prepared By ____

Signature ________________________ Date ________________

Consent for Release of Protected Health Information

I consent to the use and disclosure of my protected health information for treatment, payment and healthcare operations.

____ __________

Signature of Patient or Authorized Person Date

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: ____________