PORT ROYAL DENTISTRY

Welcome to our practice. Please take a moment to fill out all pages provided as completely as possible. This information will help ensure that our team is able to provide you with the highest level of care. If you have any questions, we will be glad to help you. We are honored you have chosen our practice, and we always welcome the referral of your family and friends.

PATIENT INFORMATION

DATE			
HOME PHONE		**CELL PHONE**	
NAME		**PREFERRED NAME**	
SSN		**BIRTH DATE**	
ADDRESS		**CITY, STATE, ZIP**	
EMAIL		**OCCUPATION**	
EMPLOYER/ SCHOOL		**EMPLOYER PHONE**	
EMERGENCY CONTACT NAME		**EMERGENCY CONTACT PHONE**	

DENTAL INSURANCE INFORMATION

PERSON RESPONSIBLE FOR ACCOUNT_____

RELATIONSHIP TO PATIENT_____ **BIRTH DATE** _____ **SSN**_____-_____-_____

ADDRESS IF DIFFERENT FROM PATIENT'S_____

EMPLOYER_____ **INSURANCE COMPANY**_____

CONTACT #_____ **GROUP #**_____ **SUBSCRIBER #**_____

DENTAL HISTORY

REASON FOR TODAY'S VISIT_____

FORMER DENTIST_____ **OFFICE NUMBER**_____

DATE OF LAST DENTAL CARE_____ **DATE OF LAST DENTAL X-RAYS**_____

DO YOU HAVE PROBLEMS WITH ANY OF THE FOLLOWING? _____ GRINDING TEETH _____ HOT/COLD SENSITIVITY

_____ BLEEDING GUMS _____ BROKEN FILLINGS _____ PAIN WITH BITING _____ SENSITIVITY TO SWEETS

_____ JAW PAIN OR CLICKING _____ BAD BREATH _____ LOOSE TEETH _____ SORE IN MOUTH

_____ FOOD COLLECTING BETWEEN TEETH

ARE YOU INTERESTED IN IMPROVING YOUR SMILE? _____

ARE YOU INTERESTED IN HAVING STRAIGHTER TEETH? _____

ARE YOU INTERESTED IN TEETH WHITENING? _____

HOW DID YOU HEAR ABOUT US?

☐ **GOOGLE** ☐ **FACEBOOK** ☐ **FRIEND** _____

☐ **OTHER** _____

Port Royal Dentistry Medical History Form

Although dental personnel primarily treat the area in and around the mouth, your mouth is a part of your entire body. Health problems that you have, or medications that you may be taking, could have an important interrelationship with the dentistry that you will receive. Thank you for taking the time to complete this form.

Patients Name (please print)**:**_____**Date of Birth:**_____ **Date:**_____

Are you under a Physician's care now? **Yes** or **No** **If Yes**; physician's name and last visit date: _____

- Are you currently taking any blood thinners? **Yes** or **No**
- Are you currently taking any osteoporosis medications? **Yes** or **No**
- Do you use tobacco products? **Yes** or **No**

Women: Are you.....

- Pregnant/Trying to get pregnant? **Yes** or **No** If **yes**; due date: _____
- If pregnant, please list OBGYN contact information: _____
- Nursing? **Yes** or **No**

ALLERGIES – Select all that apply:

Aspirin		Latex		Local Anesthetics	
Codeine		Penicillin		NSAIDS	
Erythromycin		Sulfa		Seasonal Allergies	

Please list any other allergies you have or N/A for no known allergies:_____

MEDICATIONS: Please list any medications (including vitamins/supplements) you are currently taking. Please provide list if greater than space provided.

MEDICAL CONDITIONS: Check all that apply

- ❑ Anemia
- ❑ Angina
- ❑ Artificial Heart Valve
- ❑ Blood Disease
- ❑ Congenital Heart Defect
- ❑ Heart Attack, if so, when?_____
- ❑ Heart Condition
- ❑ Heart Murmur
- ❑ Heart Surgery
- ❑ Hemophilia
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Irregular Heart Beat
- ❑ Leukemia
- ❑ Low Blood Pressure
- ❑ Mitral Valve Prolapse, if so, with or without regurgitation_____
- ❑ Pacemaker
- ❑ Rheumatic Fever
- ❑ Stents
- ❑ Stroke, if so, when?_____
- ❑ Acid Reflux
- ❑ Gastrointestinal Disease
- ❑ GERD
- ❑ Stomach Ulcers
- ❑ AIDS
- ❑ Arthritis
- ❑ Cancer, if yes. List type_____
- ❑ Chemotherapy, if so, when?_____
- ❑ Radiation, if so, when?_____
- ❑ Herpes
- ❑ HIV Positive
- ❑ HPV
- ❑ Rheumatism
- ❑ Scarlet Fever
- ❑ STD
- ❑ Tumors/Growths
- ❑ Diabetes
- ❑ Thyroid Problem
- ❑ Cirrhosis
- ❑ Hep A/B/C
- ❑ Jaundice
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Asthma
- ❑ Bronchitis
- ❑ COPD
- ❑ Emphysema
- ❑ Mouth Breathing
- ❑ Respiratory Problems
- ❑ Sinus Problems
- ❑ Sleep Apnea
- ❑ Snoring
- ❑ Tuberculosis
- ❑ Use Inhaler
- ❑ Asperger's
- ❑ Autism
- ❑ Cerebral Palsy
- ❑ Dizzy/Fainting
- ❑ Epilepsy/Seizures
- ❑ Nervous Disorder
- ❑ Artificial Joints
- ❑ Osteoporosis
- ❑ Detached Retina
- ❑ Glaucoma

Please list any other medical conditions you may have:_____

***Consent**: To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in medical status.*

_____ _____

Patient**'s Signature: (parent if minor)** **Date:**

Port Royal Dentistry
1869 North Paris Ave.
Port Royal, SC 29935
843.521.1869.

Dental Disclosure Form

I, _____, (Print Name) give authorization to Dr. Peipei Yu and/or Port Royal Dentistry staff to release and discuss my dental information with the following:

e.g. Relative or/and friend

1. **Name:** _____ **Relationship to Patient:**_____

   Contact Number: _____

2. **Name:** _____ **Relationship to Patient**:_____

   Contact Number: _____

3. **Name:** _____ **Relationship to Patient**:_____

   Contact Number: _____

_____ _____

Signature **Date**

PORT ROYAL DENTISTRY

Thank you for choosing our practice to provide for your dental health care needs. We are committed to delivering excellent service to our patients, and a part of that includes thoroughly explaining our financial, insurance, and cancellation policies. We would not be where we are without our patients!

Financial Policy

**All payments, and/or insurance co-payments, are due at the time of service

We accept the following form of payment options that would be most convenient to you:

- Cash
- Check - Any insufficient funds or returned checks will be subject to additional fees
- Visa, MasterCard, American Express or Discover
- CareCredit - Authorization required

*Should we be unable to collect an outstanding balance on your account, your account may be turned over to an outside collection agency. In this event, a fee will be added to your account to cover the expense of such collection efforts.

Insurance Policy

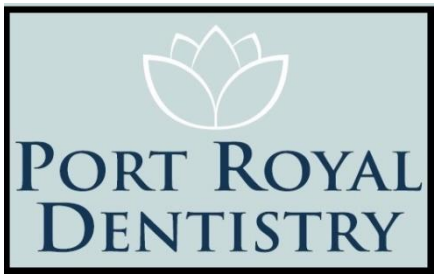
Dental benefits are meant to assist you with paying for dental treatment and are not meant to cover services in full.

As a courtesy, we will submit your dental claim to your insurance company. You are responsible for providing current and accurate information before your first appointment. Any changes to dental benefits should be given to our office staff, prior to your next appointment. We will ask for all co-payments on the day of treatment.

Verification of insurance is done as a courtesy to our patients. However, it is the **patient's responsibility** to contact insurance to obtain a full benefit breakdown, network status and coverage.

**I have read the above policies in their entirety. I understand and agree to abide by all aspects of the above policies. Any questions I may have had regarding these polices have been answered to my satisfaction.

Patient Signature: _____ Date ____/____/____



1869 North Paris Avenue
Port Royal, SC 29935
843.521.1869

Information and Records Release Authorization

I, _____, hereby authorize you to release the information contained within my dental records, including x-rays, medications prescribed, tests administered and their results, and information regarding my medical and dental histories to:

Address:
Port Royal Dentistry
1869 North Paris Avenue
Port Royal, SC 29935

Email:
office@portroyaldentistrysc.com

Phone Number:
843.521.1869

Fax Number:
843.521.1865

This authorization is limited to release of information to the individual or organization named above and to no others.

Specific Information Requested: ____ X-rays ____ Clinical Charting ____ Treatment Notes

Reason for Request: ____ Second Opinion ____ Transfer

Patient's name (printed)_____ D.O.B: _____ /_____ /_____

Patient Signature: _____ Date: _____ /_____ /_____

PORT ROYAL DENTISTRY

Broken Appointment Policy

When we make your appointment, we are reserving a room for your particular needs. We ask that if you must change an appointment, please give us at least 48 hours notice. This courtesy makes it possible to give your reserved room to another patient who would like it.

There is a 50.00 charge for no shows or cancellations less than 48 hours prior to scheduled appointments. This fee is not billable to your insurance company and should be paid prior to scheduling another appointment

We feel that your time is valuable and appreciate the confidence you place in our practice. When your appointment is made, a room is reserved, your records are prepared, and special instruments are readied for your visit.

_____ _____

Patient Signature Date

PORT ROYAL DENTISTRY

General Dental Treatment

I authorize dental treatment including necessary or advisable examination, radiographs (x-rays), diagnostic aids or local anesthesia.

In general terms, dental treatment may include but is not limited to one or a number of the following: examinations, oral prophylaxes (cleanings), fluoride treatments, sealants, dental restorations (fillings, fixed restorations), periodontal (gum) treatments, endodontic (root canal) treatments, extractions, and the use of local anesthetics. I understand that the use of local anesthetics carries a small risk for swelling, bruising, allergic reaction, changes in pain perception, or prolonged anesthesia. This consent shall be considered in effect until rescinded or revoked.

If needed, I elect to have a bonded, tooth-colored filling placed to fix my tooth. I understand that my insurance company may not provide for this service, or may only provide a partial payment for this service. I understand that payment of the entire fee for this treatment is my responsibility.

I agree to have digital photographs taken of me and/or my teeth for the purposes of documentation, lab communication and case presentation. Photos may be taken before, during and/or after my dental procedures and may be displayed in an album or on the practice website. The photos may be presented to other patients as a representation of the dental work completed by Dr. Yu. I understand that no identifying information about me will be displayed, and that my confidentiality will be maintained at all times.

Upon such diagnosis, I authorize Dr. Yu or the designated staff person to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required while providing proper care.

I understand that payment in full, and/or any insurance co-payments, are due at the time of service, unless other financial arrangements have been made in advance. I also understand that I am fully responsible for paying any outstanding balance if my insurance company has not provided payment to Port Royal Dentistry within 45 days of the date of service. I agree to assign to Port Royal Dentistry all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. Port Royal Dentistry may use my health care information and may disclose such information to my dental insurance company for the purposes of obtaining payment for services and for determining insurance benefits.

Risk of Dental Procedures in General

Included (but not limited to) are complications resulting from the use of dental instruments, drugs, medicines, analgesics (pain killers), anesthetics and injections. These complications include pain, infection, swelling, bleeding, sensitivity, numbness and tingling sensations in the lip, tongue, chin, gums, cheeks and teeth. Thrombophlebitis (inflammation to a vein), reaction to injections, change in occlusion (biting), muscle cramps and spasms. Temporomandibular jaw (TMJ) joint difficulty, loosening of teeth or restoration in teeth, injury to other tissues. Referred pain to the ear, neck and head, nausea, allergic reactions, itching, bruises, delayed healing, sinus complications and further surgery. Medication and drugs may cause drowsiness and lack of awareness and coordination (which can be influenced by the use of alcohol or other drugs), thus it is advisable not to operate any vehicle or hazardous device, or work for twenty-four hours or until recovered from their effects.

Changes in Treatment Plan

I understand that during treatment, it may be necessary to change and/or add procedures because of conditions found while working on the teeth that were not discovered during examination. Upon my consent, I will give me permission to the dentist to make any/all changes and additions as necessary. Fillings I understand that I may experience hot and cold sensitivity, pain or discomfort following routine restorative procedures and that this is usually temporary and should settle without further treatment. If in the event that my condition does not get any better, I understand that I may need further dental treatment, the most common being root canal therapy, resulting in additional costs. Alternative Treatment I understand that I have the right to choose, on the basis of adequate information, from alternate treatment plans that meet professional standards of care. Receipt of Notice of Privacy Practices My signature below acknowledges that I have received a copy of the Notice of Privacy Practices for this office.

By signing below, I consent to the general treatments and/or proposed treatment.

Patient/Guardian Signature: _____

Patient Name (Printed):_____

Date: _____