Carolina Dental DOCS

First Name: _____ Last Name: _____

Date of Birth: ___/____/_____ Gender: M or F Social Security Number: _____

Mailing Address: _____ APT: _____

City: _____ State:_____ Zip:_____

Home Phone: _____ Cell Phone:_____

How did you hear about us? _____

Responsible Party (Only Complete if someone other than patient)

First Name: _____ Last Name: _____DOB:_____

Mailing Address: _____

City: _____ State:_____ Zip:_____

Home Phone: _____ Cell Phone: _____

Email: _____

Insurance Information (If patient has private insurance other than Medicaid)

Name of Insured: _____

Relationship to Insured: _____ Policy/medicaid Number: _____

Insured SSN: _____ Insured Date of Birth: _____

Insured Employer: _____

Insurance Name: _____

PLEASE LET OUR PATIENT COORDINATOR KNOW IF YOU HAVE SECONDARY COVERAGE

Emergency Contact Name and Phone Number:

_____

Carolina Dental Docs

Date 3/12/2018

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Name of primary care doctor? ----------

Have you ever been hospitalized or had a major operation?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Are you taking any medications, pills, or drugs?	Yes No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Are you on a special diet?	Yes No	
Do you use tobacco?	Yes No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

Do you use controlled substances? Yes No If yes

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

AIDS/HIV Positive Yes No	Cortisone Medicine Yes No	Hemophilia Yes No	Radiation Treatments Yes No
Alzheimer's Disease Yes No	Diabetes Yes No	Hepatitis A Yes No	Recent Weight Loss Yes No
Anaphylaxis Yes No	Drug Addiction Yes No	Hepatitis B or C Yes No	Renal Dialysis Yes No
Anemia Yes No	Easily Winded Yes No	Herpes Yes No	Rheumatic Fever Yes No
Angina Yes No	Emphysema Yes No	High Blood Pressure Yes No	Rheumatism Yes No
Arthritis/Gout Yes No	Epilepsy or Seizures Yes No	High Cholesterol Yes No	Scarlet Fever Yes No
Artificial Heart Valve Yes No	Excessive Bleeding Yes No	Hives or Rash Yes No	Shingles Yes No
Artificial Joint Yes No	Excessive Thirst Yes No	Hypoglycemia Yes No	Sickle Cell Disease Yes No
Asthma Yes No	Fainting Spells/Dizziness Yes No	Irregular Heartbeat Yes No	Sinus Trouble Yes No
Blood Disease Yes No	Frequent Cough Yes No	Kidney Problems Yes No	Spina Bifida Yes No
Blood Transfusion Yes No	Frequent Diarrhea Yes No	Leukemia Yes No	Stomach/Intestinal Disease Yes No
Breathing Problems Yes No	Frequent Headaches Yes No	Liver Disease Yes No	Stroke Yes No
Bruise Easily Yes No	Genital Herpes Yes No	Low Blood Pressure Yes No	Swelling of Limbs Yes No
Cancer Yes No	Glaucoma Yes No	Lung Disease Yes No	Thyroid Disease Yes No
Chemotherapy Yes No	Hay Fever Yes No	Mitral Valve Prolapse Yes No	Tonsillitis Yes No
Chest Pains Yes No	Heart Attack/Failure Yes No	Osteoporosis Yes No	Tuberculosis Yes No
Cold Sores/Fever Blisters Yes No	Heart Murmur Yes No	Pain in Jaw Joints Yes No	Tumors or Growths Yes No
Congenital Heart Disorder Yes No	Heart Pacemaker Yes No	Parathyroid Disease Yes No	Ulcers Yes No
Convulsions Yes No	Heart Trouble/Disease Yes No	Psychiatric Care Yes No	Venereal Disease Yes No
			Yellow Jaundice Yes No

Have you ever had any serious illness not listed Yes No If yes

Comments:

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 (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You may refuse to sign This Acknowledgement****

I, _____ have received a copy of this office's Notice of Privacy Practice.

_____
(Please Print Name)

_____
(Signature)

_____
(Date)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An Emergency situation prevented us from obtaining the acknowledgement
- ☐ Other (Please Specify)

Carolina Dental DOCS

HIPAA Communication Permissions

By law, without your authorization, we are unable to communicate with your spouse, adult children, caregivers, or parents if you are over 18.

We will need your permission to communicate with your family or caregivers in the following circumstances:

1. Making appointments
2. Confirming appointments
3. Discussing treatment needed or performed
4. Account or Financial information

Please indicate below the names of people and their relationship to you, who we may communicate with and what information we are allowed to communicate:

Person 1: _____

☐Appointments ☐Dental/Health/Treatment ☐Account/Financial

Person 2: _____

☐Appointments ☐Dental/Health/Treatment ☐Account/Financial

☐ **I do not wish to allow my information to be shared with anyone including my spouse or other family member and/or guardian.**

Please select your preferred methods of communication:

☐ You may contact me at my home telephone number: _____

☐ You may contact me at my mobile telephone number: _____

☐ You may text my mobile telephone number.

☐ You may contact me at my work telephone number: _____

☐ You may send me an *unencrypted* email at: _____

Printed Name: _____ Date: _____

Patient/Legal Guardian Signature: _____

Columbia
2302 Bush River Rd.
Columbia, SC 29210
Ph: 803-798-875

Spartanburg
1460 John B White SR Blvd
Spartanburg, SC 29306
Ph: 864-641-0495

Blacksburg
305 W. Pine Street
Blacksburg, SC 29646
Ph: 864-839-0034

www.carolinadentaldocs.com

Dental Permission Slip

Carolina Dental Docs is a dental office/mobile unit specializing in youth dental health. We have a full staff of extremely qualified dental professionals that are trained to handle each child with exceptional care. We currently have four locations to suit your child's dental needs. We see children in our office/mobile unit from ages of 0 to 20 and accept Medicaid as well as most major insurances.

Your facility has allowed us to come perform dental exams, cleanings, x-rays and fluoride treatments. We want your child to be as comfortable as possible in the dental office/ mobile unit and to prevent or calm any fear they may have. We want to assure them that the dentist is their friend and is there to help them.

The dental exam will be performed by a Licensed Dentist, the cleaning and fluoride will be performed by a licensed Dental Hygienist and Assistant. Once the dental exam is performed on your child, we will send home a form explaining what we found and if any other services are needed. Please complete the permission slip at the bottom of this page and return it to your child's facility, our conveniently located offices are available for follow-up on your child if additional treatment is required, or we can refer to your normal family dentist. We look forward to seeing your child soon!

( )I DO / ( ) I DO NOT give permission for Carolina Dental Docs to perform a dental exam and cleaning along with any other necessary 6 month treatment such as x-rays, fluoride treatment, etc. on my child.

Child's Name (Print): _____Child's DOB: _____

Parent Name or Legal Guardian (Print): _____

Parent or Legal Guardian's Signature:_____Date:_____

Photo Release Form

Permission to use Photograph

Event: Routine Dental Appointment

Location: Carolina Dental Docs

I grant Carolina Dental Docs, the right to take photographs of me and my family in connection with the above-identified event. I authorize Carolina Dental Docs, its assigns and transferees to copyright, use and publish the same in print and or electronically.

I agree that Carolina Dental Docs may use such photographs of me with or without my name and for any lawful purpose, including for examples such purposes as publicity, illustration, advertising, and web content.

This consent will be upheld indefinitely until revoked in writing.

I have read and understand the above:

Patient Name:_____

Signature: _____

Print name: _____

Date: _____

☐ **By checking here I am REFUSING to give permission to have my child's picture taken and posted anywhere in association with CDD.**