NEW PATIENT FORM

3026 FARROW ROAD
COLUMBIA, SC 29203
WWW.DAVISANDDINGLE.COM

HOW DID YOU HEAR ABOUT US:

INTERNET RADIO YELLOW PAGES WORK SCHOOL PAPER

PERSON(PLEASE NAME)______________________________

CONSENT FOR SERVICES

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon the reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental service, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients' insurance forms or assist in making collections from insurance companies and will credit any such collections to the patients account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that the fee estimate listed for this dental care can only be extended for a period of three months from the date of the patient examination. In consideration for the professional services rendered to me or at my request by my doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee at the time said services are rendered. I grant my permission to you or your assignee to telephone me at home/cell or at my work to discuss matters related to this form

PATIENT INFORMATION

PATIENTS NAME: LAST______________________________ FIRST______________________________ MI_________

GENDER (CHECK ONE)**:** FEMALE MALE

MARITAL STATUS (CHECK ONE)**:** MARRIED SINGLE CHILD OTHER

BIRTHDATE:______________________ **SOCIAL SECURITY NUMBER:**______________________

ADDRESS: STREET____ APT#_____________

CITY________________________________ STATE:____________ ZIP:____________

EMAIL ADDRESS:____

PHONE:(HOME/CELL)_______________ (WORK) __________________ EXT:_____ BEST TIME TO CALL:________

HEALTH INFORMATION

AIDS/HIV
ALLERGIES
____
BLOOD THINNER
ANEMIA
ARTHRITIS
ARTIFICIAL JOINTS D ASTHMA
BLOOD DISEASE D CANCER
DIABETES
DIZZINESS
EXCESSIVE BLEEDING
FAINTING
GLAUCOMA
GROWTHS

HAY FEVER
HEAD INJURIES
HEART DISEASE
HEART MURMUR
HEPATITIS
HIGH BLOOD PRESSURE
JAUNDICE
KIDNEY DISEASE
LIVER DISEASE
MENTAL DISORDERS
PACEMAKER
CURRENTLY PREGNANT:
DUE DATE ____________
RADIATION TREATMENT

RESPIRATORY PROBLEMS
RHEUMATIC FEVER
RHEUMATISM
SINUS PROBLEMS
STOMACH PROBLEMS
STROKE
TUBERCULOSIS
TUMORS
ULCERS
VENEREAL DISEASE
CODEINE ALLERGY
PENICILLIN ALLERGY
OTHER:
____

DAVIS & DINGLE
FAMILY DENTISTRY

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Have you ever had any complications following dental treatment? Yes No

If yes, please explain ____

Have you been admitted to a hospital or needed emergency care during these past two years? Yes No

If yes, please explain____

Are you now under the care of a physician? Yes No

If yes, please explain____

List any medication you are taking (include non-prescription medications):

____

____

____

____

To the best of my knowledge, all the preceding answers and information are true and correct. If I ever have any change in my health I will inform the doctors at the next appointment without fail.

____ ________________________________
SIGNATURE OF PATIENT, PARENT OR GUARDIAN DATE

RESPONSIBILITY INFORMATION

THE FOLLOWING IS FOR: THE PATIENT'S SPOUSE THE PERSON RESPONSIBLE FOR PAYMENT

NAME: LAST______________________________ FIRST______________________________ MI_________

GENDER (CHECK ONE)**:** FEMALE MALE

MARITAL STATUS (CHECK ONE)**:** MARRIED SINGLE CHILD OTHER

BIRTHDATE:______________________ **SOCIAL SECURITY NUMBER:**______________________

ADDRESS: STREET____ APT#_____________

CITY________________________________ STATE:____________ ZIP:____________

EMAIL ADDRESS:____

PHONE:(HOME/CELL)_______________ (WORK) __________________ EXT:_____ BEST TIME TO CALL:________

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EMPLOYEMENT INFORMATION

THE FOLLOWING IS FOR: THE PATIENT'S SPOUSE THE PERSON RESPONSIBLE FOR PAYMENT

EMPLOYER'S NAME:________________________________

OCCUPATION: ________________________________

ADDRESS: STREET____________________________

CITY________________ STATE:______ ZIP:______

INSURANCE INFORMATION

NAME OF INSURED:________________________________

IS INSURED A PATIENT: YES NO **INSURED BIRTHDAY:**__________ **ID#:**__________

GROUP#:__________ **INSURED ADDRESS:**________________________

APT#______ CITY:________________ STATE:______ ZIP:______

INSURED EMPLOYER'S NAME:________________________________

EMPLOYER'S ADDRESS: STREET:____________________________

CITY:________________ STATE:______ ZIP:______

PATIENTS RELATIONSHIP TO INSURED: SELF SPOUSE CHILD OTHER

INSURANCE PLAN NAME AND ADDRESS:____________________________

PHONE:(HOME/CELL)________ (WORK) ________ EXT:___ BEST TIME TO CALL:______

SECONDARY **NAME OF INSURED:**________________________________

IS INSURED A PATIENT: YES NO **INSURED BIRTHDAY:**__________ **ID#:**__________

GROUP#:__________ **INSURED ADDRESS:**________________________

APT#______ CITY________________ STATE:______ ZIP:______

INSURED EMPLOYER'S NAME:________________________________

EMPLOYER'S ADDRESS: STREET:____________________________

CITY:________________ STATE:______ ZIP:______

PATIENTS RELATIONSHIP TO INSURED: SELF SPOUSE CHILD OTHER

INSURANCE PLAN NAME AND ADDRESS:____________________________

To the best of my knowledge, all the preceding answers and information are true and correct. If I ever have any change in my health I will inform the doctors at the next appointment without fail.

____________________________ ________________

SIGNATURE OF PATIENT, PARENT OR GUARDIAN DATE

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PATIENT DENTAL HISTORY

Are your teeth Sensitive to:

Yes **No** Heat?

Yes **No** Cold?

Yes **No** Sweets?

Yes **No** Biting Pressure?

Yes **No** Does food constantly get stuck between certain teeth?

Yes **No** Do you get frustrated because you always have something to be treated or repaired when you visit a dentist?

Yes **No** Are you dissatisfied with your teeth in any way?

Yes **No** Are you dissatisfied with the way your teeth look? i.e. color, shape, spaces, etc.

Yes **No** Do you have any fillings that show in your front teeth?

Yes **No** Do any of your fillings show when you smile?

Yes **No** If any of your mercury amalgam fillings need replacement, would you prefer to have a more natural, tooth-colored restoration instead?

Yes **No** Have you ever had any teeth removed? (If yes, how long have these teeth been missing?)

Yes **No** Do your gums bleed when brushing?

Yes **No** Do you ever avoid any part of the mouth while brushing?

Yes **No** Do you have an unpleasant taste or odor in your mouth?

Yes **No** Do you smoke?

Yes **No** How often do you floss?

Yes **No** Have you been instructed regarding proper home care?

Remarks or concerns?(Explain)____

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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 Practices.

Please Print Name: ____

Signature: ____

Date: __________________________

MISSED APPOINTMENT POLICY

We are delighted you have chosen Davis and Dingle Family Dentistry to provide you and/or your family's dental care and we want to ensure that you are getting the best care possible. This is why it is so important to keep your scheduled appointments.

Effective December 2016, our missed appointment fee is $50.00. This fee is not covered by insurance.

A missed appointment is when you fail to show up for a scheduled appointment or when you fail to notify us of the cancellation with less than 48 hours' notice. When you miss your appointment, you compromise your care, and prevent other patients from being seen who are waiting for an open appointment.

The doctor/patient relationship is built on mutual trust and respect. As a courtesy, we make every effort to contact you 2 weeks to 48 hours prior to your scheduled appointment time. We ask that you call (803) 255-0200, and speak with one of our staff members, or send an e-mail to, customerservice@davisanddingle.com.

We appreciate your understanding of the need for this policy.

____ ________________________________
SIGNATURE OF PATIENT, PARENT OR GUARDIAN 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 acknowledgement
- Other (Please specify)

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