TYLAN CREEK FAMILY DENTISTRY

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PATIENT INFORMATION:

Name: _____Preferred Name _____

Address: _____ City & Zip: _____

SS#_____ -_____ -_____ Birthday: _____/_____/_____ Sex: _____

Marital Status: Single Married Divorced Widowed

Place of Employment: _____

Phone: _____ Cell: _____ E-mail: _____

We confirm through electronic emails and texts prior to making phone calls. Please check any/all boxes that you would like to receive confirmation reminders: ***text*** ☐ ***email*** ☐

Responsible Party **(if minor)**: _____ Relationship to Patient: _____

In Case of Emergency (closest relative or friend):

Name: _____ *Phone:* _____

Ins. Policy Holder Information:

Dental Ins. Co. _____ Policy #_____

Employer: _____

Name of Policyholder **(if different from above)**: _____

Address: _____ City & Zip: _____

Phone: _____ Cell: _____ E-Mail:_____

SS# _____ -_____ -_____ Birthday: _____/_____/_____

Whom may we thank for referring you to our office? _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body.

Are you under a physician's care now?	**Yes**	**No**	**If yes:**
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 medications, pills, or drugs?	**Yes**	**No**	**If yes:**
Do you take, or have 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**	**If yes:**
Do you use tobacco?	**Yes**	**No**	**If yes:**
Do you use a controlled substance?	**Yes**	**No**	**If yes:**
Have you ever been told you need to premedicate prior to dental procedures?	**Yes**	**No**	**If yes:**

Women: Are you…… **Taking oral contraceptives** **Pregnant** **Nursing** **Trying to get pregnant**

Are you allergic to any of the following? **Aspirin** **Penicillin** **Codeine** **Acrylic**

Metal **Latex** **Sulfa Drugs** **Local Anesthetic**

Any Allergy not listed? **Yes** **No** **If yes:**

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

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

Have you ever had any serious illness not listed above? Yes No If yes: _____

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: _____ Date:_____

Tylan Creek Family Dentistry Powdersville
2710 Highway 153
Piedmont, SC 29673

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice is available upon request.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of privacy Practices, which will contain the changes. Those changes may apply to any or your protected information that we maintain.

You may obtain copy or our Notice of Privacy Practices, including any revisions of our Notice at any time by contacting:

Telephone: (864) 603-2200
Address: 153 Hwy 153 Piedmont SC 29673

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contract Person listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____Date: _____

CONSENT TO TREAT

Patient's Name: _____ DOB: _____

I give consent for myself/child to receive dental treatment deemed necessary by the providers at Tylan Creek Family Dentistry. These procedures include, but are not limited to; examinations, oral prophylaxis (cleanings), fluoride treatments, sealants, restorations (amalgam or composite fillings and crowns), periodontal (gum) treatments, endodontic (root canal) treatments, extractions, and the use of local anesthetics and nitrous oxide (upon request). I understand that the use of local anesthetics carries a small risk of swelling, bruising, allergic reaction, changes in pain perception, or prolonged anesthesia. This consent shall be considered in effect until rescinded or revoked.

_____	_____	_____	_____
(Printed Name)	(Signature)	(Relationship)	(Date)

YOU ARE ENTITILED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT

RELEASE OF INFORMATION

The following individuals are authorized to obtain information in regards to my medical information (including, but not limited to, treatment given and/or diagnosed, account information, and scheduled appointments. This signed release shall be considered in effect until rescinded or revoked. If the patient is a minor, parents will need to list themselves as well.

_____	_____	_____
Name	Relationship to Patient	Date
_____	_____	_____
Name	Relationship to Patient	Date

Financial Arrangement

While we understand that it is often uncomfortable to discuss payment for our services, it is essential that our patients are aware of associated fees and various options of payment that are available. *It is important to understand that our primary concern is our relationship with our patients, not their insurance companies.* We feel strongly that our use of the finest procedures, combined with extensively trained staff members, allows us to provide the highest level of care available anywhere in the country. Fortunately, our practice offers several payment options that make this highest level of care affordable for everyone.

1. **Pay in Advance**-It is certainly preferred for full payment to be made prior to the time services are rendered. If restorative services are proposed at your appointment, we offer an 8% courtesy fee reduction for payment made at time of proposal. In exchange for offering this discount, we ask that you pledge to keep your scheduled appointment. If you do not provide us with at least 48 hours' notice of cancellation or rescheduling of appointment, the 8% discount will be nullified.

2. **Pay over Time-** If you choose not to take advantage of the discounted option, we can help make arrangements for you to make regular monthly payments. Such payments can be stretched out over a 6 to 12-month period, interest free. All it takes is a quick credit application which we process here in our office.

3. **Pay at Time Services Are Rendered**- If you have insurance, we will collect payment of your estimated portion at the time services are rendered and will accept assignment of benefits from your insurance company to cover the balance. You will, of course, be responsible for paying any balance that may remain after your insurance claim is settled.

   We file insurance as a courtesy to our patients. Please be aware that some, or perhaps all of the services provided may be non-covered services and not considered reasonable and usual by your insurance company. Also, some insurance companies will deny receipt of your claim. We recommend that you follow-up with your insurance company within the next 14 days and advise us if there is a problem. Additionally, some insurance companies will request additional information such as dental records, x-rays, etc., which usually delays payment. We respond to each request as quickly as we reasonably can. We ask that you do the same if your insurance company is requesting information directly from you. If for any reason we have not received payment from your insurance company within 90 days, you will be responsible for paying the existing balance immediately and any future payments by the company will go directly to you.

   ***Some Delta Dental Insurance Policies will not pay the provider directly and full payment must be made before services are rendered. We will still file your claim for you however the insurance payment is sent directly to the Policy Holder**.

   ***Return checks will be subject to a $30.00 returned check charge and any other collection fees that may be incurred**

WARRANTY INFORMATION

We believe in our work and want you the patient to believe in it as well. Therefore, we offer a warranty on all work we do*.

- Fillings & Sealants are under warranty for one (1) year.
- Crowns, Root Canals & Bridges are under warranty for three (3) years.
- CEREC Restorations are under warranty for three (3) years.
- Dentures are under warranty for one (1) year from seat date.
- Partials are under warranty for two (2) years from seat date. This does not include temporary partials.

* Warranty is only valid if patient continues on six (6) month recall appointments (for denture placement the patient must come in for six (6) month periodic oral evaluations). We monitor the progress/condition of all work done at these appointments, as well as your overall health and oral hygiene. It is important to realize that even the best restoration will fail if optimal gum health is not maintained. Warranty includes replacement at no charge or amount charged for original work credited towards other work that might need to be done.

APPOINTMENT AGREEMENT

At Tylan Creek Family Dentistry, we pride ourselves in respecting our patients' busy schedules and on completing their scheduled treatment in a timely manner. You will always be seated within 10 minutes of your scheduled arrival and you will always be dismissed by your scheduled completion time. We spend hours every month refining ways to ensure that your scheduled time with us will never cause disruption in the remainder of your daily schedule. We take this task seriously, and that is why our patients have never had lengthy waits and never will. We have discovered that in nearly every single instance that we have failed in this commitment, it is due to a patient failing to show up for scheduled treatment without giving us 48 hours' notice. The result is a scramble to work someone into a time slot, whose needs don't quite fit with the time and resources allotted. We consider our appointment time to be a verbal contract. We require you to give us 48 hours' notice of any changes to this contract. Doing so will allow us to get in another patient whose needs precisely fit into that available schedule slot, and prevent that time from being permanently lost. That way we continue to always be on time, and more importantly so will you.

If you should have any questions regarding any of our policies, please feel free to discuss any concerns with us. I acknowledge that I have received, read, and discussed any concerns of Tylan Creek Family Dentistry's attached Financial, Warranty, and Appointment Policy.

Thank you and we look forward to providing you with outstanding care.

_____	_____	_____
(Printed Name)	(Signature)	(Date)