



## Patient Registration

Today's Date \_\_\_/\_\_\_/\_\_\_

### Patient Information

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ MI: \_\_\_\_\_

Mailing Address \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Cell Phone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Sex: \_\_\_\_\_ Martial Status (S,M,D,W): \_\_\_\_\_

Social Security: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

### Primary Dental Insurance

Insurance Company: \_\_\_\_\_

Group Number: \_\_\_\_\_ Member ID: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Relationship: \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Social Security : \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Employer: \_\_\_\_\_ Phone Number: \_\_\_\_\_



## Records Release Form

I \_\_\_\_\_ Hereby authorize,  
Print Name

\_\_\_\_\_ to release my Dental records.  
Former Dental Office

Please fax treatment plans and any other pertinent information to  
(843)650-4510 within 3 business days.

If X-Rays are digital please email them to [Info@tidelandsdental.com](mailto:Info@tidelandsdental.com).

If X-Rays are not digital please mail them to 1625 Glenns Bay Road  
Surfside Beach, SC,29575

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Date

## Tidelands Dental Policies




**Appointments:** We ask that you keep all appointments and be here on time. If you need to change an appointment day or time, please give us a notice of 2 business days. A broken appointment fee may be charged, as we pay our staff be with just you for the prescribed amount of time.

**Payments:** We accept Visa, Mastercard, and Discover. We also work with Care Credit, a company that offers financing with 6 months free interest for work over \$200. We do not offer payment plans.

**Insurance:** If you have insurance, we will still estimate the portion they may pay and you are responsible for paying the balance the day of the service. If there is a credit on your account after they pay, you can keep it on your account or we will send you a refund. If there is a balance, we will send you a statement with the balance due in 10 days. We do not file secondary insurance. We are happy to submit a pre-estimate to your insurance company. It takes 6-8 weeks to get back.

### Notice of Privacy practice acknowledgement

I understand that, under the health Insurance Portability & Accountability Act of 1996 (HIPAA) I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

-  Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
-  Obtain payment from third-party payers
-  Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received read and understand your Notice of Privacy Practices Acknowledgement. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I have read, understand, and agree to the above polices

Print Name: \_\_\_\_\_

Sign Name: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

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.

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 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

Do you use tobacco?  Yes  No

Do you use controlled substances?  Yes  No If yes

Women: Are you...

Pregnant/Trying to get pregnant?

Are you allergic to any of the following?

Aspirin  Penicillin  Codeine  Acrylic  
 Metal  Latex  Sulfa Drugs  Local Anesthetics

Other?  If yes

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

AIDS/HIV Positive	<input type="radio"/> Yes <input type="radio"/> No	Hemophilia	<input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments	<input type="radio"/> Yes <input type="radio"/> No	Alzheimer's Disease	<input type="radio"/> Yes <input type="radio"/> No
Diabetes	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis A, B, C	<input type="radio"/> Yes <input type="radio"/> No	Anemia	<input type="radio"/> Yes <input type="radio"/> No	Herpes	<input type="radio"/> Yes <input type="radio"/> No
Rheumatic Fever	<input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures	<input type="radio"/> Yes <input type="radio"/> No	High Cholesterol	<input type="radio"/> Yes <input type="radio"/> No
Scarlet Fever	<input type="radio"/> Yes <input type="radio"/> No	Artificial Heart Valve	<input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding	<input type="radio"/> Yes <input type="radio"/> No	Shingles	<input type="radio"/> Yes <input type="radio"/> No
Artificial Joint	<input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease	<input type="radio"/> Yes <input type="radio"/> No	Asthma	<input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat	<input type="radio"/> Yes <input type="radio"/> No
Sinus Trouble	<input type="radio"/> Yes <input type="radio"/> No	Blood Disease	<input type="radio"/> Yes <input type="radio"/> No	Leukemia	<input type="radio"/> Yes <input type="radio"/> No	Breathing Problems	<input type="radio"/> Yes <input type="radio"/> No
Frequent Headaches	<input type="radio"/> Yes <input type="radio"/> No	Liver Disease	<input type="radio"/> Yes <input type="radio"/> No	Stroke	<input type="radio"/> Yes <input type="radio"/> No	Cancer	<input type="radio"/> Yes <input type="radio"/> No
Lung Disease	<input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No	Chemotherapy	<input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse	<input type="radio"/> Yes <input type="radio"/> No
Tonsillitis	<input type="radio"/> Yes <input type="radio"/> No	Chest Pains	<input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure	<input type="radio"/> Yes <input type="radio"/> No	Osteoporosis	<input type="radio"/> Yes <input type="radio"/> No
Tuberculosis	<input type="radio"/> Yes <input type="radio"/> No	Cold Sores/Fever Blisters	<input type="radio"/> Yes <input type="radio"/> No	Heart Murmur	<input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints	<input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder	<input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker	<input type="radio"/> Yes <input type="radio"/> No	Ulcers	<input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease	<input type="radio"/> Yes <input type="radio"/> No

Have you ever had any serious illness not listed above?  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: \_\_\_\_\_