Welcome to Irmo Smiles!

We are delighted that you have chosen our office to evaluate your dental needs. We strive to provide the most thorough dental service in the most caring and relaxed atmosphere available. Your addition to our family of happy and satisfied patients would be most welcomed.

As a new patient, your initial appointment will consist of a thorough oral evaluation that will include a comprehensive examination to check for oral cancer, gum disease, bite problems, jaw joint problems, cavities and broken or damaged teeth along with a dental prophylaxis (cleaning). Your doctor will evaluate any existing dentistry or dental appliances you currently have and talk with you about concerns you may have regarding the appearance of your smile. Your examination will include all x-rays and tests necessary to perform a complete diagnosis. The findings of the examination will be discussed in full detail and specific recommendations will be made.

Enclosed you will find confidential patient information forms for you to complete and bring with you. We recognize that your time is important. Except in emergency situations, you can expect us to be on time for you. If for some reason you find that you will be unable to keep your appointment, we ask that you notify us at least 48 hours in advance.

We look forward to meeting you at your scheduled appointment.

Sincerely,

Appointment Coordinator
Irmo Smiles

Dental
Adult Patient Information

Patient Information

Today's Date _____

Your Name

Last _____ First _____ Middle _____ ○ Mr. ○ Mrs. ○ Miss

Date of Birth _____ Age _____ SSN _____ Marital Status _____

Mailing Address

Street _____ Apt. # _____

City _____ State _____ Zip _____

Email _____ Cell Phone _____ Home Phone _____

Employer _____ Job Title _____ Work Phone _____

How did you hear about our office?

○ Family ○ Friend ○ Close to home/work ○ Other _____

Responsible Party

This person is responsible for payment if patient is minor/under the age of 18.

Your Name _____ ○ Mr. ○ Mrs. ○ Miss

Relationship to patient _____ Date of Birth _____ SSN _____

Mailing Address _____

Email _____ Cell Phone _____ Home Phone _____

Employer _____ Job Title _____ Work Phone _____

Insurance Information

You may skip this section if we have received your insurance information prior to appointment.

Subscriber's Name _____ DOB _____ SSN _____

Subscriber's Address (if different from above) _____

Subscriber's Phone (cell) _____ Alternate Phone _____

Subscriber's Employer _____ Occupation _____

Insurance Company _____ Phone _____

Group # _____ ID# _____

Dental
Adult Medical History

Medical History

Do you now, or have you ever had any of the following? (Please check all that apply.)

- ◯ AIDS/HIV
- ◯ Allergies
- ◯ Anemia
- ◯ Anesthesia Allergy
- ◯ Arthritis
- ◯ Artificial Joints
- ◯ Asthma
- ◯ Beta Blocker
- ◯ Blood Disease
- ◯ Blood Thinners
- ◯ Cancer
- ◯ Cephalosporin Allergy
- ◯ Codeine Allergy
- ◯ Diabetes
- ◯ EES
- ◯ Epilepsy
- ◯ Erythromycin Allergy
- ◯ Excessive Bleeding
- ◯ Fainting
- ◯ Glaucoma
- ◯ Growths
- ◯ Hay Fever
- ◯ Head Injuries
- ◯ Heart Disease
- ◯ Heart Murmur
- ◯ Hepatitis ◯ A ◯ B ◯ C
- ◯ High Blood Pressure
- ◯ Kidney Disease
- ◯ Latex Allergy
- ◯ Liver Disease
- ◯ Mental Disorders
- ◯ Mitral Valve Prolapse
- ◯ Motrin Allergy
- ◯ Nervous Disorders
- ◯ Pacemaker
- ◯ Penicillin Allergy
- ◯ Radiation Treatment
- ◯ Respiratory Problems
- ◯ Rheumatic Fever
- ◯ Rheumatism
- ◯ Sinus Problems
- ◯ Stroke
- ◯ Sulfur Allergy
- ◯ Tetracycline Allergy
- ◯ Tuberculosis
- ◯ Tumors
- ◯ Ulcers
- ◯ Venereal Disease
- ◯ Other _____

Dental History

Date of last dental visit _____ Reason for visit _____

Have you ever had complications following a dental treatment? ◯ Yes ◯ No
If yes, please explain. _____

Have you been admitted to a hospital or received emergency care during the past two years? ◯ Yes ◯ No
If yes, please explain. _____
Name of physician _____ Phone _____

Please list all medications you are currently taking. _____
Do you have health problems that need further clarification? ◯ Yes ◯ No
If yes, please explain. _____

Women Only:
Are you pregnant or think you may be pregnant? ◯ Yes ◯ No
Are you nursing? ◯ Yes ◯ No
Are you taking birth contrlol pills? ◯ Yes ◯ No

Consent for Services

As a condition of your treatment by this office, financial arrangements may be made in advance. The practice depends upon 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 services, 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. The office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial agreements are satisfied. I understand that the fee estimate listed for dental care can only be extended for a period of 6 months from the date of the examination. In consideration for the professional services rendered to me, or per my request, by the doctor, I agree to pay the reasonable value of said services to doctor or his assignee at the time services are rendered or within 5 days of billing if credit is extended. I further agree that the reasonable value of services shall be billed unless objected to, by me, in writing within time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of and further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. I grant my permission to you or your assignee, to telephone me at numbers I have provided to discuss matters related to this form. I have read the above conditions of treatment and payment and agree to their consent.

Patient Signature/Legal Guardian for Minors _____ **Date** _____

Irmo Smiles Financial Policy

Thank you for choosing Irmo Smiles for your dental needs. Our staff is committed to providing you with the best care possible. Your clear understanding of our financial policy is critical to our professional relationship. In order to eliminate the possibility of financial misunderstandings, we require a signature to document that you have read and understand this policy.

Irmo Smiles prepares a treatment plan estimate so that patients can understand the estimated costs of their recommended treatment prior to its start. The treatment plan estimate is a good-faith attempt to predict the cost of treatment based on the facts known to Irmo Smiles when the estimate is made. As treatment progresses, your dentist may determine that different or additional treatment is necessary and the cost of treatment may change.

INSURANCE: Our staff will provide an estimate of insurance benefits for planned treatment in an attempt to calculate the patient's financial responsibility. However, insurance plans vary considerably and we cannot guarantee what portion of services will or will not be covered. It is the responsibility of the patient/guarantor to provide accurate and timely insurance information to our staff. Inaccurate or untimely information given to the staff that results in denial or non-coverage by the insurance company results in the guarantor being financially responsible for payment. Examples of inaccurate or untimely information include but are not limited to coverage which has changed or terminated and procedures which have been performed at other offices but have not been fully processed by the insurance company. Dental insurance is a contract between the patient and their insurance company, as such it is the patient's responsibility to understand and verify eligibility before procedures are performed. Any balance not paid by the insurance company becomes the patient's financial responsibility.

PAYMENT/BILLING: Full payment is due at the time services are rendered. In the event that a balance exists after an appointment, said balance must be paid with 30 days unless prior arrangements have been made. We realize that temporary financial problems may affect timely payment on an account. If such problems arise it is the patient's responsibility to contact our billing department promptly for payment arrangements and assistance in management of the account. Any balance remaining after 60 days is subject to referral to a collections agency. Patient/guarantor will be responsible for any costs incurred if account is turned over to a collection agency including collection agency fees, attorney fees and any associated court costs.

FEES: A $35.00 fee will be assessed for all returned checks. Interest will accrue on all balances unpaid within 30 days of the date of service at a rate of 1.5% per month.

I, _____ (print name) have read, understand and agree to the Irmo Smiles Financial Policy.

Patient/Guarantor's Signature _____ Date _____

Authorization for the Use and Disclosure of Protected Health Information

I hereby authorize Irmo Smiles to use or disclose my Protected Health Information as described below.

I understand that the information I authorize a person/facility to receive may be re-disclosed and no longer protected by state and federal regulations.

Today's Date _____

Patient Name _____

Date of Birth _____ Social Security Number _____

Address _____

_____

Telephone Number _____ Email _____

Name of Person Authorized to **RELEASE** the Information: **IRMO SMILES FAMILY & COSMETIC DENTISTRY**

Name of Person(s) Authorized to **RECEIVE** the Information:

Name _____ Telephone _____

Address _____

Name _____ Telephone _____

Address _____

Purpose of Disclosure _____

Dates of Treatment _____

Information to be used/disclosed:

○ Complete Chart ○ X-Rays ○ Clinical Notes ○ Billing Summary ○ Procedure Summaries

This authorization, as may be applicable, extends to any medical records covered by any privilege, including without limitation to psychiatric, psychological and mental testing and records; records relating to drug treatment and/or substance abuse; records related to sexually transmitted diseases and/or social service notes.

Patient Signature _____ Date _____

Signature of Parent/Guardian _____ Date _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

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 healthcare information, and of other important matters about your protected health information.

A copy of our notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

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 of your protected health information that we maintain.

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 contact person listed on this form. 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 the 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 health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT ONCE SIGNED

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

Telephone (803)781-2930 • Fax (803)749-8566
Email: staff@irmosmiles.com
Address: 7321 St. Andrews Road, Irmo, SC 29063

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:

_____