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 is 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. We recognize that your time is important. Except in emergency situations, you can expect us to be on time for you.

We look forward to helping you look and feel your best through good oral health.

Sincerely,

Appointment Coordinator
Irmo Smiles

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 control pills? ◯ Yes ◯ No

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

Dental
Adult Patient Information

Patient Information

Today's Date _____

Your Name

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

Date of Birth _____ Age _____ SSN _____ Marital Status _____

Emergency Contact _____ **Phone #** _____

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# _____

General Consent for Treatment

I understand that the purpose of this form is to obtain consent for dental treatment. In general terms, treatment is: dental restorations, sealants, extractions, exams, cleanings, local anesthetic, and nitrous oxide. I understand that every dental patient has the right to informed consent and other consent may be provided for more specific treatment. That means that as a patient, or as a legal guardian for a patient, I should understand what treatment is being proposed, what the possible complications and risks are, and what the alternatives are to the treatment.

DENTAL TREATMENT

I understand that complications may occur during or after treatment and that no dental treatment is completely risk free, as the practice of dentistry is not an exact science. A partial listing of the risks known to be associated with dental treatment are:

Infections, bleeding, bruising, paresthesia or numbness of tongue, mouth or face, instrument breakage, swallowing or aspiration of objects, allergic reactions to drugs, jaw pain or difficulty opening mouth, temporary soreness, temperature sensitivity, bacterial endocarditis, additional oral surgery, hospitalization, or further treatment upon complications.

ANESTHETIC

For the administration of local anesthetic, I understand that for many treatments and procedures I will be given a local anesthetic injection and that in a certain percentage of cases patients have had an allergic reaction to the anesthetic, an adverse medication reaction to the anesthetic, or temporary or permanent injury to nerves and/or blood vessels from the injection. I understand that the injection area(s) may be uncomfortable following treatment and that my jaw may be stiff and sore from holding my mouth open during treatment.

ACKNOWLEDGMENT

I have read and understand the information stated above. I have the right to ask for more information if I have any concerns, and I will use that right to its fullest extent. I understand the success of this treatment and the avoidance of treatment complications depends upon my complying with the instructions, restrictions, and any recommendations, that have been explained to me. I also understand that I am to notify the dentist immediately of any suspected complications, where further treatment may be discussed or administered, which is not currently anticipated.

Signature: _____ Date: _____

Relationship to Patient: _____

Appointment Policy

Seeing your dentist every 6 months is an important part of maintaining your dental health. It is especially important that you keep your appointments! Valuable time has been reserved for your dental care. A missed appointment results in lost time which could be used for another patient waiting for treatment. Every effort is made to keep on schedule so we respectfully ask patients to be prompt and keep their appointments. The office attempts to schedule appointments at your convenience and when time is available.

Please take a moment to familiarize yourself with our appointment policy.

Broken/Missed Appointments

Your scheduled appointment is reserved specifically for you. We try to remind patients by telephone, email and/or text prior to the appointment, but please do not depend on this courtesy. If a cancellation is unavoidable, please call the office at least 24 hours in advance so that we may give your appointment time to another patient. If you do not cancel your appointment with 24 hours' notice or if you do not come to the appointment, we will consider this to be a broken/missed appointment. Broken appointment fees will be billed to the patient, not to the insurance company. The fee must be paid before scheduling your next appointment. If 2 broken appointments occur, our office reserves the right not to schedule any subsequent appointments for you.

Occasionally, illnesses or other unexpected emergencies make it necessary to cancel an appointment with less than 24 hours of notice. Please contact our office immediately and we will do our best to accommodate your situation.

Late Arrivals

If you arrive more than 10-15 minutes late for your appointment, you may be asked to reschedule for the next available appointment time. Again, please call at least 24 hours in advance if a cancellation is unavoidable.

Appointment Delays

We strive to see all patients on time for the scheduled appointment. We make every effort to stay on schedule. Additionally, there are times when our schedule is delayed to accommodate an injured patient or emergency. Please accept our apology in advance should this occur during your appointment. We will provide you the same courtesy if you are in need of emergency treatment. We ask that if you are not called back in a timely fashion, please notify a staff member.

Please plan to arrive 10 minutes before your scheduled appointment. This allows time for parking and time to complete any additional paperwork. A parent or legal guardian must be present in the office during the initial examination or any restorative appointments if the patient is under the age of 18.

For the safety and privacy of all patients, other family members who are not being treated should remain in the reception area.

I have read and understand the Irmo Smiles appointment policy.

_____ _____

Patient/Parent/Guardian Signature **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 cost of treatment may change. The fee estimate for dental care can only be extended for a period of 6 months from the date of the examination.

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.

NOTE: Irmo Smiles is NOT an in-network provider with any insurance plan for dental services. We are in-network with some insurance plans for orthodontic services ONLY.

PAYMENT/BILLING: Full payment is due at the time services are rendered. Any patient who does not pay their balance at the time of service will be placed in a pre-payment status for a period of 18 months. During this period said patient will be required to pre-pay their portion of any treatment before scheduling and will be ineligible for in-house payment arrangements. In the event that financial arrangements are needed all arrangements must be made at the time of scheduling the appointment. 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 and reporting to the 3 major credit bureaus. 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 $30.00 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. A $50 fee per appointment hour will be assessed for any missed or broken appointments with less than 24 hours notice.

I, _____(print name) have read, understand and agree to the Irmo Smiles Financial Policy. I grant my permission to you or your assignee, to telephone me at numbers I have provided to discuss matters related to this form.

_____ _____

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**

_____ _____

Parent/Guardian Signature (if paitent is a minor) **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 is available to you upon request. 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:

_____