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
Patient Information

Today’s Date _____________________________

Your Name
Last ___________________ First ___________________ Middle ___________________  O Mr.  O Mrs.  O 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?
  O Family  O Friend  O Close to home/work  O Other ___________________

Responsible Party

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

Your Name _____________________________  O Mr.  O Mrs.  O 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
- Other ___________
- Codeine Allergy
- Diabetes
- EES
- Epilepsy
- Erythromycin Allergy
- Excessive Bleeding
- Fainting
- Glaucma
- Growths
- Hay Fever
- Head Injuries
- Heart Disease
- Heart Murmur
- Hepatitis A
- Hepatitis B
- Hepatitis 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
- Rheumatism
- Sinus Problems
- Stroke
- Sulfur Allergy
- Tetracycline Allergy
- Tuberculosis
- Tumors
- Ulcers
- Venereal Disease

## 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. 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 _____________

## 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
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.

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. 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 $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 ______________
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: