Coastal Dental Group

Name: _____ Preferred Name: _____

Birthdate: _____ SSN: _____ Gender: _____

Marital Status: Single Married Divorced Widowed

Home Address: _____

City: _____State:_____ Zip Code:_____

Home Phone: _____ Cell Phone:_____ Work Phone:_____

Email: _____

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*** ☐

In Case of Emergency (closest relative or friend):

Name/Relationship: _____ *Phone:* _____

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

Employer: _____

Dental Ins. Co. _____ Policy #_____

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

Address: _____ City & Zip: _____

Phone: _____ Cell: _____

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

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

Coastal Dental Group
11990 Frontage Road Unit #8
Murrells Inlet, SC 29576

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORM

Patient's Name: _____ DOB: _____

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.

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.

I give consent for myself/child to receive dental treatment deemed necessary by the providers at Coastal Dental Group. 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)

You are entitled to and may obtain a copy or our Notice of Privacy Practices, including any revisions of our Notice at any time by contacting us: Coastal Dental Group
11990 Frontage Road Unit #8 Murrells Inlet, SC 29576
(843)651-0314

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

Medical History

Name of Medical Doctor:_____City/State:_____

List all medications that you are now taking:

_____ _____

_____ _____

_____ _____

_____ _____

Do you take ANY kind of blood thinners, not listed above? If yes, which one_____

Do you now or have you EVER taken Fosamax, Boniva, Avtonel, or any other medication containing biosphonates? If yes, length of time taken and date of last dose. _____

Are you allergic to any of the following?

Are you allergic to any of the following?	**Anesthetic**	**Codeine**	**Metals/Acrylic**	**Penicillin**
	Asprin	**Ibuprofen**	**Latex**	**Sulfa**
Any Allergy not listed?	**Yes** **No**	**If yes:**		

Have you had or do you have any of the following:

Y N	**AIDS/HIV**	**Y N**	**High Blood Pressure**
Y N	**Alzheimers/Dementia**	**Y N**	**Joint Replacement**
Y N	**Artificial Heart Valve**	**Y N**	**Kidney Disease**
Y N	**Asthma**	**Y N**	**Liver Disease**
Y N	**Bleeding Problems**	**Y N**	**Pregnancy (including prior)**
Y N	**Cancer**	**Y N**	**Psychiatric Treatment**
Y N	**Diabetes**	**Y N**	**Sinus Trouble**
Y N	**Drug Addiction**	**Y N**	**Stroke**
Y N	**Heart Murmur**	**Y N**	**Ulcers**
Y N	**Heart Attack**	**Y N**	**Rheumatic Fever**
Y N	**Hepatitis A,B, or C**	**Other not listed**	

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:_____**

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.

- For my convenience, this office may release my information to my insurance company, and receive payment directly from them.
- Every effort will be made to help me with my insurance, but if insurance does not pay, I will still be responsible.
- I understand that if I begin major treatment that involves lab work (including: crowns, bridges, partials, dentures, and night guards) I will be responsible for the fee at the time of service.
    - If sent to collections, I understand that I will be responsible for all incurred charges.
- I agree to pay $30 fee for any broken appointment without 24 hours notice.
- Financing is available thru Care Credit, as we do not offer any in-office payment plans.

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

_____ _____ _____

(Printed Name) (Signature) (Date)