Palmetto Smiles
OF BEAUFORT
PHYSIOLOGIC DENTISTRY

How did your hear about us? Internet Search ☐ Print Ad ☐ Social Media ☐ Other _____

Patient Information

Name _____ Birthday _____/_____/_____ Age _____ Male ☐ Female ☐

Social Security # _____ - _____ - _____ Cell Phone # _____ Home Phone # _____

Street Address _____

City _____ State _____ Zip Code _____

Email _____

Employer's Name _____ Employer's Address _____

In Case of Emergency Contact _____ Phone # _____ Relationship _____

Marital Status (Please Circle) Divorced Married Separated Single Widowed

Primary Dental Insurance
if applicable

Insurance Company Name _____ Group # (Plan, Local or Policy #) _____

Insurance Company Phone # _____

Insured's Name _____ Birthday _____/_____/_____ Relationship to Insured _____

Insured's Employer _____

Insured's Social Security # _____ - _____ - _____ Insured's Address _____

Secondary Dental Insurance
if applicable

Insurance Company Name _____ Group # (Plan, Local or Policy #) _____

Insurance Company Phone #_____

Insured's Name _____ Birthday _____/_____/_____ Relationship to Insured _____

Insured's Employer _____

Insured's Social Security # _____ - _____ - _____ Insured's Address _____

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.

Medical History

Do you have a primary care physician? Yes ☐ No ☐ If yes, who? _____

Are you currently under a physician's care for a medical condition? Yes ☐ No ☐ If yes, please explain: _____

Have you ever been hospitalized or had a major operation? Yes ☐ No ☐ If yes, please explain: _____

Have you ever had a serious head or neck injury? Yes ☐ No ☐ If yes, please explain: _____

Are you taking any medications, pills, or drugs? Yes ☐ No ☐ If yes, please list them: _____

Do you take (or have you taken) Phen-Fen or Redux? Yes ☐ No ☐

Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates? Yes ☐ No ☐

Are you on a special diet? Yes ☐ No ☐

Do you use tobacco? Yes ☐ No ☐

Do you use controlled substances? Yes ☐ No ☐

Women: Are you…

… pregnant/trying to get pregnant? Yes ☐ No ☐

… taking oral contraceptives? Yes ☐ No ☐

… nursing? Yes ☐ No ☐

Are you allergic to any of the following?

Aspirin ☐ Penicillin ☐ Codeine ☐ Latex ☐ Acrylic ☐ Metal ☐ Local anesthetics ☐ Sulfa drugs ☐ Other _____

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

- ☐ AIDS/HIV Positive
- ☐ Alzheimer's Disease
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Breathing Problem
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Cold Sores/Fever Blisters
- ☐ Congenital Heart Disorder
- ☐ Convulsions
- ☐ Cortisone Medicine
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Easily Winded
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Excessive Thirst
- ☐ Fainting Spells/Dizziness
- ☐ Frequent Cough
- ☐ Frequent Diarrhea
- ☐ Frequent Headaches
- ☐ Genital Herpes
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack/Failure
- ☐ Heart Murmur
- ☐ Heart Pacemaker
- ☐ Heart Trouble/Disease
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hives or Rash
- ☐ Hypoglycemia
- ☐ Irregular Heartbeat
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Pain in Jaw Joints
- ☐ Parathyroid Disease
- ☐ Psychiatric Care
- ☐ Radiation Treatments
- ☐ Recent Weight Loss
- ☐ Renal Dialysis
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Spina Bifida
- ☐ Stomach/Intestinal Disease
- ☐ Stroke
- ☐ Swelling ofLimbs
- ☐ Thyroid Disease
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors or Growths
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Yellow Jaundice

If you have ever had any serious illness(es) not listed above, please list it here: _____

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 Palmetto Smiles of Beaufort of any changes in medical status.

_____

Patient Name (please print)

_____ _____/_____/_____

Signature of Patient, Parent, or Guardian Date

Sleep Questionnaire

Sleep Quality

How would you rate the quality of your sleep? Very Poor 1 2 3 4 5 6 7 8 9 10 Excellent

Why would you give it that rating? Please explain: _____

Have you been told that you snore? Never ☐ Rarely ☐ Frequently ☐ Always ☐

If you snore, does it disturb others? Yes ☐ No ☐ I don't know ☐

Does your bed partner snore? Yes ☐ No ☐ I don't know ☐

Do you have any difficulty getting to sleep? Yes ☐ No ☐

Do you stay asleep all night? Yes ☐ No ☐

Do you get up to go to the bathroom? Yes ☐ No ☐

If so, do you get back to sleep easily? Yes ☐ No ☐ I don't know ☐

Do you wake feeling refreshed each morning? Yes ☐ No ☐

Would you like to go back to sleep if you could? Yes ☐ No ☐

Sleep Symptoms

Do you fall asleep in front of TV? Never ☐ Rarely ☐ Frequently ☐ Always ☐

Do you ever feel tired from not enough sleep? Never ☐ Rarely ☐ Frequently ☐ Always ☐

Do you ever wake with a headache? Never ☐ Rarely ☐ Frequently ☐ Always ☐

Do you ever notice a sore jaw or cheek muscles in the morning? Never ☐ Rarely ☐ Frequently ☐ Always ☐

Do you ever wake with a sore throat without infection? Never ☐ Rarely ☐ Frequently ☐ Always ☐

Have you noticed any changes in your voice? Never ☐ Rarely ☐ Frequently ☐ Always ☐

Does your jaw click? Never ☐ Rarely ☐ Frequently ☐ Always ☐

Do you get neck pain? Never ☐ Rarely ☐ Frequently ☐ Always ☐

Has anyone ever told you that you grind your teeth? Never ☐ Rarely ☐ Frequently ☐ Always ☐

Medical History

Have you ever been diagnosed with? Fibromyalgia ☐ Chronic Fatigue ☐ Irritable Bowel Syndrome ☐

Are you on medication or treatment for any of the following? Anxiety ☐ Blood Pressure ☐ Cholesterol ☐ Chronic Pain ☐ Depression ☐ Diabetes ☐ Gastric Reflux ☐ Heart Disease ☐

How many cups of coffee or tea do you consume most days? 0 1 2 3 4 5 6 7 8 9 10+

How many days per week do you consume alcohol within 2-3 hours of going to bed? 0 1 2 3 4 5 6 7

How many days per week do you take sleep medication to help you sleep? 0 1 2 3 4 5 6 7

Do you smoke? Yes ☐ No ☐ If yes, how long ago did you stop smoking? _____

Have you gained weight in recent years? Yes ☐ No ☐

Women: Are you pregnant or post menopausal? Yes ☐ No ☐ I don't know ☐

Sleep History

Have you ever had a sleep study? Yes ☐ No ☐ If yes, why did you have a sleep study? _____

Have you been diagnosed with sleep apnea? Yes ☐ No ☐ I don't know ☐

Have you been prescribed CPAP? Yes ☐ No ☐ I don't know ☐

If yes, how often do you use it? Never ☐ Rarely ☐ Frequently ☐ Always ☐

Do you wear or have you been made a sleep guard for grinding, snoring, or sleep apnea? Yes ☐ No ☐

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Smile Survey

Name _____

Please Mark an "X" Below Next To The Statements You Agree With

_____ I wish my teeth were whiter.

_____ I wish I had a broader smile.

_____ Some of my teeth are too small.

_____ Some of my teeth are too large.

_____ I wish my teeth were straighter.

_____ My gums show too much when I smile.

_____ My smile shows too much space between some of my teeth.

_____ I sometimes hesitate to smile.

_____ I wish I could change some features of my smile.

_____ I don't know all the options available for enhancing my smile.

_____ I am concerned over what the end result might look like.

_____ I am concerned about the fees related to changing my smile.

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Important Information

Terms of Payment

The following is a guide to the terms of payment accepted by Palmetto Smiles of Beaufort, LLC. We are committed to working with you to match a payment plan that fits your needs; therefore we offer different options to our patients.

Payment Options

- We accept Visa, MasterCard, Discover, money order, cash or personal check
- A convenient interest free payment plan through Care Credit, an outside financial institution

Dental Insurance

We will gladly assist you with your dental insurance plan. To help us assist you in determining your maximum benefit, please bring your insurance card to your first visit. Most plans cover only a portion of the dental fee, therefore as a courtesy to our patients we will file for primary insurance for you but we ask that you pay the non-covered balance at the time of service unless prior arrangements have been made. If your insurance company has not paid within 60 days you will be billed for the unpaid balance and payment in full will be expected at this time. We recommend you become directly involved in communication with your insurance company in order to expedite payment.

Patient Records

I authorize Palmetto Smiles of Beaufort, LLC to scan any and all documentation of treatment from any previous dental facility. I assume responsibility of those records once Palmetto Smiles of Beaufort, LLC has digitized them into my current treatment plan.

Appointments

In order to allow the best possible care for our patients we reserve a specific time just for you and make every effort to see you as scheduled. We appreciate your promptness and your consideration in not changing your scheduled time. However, if you need to change your scheduled appointment a 48 hour notice is expected or a late fee/loss of reservation fee will accrue.

Patient Agreement

- I understand that my insurance policy is an agreement between myself and the insurance company therefore I am ultimately responsible for all fees incurred for my dental treatment regardless of payment or denial of my insurance claims by my insurance company.
- I understand that any balance over 30 days old will accrue an interest rate of 1.5%
- I authorize insurance payment directly to Palmetto Smiles of Beaufort, LLC
- I authorize the release of necessary information to my insurance company to determine liability for payment and to obtain reimbursement for any claims.
- If this account is assigned to an attorney or collection agency, I agree to be responsible for any attorney fees, and the court cost incurred.

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Informed Consent & Notice Of Privacy Practices

In the course of providing services to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct healthcare operations involving our practice. The "Notice of Privacy Practices" that are available for your review describes these uses and disclosures in detail and are posted in our office.

By signing this form, you are consenting to the following:

- Examination, diagnostic studies, and treatment as deemed appropriate by Dr. Jennifer Wallace
- Release of information including all medical records, x-rays, photos and other reports concerning that care for insurance purposes or further dental care inside or outside of our office when necessary
- Payment of authorized benefits to be made on your behalf to Palmetto Smiles of Beaufort for any services furnished by Dr. Jennifer Wallace's practice
- Authorize any holder of dental or medical information about me to be released if needed to determine these benefits or benefits payable for related service
- Photography relating to my dental treatment by the doctors and/or staff of this office

Photos that we take during and/or after treatment help with (but not limited to): treatment documentation, education of other patients or of other doctors or their staff, proper lab fabrication of prostheses, or for publication or marketing. We will acquire additional verbal or written consent before publishing any photos.

_____ _____/_____/_____
Signature of Patient Date

_____ _____/_____/_____
Signature of Responsible Party Date