TIME 02:09 PM

DATE 7/9/2018

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

Emerg Contact

Emerg Contact #

Saved First

Verified

Employer

Employer ID

Benefit Start (CY/M)

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Time 2:10 PM

Hampton Dentistry

Date 7/9/2018

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

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, c

Are you under a physician's care now?	Yes No	If yes
Have you ever been hospitalized or had a major operation?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Are you taking any medications, pills, or drugs?	Yes No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Are you on a special diet?	Yes No	
Do you use tobacco?	Yes No	
Do you use controlled substances?	Yes No	If yes

Women: Are you...

Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic

Metal Latex Sulfa Drugs Local Anesthetics

Other? If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes No	Cortisone Medicine	Yes No	Hemophilia	Yes No	Radiation Treatments	Yes No
Alzheimer's Disease	Yes No	Diabetes	Yes No	Hepatitis A	Yes No	Recent Weight Loss	Yes No
Anaphylaxis	Yes No	Drug Addiction	Yes No	Hepatitis B or C	Yes No	Renal Dialysis	Yes No
Anemia	Yes No	Easily Winded	Yes No	Herpes	Yes No	Rheumatic Fever	Yes No
Angina	Yes No	Emphysema	Yes No	High Blood Pressure	Yes No	Rheumatism	Yes No
Arthritis/Gout	Yes No	Epilepsy or Seizures	Yes No	High Cholesterol	Yes No	Scarlet Fever	Yes No
Artificial Heart Valve	Yes No	Excessive Bleeding	Yes No	Hives or Rash	Yes No	Shingles	Yes No
Artificial Joint	Yes No	Excessive Thirst	Yes No	Hypoglycemia	Yes No	Sickle Cell Disease	Yes No
Asthma	Yes No	Fainting Spells/Dizziness	Yes No	Irregular Heartbeat	Yes No	Sinus Trouble	Yes No
Blood Disease	Yes No	Frequent Cough	Yes No	Kidney Problems	Yes No	Spina Bifida	Yes No
Blood Transfusion	Yes No	Frequent Diarrhea	Yes No	Leukemia	Yes No	Stomach/Intestinal Disease	Yes No
Breathing Problems	Yes No	Frequent Headaches	Yes No	Liver Disease	Yes No	Stroke	Yes No
Bruise Easily	Yes No	Genital Herpes	Yes No	Low Blood Pressure	Yes No	Swelling of Limbs	Yes No
Cancer	Yes No	Glaucoma	Yes No	Lung Disease	Yes No	Thyroid Disease	Yes No
Chemotherapy	Yes No	Hay Fever	Yes No	Mitral Valve Prolapse	Yes No	Tonsillitis	Yes No
Chest Pains	Yes No	Heart Attack/Failure	Yes No	Osteoporosis	Yes No	Tuberculosis	Yes No
Cold Sores/Fever Blisters	Yes No	Heart Murmur	Yes No	Pain in Jaw Joints	Yes No	Tumors or Growths	Yes No
Congenital Heart Disorder	Yes No	Heart Pacemaker	Yes No	Parathyroid Disease	Yes No	Ulcers	Yes No
Convulsions	Yes No	Heart Trouble/Disease	Yes No	Psychiatric Care	Yes No	Venereal Disease	Yes No
						Yellow Jaundice	Yes No

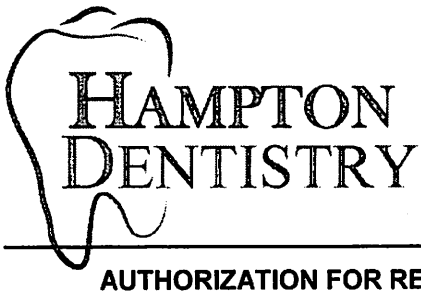
Have you ever had any serious illness not listed above? Yes No If yes

Comments:

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:

X_____ Date:_____



HAMPTON DENTISTRY
Emerson F Gower III, DMD
649 W Carolina Ave
Hampton, SC 29918
(803) 943-4895
Fax: (803) 573-1018

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient: _____

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

Privacy Notice

I acknowledge notice of Hampton Dentistry's privacy practices and authorize the release of information as defined in the Hampton Dentistry Notice of Privacy Practices posted in the lobby. This notice describes how health information about you may be used and disclosed and how you can get access to this information. We are required by federal and state law to maintain the privacy of your health information. We may use or disclose your health information for such reasons as: another health care provider treating you, to obtain payment for services rendered, in connection with our healthcare operations, in reasonably suspected abuse or neglect cases, national security and for appointment reminders. You have the right to access, amend, request a disclosure accounting, and request alternative communications regarding your health information. Any such request must be in writing and you are responsible for reasonable fees associated with the reproduction of the requested records. A copy of the Hampton Dentistry Notice of Privacy Practices will be provided to you if requested.

Consent for Procedure

This is to certify that I consent to the performing of the dental and oral surgery procedures that may be necessary or advisable, including the use of local anesthetic as indicated, photos, and releasing of information to insurance companies as necessary. I will assume responsibility for fees associated with any of the above. I agree that any dispute about the reasonableness or computation of fees, or any claim of negligent or intentional acts or omissions in the rendering of professional services by any member of Hampton Dentistry's staff or doctors, shall be submitted to binding arbitration. It is understood by both doctor and patient that by agreeing to submit all claims or assertions that either patient or doctor may have against the other, arising out of this agreement, all disputes shall be resolved through arbitration.

Appointment Policy - Please Read Carefully

I understand that Hampton Dentistry requires advance notice if an appointment has to be cancelled or rescheduled and that after two missed appointments, HamptonHampton Dentistry may not reserve appointments in advance. I understand that I may be charged for any appointments cancelled or broken without 24 hours advanced notice.

Payment Policy - Please Read Carefully

I understand that payment in full is expected at the time of service unless other arrangements have been made prior to my appointment. Hampton Dentistry accepts Cash, Check, Visa, MasterCard, Discover Card and offers extended payment and no interest payments options through Care Credit. I understand that payment by check is accepted; however in the unlikely event my check is returned, Hampton Dentistry reserves the right to re-present the item electronically, plus charge me the posted returned check fee and the state allowed processing fee. I authorize Hampton Dentistry to verify my past and present credit references.

I understand that Estill Dentistry will file insurance claims for me if I have dental insurance. Hampton Dentistry will contact my insurance company and determine my financial responsibility as closely as possible. I will be expected to pay this amount on the date of service. I understand that this is an estimate and Hampton Dentistry cannot guarantee its accuracy. After my insurance company pays their portion, Hampton Dentistry will provide me with a statement that clearly displays any balance remaining. This amount will be due upon notification. I understand that my insurance policy is a contract between me and my insurance carrier and that it is my responsibility to understand my plan benefits. If for any reason my insurance carrier denies the claim or does not pay as estimated, the balance will become my responsibility.

I understand that any past due balance is subject to a monthly finance charge. In the unfortunate circumstance that my account becomes more than 60 days overdue, Hampton Dentistry may send my account to a collection agency. I agree that if my account is assigned to a collection agency for collections, I may be charged a collection fee of up to $50.

I HAVE READ AND UNDERSTAND THIS FORM AND HAMPTON DENTISTRY'S POLICIES RELATED TO PRIVACY NOTICE. APPOINTMENTS, AND PAYMENT POLICY AND I CERTIFY THAT I CONSENT TO THE PERFORMING OF DENTAL AND ORAL SURGERY PROCEDURES THAT MAY BE NECESSARY OR ADVISABLE. I AM SIGNING THIS DOCUMENT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Patient signature and date: _____