Hilton Head Dental, PA

Experience the Difference

Thank you for Selecting Our Dental Team

To help us meet all your healthcare needs, please fill out this form completely in ink.
If you have any questions or need assistance, please ask us and we will be happy to help.

Initial:

Patient Information (Confidential)

Patient Number

Name Date

Soc.sec # Birth date Home Phone

Address City State Zip

Email Fax Cell Phone

Check Appropriate Box: Minor Single Married Divorced Widowed Separated

If Student,Name of School/ College City State Full Time Part Time

Patient's or Parent's Employer Work Phone

Business Address City State Zip

Spouse or Parent's Name Employer Work Phone

How did you hear about our office (all time apply) Yellow Pages Magazine Radio Website Location

Cable Mail Invitation Referral Other

Person to Contact in Case of Emergency Phone

Responsible Person

Name of Person Responsible for this Account Relationship to Patient

Address Home Phone

Driver's License # Birth Date Financial Institution

Employer Work Phone SSN#

Is this Person Currently a Patient in our Office? Yes No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

Cash Personal Check Credit Card VISA Master Card Amer.Express Discover

Insurance Information

Name of Insured Relationship to Patient

Birth Date Social Security # Date Eomployed

Name of Employer Union or Local # Work Phone

Employer Address City State Zip

Insurance Company-Please fill out attached Questionare

Do you have any additional Insurance? Yes No

Name of Insured Relationship to Patient

Birth Date Social Security # Date Eomployed

Name of Employer Union or Local # Work Phone

Employer Address City State Zip

Insurance Company

Patient Medical History

Physician **Office Phone** **Date of Last Exam**

	Yes	No
1. Are you under medical treatment now?		
2. Have you ever been hospitalized for any surgical operation or surgical operation or serious illness within the last 5 years? If yes Please explain _____		
3. Are you taking any medication(s) Including non-Prescription medicine? if yes what medicine are you taking? _____		
4. Have you ever taken Phen-fen/Redux?		
5. Do you use Tobacco?		
6. Do you use controlled substances?		
7. Are you wearing contact lenses?		

8. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure			Heart Disease			Chest Pains		
Heart Attack			Cardiac Pacemaker			Easily Winded		
Rheumatic Fever			Heart Murmur			Stroke		
Swollen Ankles			Angina			Hay Fever/ Allergies		
Fainting/ Seizures			Frequently Tired			Tuberculosis		
Asthma			Anemia			Radiation Therapy		
Low blood Pressure			Emphysema			Glaucoma		
Epilepsy / Convulsions			Cancer			Recent Weight Loss		
Leukemia			Arthritis			Liver Disease		
Diabetes			Joint Replacement or Implant			Heart Trouble		
Kidney Disease			Hepatitis/Jaundice Sexually			Respiratory Problems		
AIDS or HIV Infection			Transmitted Disease Stomach			Mitral Valve Prolapse		
Thyroid Problem			Troubles/ Ulcers			Other _____		

9. Are you allergic to or have you had any reactions to the following:

	Yes	No
Local Anesthetics (e.g. novocain)		
Penicillin or any other Antibiotics Sulfa		
Drugs		
Barbiturates		
Sedatives		
Iodine		
Aspirin		
Any Metals (e.g. nickel, mercury, etc,)		
Latex Rubber		
Other _____		

10. Women Only:

	Yes	No
a) Are you pregnant or think you may be pregnant?		
b) Arc you nursing?		
c) Are you taking oral contraceptives?		

Patient Dental History

Name of Previous Dentist: _____ Date of Last Exam: _____

Previous Dentist Location: _____ Date of Last Cleaning: _____

	Yes	No
1. Do your gums bleed while brushing or flossing?		
2. Are your teeth sensitive to hot or cold liquids/foods?		
3. Are your sensitive to sweet or sour liquids/foods?		
4. Do you feel pain lo any of your teeth?		
5. Do you have any sores or lumps in or near your mouth?		
6. Have you had any head, neck or jaw injuries?		
7. Have you ever experienced any of the following problems in your jaw?		
Clicking		
Pain (joint, ear, side of face)		
Difficully in opening or dosing		
Difficulty in chewing		

	Yes	No
8. Do you have frequent headaches?		
9. Do you clench or grind your teeth?		
10. Do you bite your lips or cheeks frequently?		
11. Have you ever had any difficult extractions in the past?		
12 Have you ever had any prolonged bleeding following extractions?		
13. Have you had any orthodontic treatment?		
14. Do you wear dentures or partials? If yes, date of placement		
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?		
16. Do you like your smile?		

The health information that I have given is correct to the best of my knowledge. All information is strictly confidential and it is my responsibility to inform this office of any changes in my medical status.I am fully aware of HILTON HEAD DENTAL'S payment policy. Payment is due in full at the lime of treatment, unless prior arrangements have been approved. Our office will be ht1ppy to file your insurance, having the insurance company responsible lo you.

Signature Date

Hilton Head Dental, PA

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INSURANCE QUESTIONNAIRE

DATE: PATIENT NAME:

SS#: DOB:

INSURANCE SUBSCRIBER'S NAME:

SS#: DOB:

PATIENT'S RELATIONSHIP TO SUBSCRIBER: Self Spouse Child Other

Employer's Name: Group #

Dental Insurance Company:

Insurance Claims Address:

PLEASE CONTACT YOUR BENEFIT PLAN AD MINSTRATOR OR INSURANCE REPRESENTATIVE IF YOU NEED ASSISTANCE IN COMPLETING THE FOLLOWING SECTION:

PLEASE ASK YOUR INSURANCE REPRESENTATIVE THE FOLLOWING QUESTIONS:

What is the Policy Effective Date? Is coverage: Single? Spouse? Family?

What is the Maximum Benefit Amount? Is there a deductible? If yes, what is the dollar amount?

What does the deductible apply to?

At what percentage are the following services paid? Preventive? % Basic? % Major? %

How often are preventive cleanings allowed?

Is exam included?

How often are X-rays allowed? Bitewings? Full Mouth Series? Panorex? Is there a Missing Tooth Clause?

Are there any Waiting Periods?

Are Periodontal Services covered? If yes, under Basic? Under Major?

For Scaling/Root Planing? For Gross Debridement? For Fine Scale/Periodontal Maintenance?

Are Endodontic Services covered? (Root Canal Therapy) If yes, under Basic? Major?

Is replacement of Prosthesis covered? (Crowns, Bridges and/or Partials/Dentures) If yes, after how many years?

Is there Orthodontic coverage? If yes, what is the age limit? What is the dollar amount limit?

Does this include removable orthodontic appliance?

Is Pre-Determination necessary? If yes, what is the dollar amount?

Electronic Submission? If yes, Payor ID#

THANK YOU FOR YOUR ASSISTANCE IN PROVIDING THIS INFORMATION. FILING INSURANCE CLAIMS IS A SERVICE HILTON HEAD DENTAL, P.A. IS PLEASED TO PROVIDE FOR OUR PATIENTS WITHOUT CHARGE.

SMILE QUESTIONNAIRE

1. HOW HIGH ON YOUR LIST OF PRJORITIES IS YOUR DENTAL CARE?

HIGH MEDIUM LOW

2. IS YOUR MAIN REASON FOR COMING TO THE DENTIST.....

HYGIENE COSMETIC TOOTHACHE

3. DO YOU LIKE THE APPEARANCE OF YOUR TEETH, YOUR SJ\1ILE?

YES NO IF NOT, PLEASE EXPLAIN

4. DO YOU LIKE THE COLOR OF YOUR TEETH? YES NO

IF NOT, PLEASE EXPLAIN

5. DO YOU LIKE THE SHAPE OF YOUR TEETH? YES NO
PLEASE EXPLAIN

6. DO YOUR-4..VE SPACES THAT YOU DO NOT LIKE? YES NO
PLEASE EXPLAIN

7. ARE THERE OLD FILLINGS OR DENTAL WORK THAT YOU DO NOT LIKE?

YES NO PLEASE EXPLAIN

8. IS THERE ANYTHING SPECIFIC YOU \VOULD LIKE TO CHANGE IN THE APPEARANCE OF YOUR TEETH?

9. HOW WOULD YOU LIKE YOUR TEETH TO LOOK?

10. HOW COMFORTABLE ARE YOU COMING TO THE DENTIST?
SCALE 1 TO 10

Hilton Head Dental Dr Daniel P Lawless 222 Pembroke Dr., Ste 102 HHI, SC 29926 843-681-6200

PAYMENT POLICY

As a courtesy, we will file your insurance claims, therefore we will request a copy of your insurance card at the time of each visit. Patients are responsible for any deductible, co-payment, or charges not reimbursed or allowed by insurance.

If the patient is a minor (18 years or younger), the parent or guardian is responsible for payment of the account, in accordance with the outlined policy above.

You will receive statements. If your account is not pain in full within 60 days, your account will be considered past due and will be subject to interest charges up to 8%. Any account send to a collection agency will incur additional fees and you will be responsible for all collection fees and attorney costs incurred.

Please be aware we will add a $50 fee for returned checks.

Patients having dental insurance will be expected to contact their insurance carrier if there is a delay in payment. Please understand that insurance is a contract between you and your carrier, therefore, you are responsible for your bill. If you have difficulty paying your account, please contact our billing department.

In case of divorce, the parent who brings the child/children in for treatment is responsible for payment; There are no exceptions.

ACKNOWLEGEMENT AND AUTHORIZATION

I have read, understand and agree to the above policies. I understand the charges not covered by my insurance company, for any reason as well as co-payments and deductibles are my responsibility.

I authorize and assign my insurance benefits to be paid directly to Hilton Head Dental.

I authorize Hilton Head Dental to release any dental or other information to my insurance company when requested.

_____

Patients Signature Todays Date

MULTIPLE INSURANCES

If there are multiple insurances, in network or not, the primary insurance company will be the only insurance company that has any "write-offs / adjustments" if applicable. We will then file the second insurance claim for you at that time. The remaining balance will be the patients' responsibility.

_____

Patients Signature Todays Date

INSURANCE CLAIM APPEAL

We provide as a courtesy to our patients, the initial submission of a claim at no cost to you. However, if insurance companies need a re-submission of a claim, a $36 service fee may be required to cover each appeal we send to the insurance company. You may also decide to deal directly with the insurance company yourself. Please check either box and provide a signature stating that you have read the above policies and agree to follow them accordingly.

☐ YES, I agree to pay a $36 service fee for each claim appeal that is sent to my insurance company

☐ NO, I choose not to pay a $36 service fee for claim appeals and will deal directly with my insurance company.

MISSED APPOINTMENT POLICY

Should you need to cancel your appointment, please notify our team 48 hours prior to your scheduled appointment. Our office policy requires a $55 fee be charged to you for missed appointments without this notice.

_____

Patients Signature Todays Date

X-ray DUPLICATING POLICY

We may include a nominal fee of for the duplication of x-rays. Any x-rays provided from other dentists will be returned to you if necessary.

_____

Patients Signature Todays Date

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICE

I have reviewed a copy of the notice of privacy practices for HHD.

_____

Patients Signature Todays Date