



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.

Patient Information (Confidential)

Patient Number _____

Date _____

Name _____

Soc. Sec. # _____ Birthdate _____ 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 (check all that apply) Yellow Pages Magazine Radio Website Location

Cable Mail Invitation Referral _____ Other _____

Person to Contact in Case of Emergency _____ Phone _____

Responsible Party

Relationship to Patient _____

Name of Person Responsible for this Account _____

Address _____ Home Phone _____

Driver's License # _____ Birthdate _____ 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 MasterCard Amer. Express Discover

Insurance Information

Relationship to Patient _____

Name of Insured _____

Date Employed _____

Birthdate _____ Social Security # _____

Work Phone _____

Name of Employer _____ Union or Local # _____

State _____ Zip _____

Employer Address _____ City _____

Insurance Company - Please fill out attached Insurance Questionnaire

Do You Have Any Additional Insurance? Yes No If Yes, Complete the Following

Relationship to Patient _____

Name of Insured _____

Date Employed _____

Birthdate _____ Social Security # _____

Work Phone _____

Name of Employer _____ Union or Local # _____

State _____ Zip _____

Employer Address _____ City _____

Insurance Company _____

Over Please

Patient Medical History

| Physician _____ | Office Phone _____ | Date of Last Exam _____ | |
|-------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| 1. Are you under medical treatment now? | <input type="checkbox"/> | 9. Are you allergic to or have you had any reactions to the following: | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain _____ | <input type="checkbox"/> | 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 _____ | <input type="checkbox"/> <input type="checkbox"/> |
| 3. Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking? _____ | <input type="checkbox"/> | 10. Women Only: a) Are you pregnant or think you may be pregnant? b) Are you nursing? c) Are you taking oral contraceptives? | <input type="checkbox"/> <input type="checkbox"/> |
| 4. Have you ever taken Phen-Fen/Redux? | <input type="checkbox"/> | | <input type="checkbox"/> <input type="checkbox"/> |
| 5. Do you use tobacco? | <input type="checkbox"/> | | <input type="checkbox"/> <input type="checkbox"/> |
| 6. Do you use controlled substances? | <input type="checkbox"/> | | <input type="checkbox"/> <input type="checkbox"/> |
| 7. Are you wearing contact lenses? | <input type="checkbox"/> | | <input type="checkbox"/> <input type="checkbox"/> |
| 8. Do you have or have you had any of the following? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| High Blood Pressure | <input type="checkbox"/> | Heart Disease | <input type="checkbox"/> <input type="checkbox"/> |
| Heart Attack | <input type="checkbox"/> | Cardiac Pacemaker | <input type="checkbox"/> <input type="checkbox"/> |
| Rheumatic Fever | <input type="checkbox"/> | Heart Murmur | <input type="checkbox"/> <input type="checkbox"/> |
| Swollen Ankles | <input type="checkbox"/> | Angina | <input type="checkbox"/> <input type="checkbox"/> |
| Fainting / Seizures | <input type="checkbox"/> | Frequently Tired | <input type="checkbox"/> <input type="checkbox"/> |
| Asthma | <input type="checkbox"/> | Anemia | <input type="checkbox"/> <input type="checkbox"/> |
| Low Blood Pressure | <input type="checkbox"/> | Emphysema | <input type="checkbox"/> <input type="checkbox"/> |
| Epilepsy / Convulsions | <input type="checkbox"/> | Cancer | <input type="checkbox"/> <input type="checkbox"/> |
| Leukemia | <input type="checkbox"/> | Arthritis | <input type="checkbox"/> <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | Joint Replacement or Implant | <input type="checkbox"/> <input type="checkbox"/> |
| Kidney Diseases | <input type="checkbox"/> | Hepatitis / Jaundice | <input type="checkbox"/> <input type="checkbox"/> |
| AIDS or HIV Infection | <input type="checkbox"/> | Sexually Transmitted Disease | <input type="checkbox"/> <input type="checkbox"/> |
| Thyroid Problem | <input type="checkbox"/> | Stomach Troubles / Ulcers | <input type="checkbox"/> <input type="checkbox"/> |
| | | | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| | | | Chest Pains Easily Winded Stroke Hay Fever / Allergies Tuberculosis Radiation Therapy Glaucoma Recent Weight Loss Liver Disease Heart Trouble Respiratory Problems Mitral Valve Prolapse Other _____ |

Patient Dental History

| Name of Previous Dentist _____ | Date of Last Exam _____ | | |
|-------------------------------------------------------------------------|----------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------|
| Previous Dentist's Location _____ | Date of Last Cleaning _____ | | |
| | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| 1. Do your gums bleed while brushing or flossing? | <input type="checkbox"/> | 8. Do you have frequent headaches? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 2. Are your teeth sensitive to hot or cold liquids/foods? | <input type="checkbox"/> | 9. Do you clench or grind your teeth? | <input type="checkbox"/> <input type="checkbox"/> |
| 3. Are your teeth sensitive to sweet or sour liquids/foods? | <input type="checkbox"/> | 10. Do you bite your lips or cheeks frequently? | <input type="checkbox"/> <input type="checkbox"/> |
| 4. Do you feel pain to any of your teeth? | <input type="checkbox"/> | 11. Have you ever had any difficult extractions in the past? | <input type="checkbox"/> <input type="checkbox"/> |
| 5. Do you have any sores or lumps in or near your mouth? | <input type="checkbox"/> | 12. Have you ever had any prolonged bleeding following extractions? | <input type="checkbox"/> <input type="checkbox"/> |
| 6. Have you had any head, neck or jaw injuries? | <input type="checkbox"/> | 13. Have you had any orthodontic treatment? | <input type="checkbox"/> <input type="checkbox"/> |
| 7. Have you ever experienced any of the following problems in your jaw? | <input type="checkbox"/> | 14. Do you wear dentures or partials? If yes, date of placement _____ | <input type="checkbox"/> <input type="checkbox"/> |
| Clicking | <input type="checkbox"/> | 15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? | <input type="checkbox"/> <input type="checkbox"/> |
| Pain (joint, ear, side of face) | <input type="checkbox"/> | 16. Do you like your smile? | <input type="checkbox"/> <input type="checkbox"/> |
| Difficulty in opening or closing | <input type="checkbox"/> | | |
| Difficulty in chewing | <input type="checkbox"/> | | |

Authorization and Release

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 time of treatment, unless prior arrangements have been approved. Our office will be happy to file your insurance, having the insurance company responsible to you.



Hilton Head Dental, P.A.

Experience the Difference

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: _____

Dental Insurance Co: _____ Group #: _____

Insurance Claims Address: _____

PLEASE CONTACT YOUR BENEFIT PLAN ADMINISTRATOR 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 PRIORITIES 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 SMILE?
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 YOU HAVE 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 WOULD 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 paid in full within 60 days, your account will be considered past due and will be subject to interest charges up to 8%. Any account sent 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.

ACKNOWLEDGEMENT 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 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