WELCOME

Steven R. Bates, D.M.D.
8385 Dorchester Rd., N. Charleston, SC 29418

We are pleased to welcome you to our practice and would like to thank you for selecting our dental care team. We will strive to provide you with the best possible care. To help us meet your needs, please familiarize yourself with our office policies.

OFFICE HOURS and APPOINTMENTS

We see all patients on an appointment basis. We ask that you call our office in advance so that we may reserve time for you. We respect our patients' time and make every effort to remain on schedule; we request that you extend the same courtesy. Our office hours are:

Monday - Tuesday - Wednesday - Thursday 8 a.m.-5 p.m.
Friday - 8 a.m. - 1 p.m.

CANCELLATION POLICY

We pride ourselves in providing extra time for the personal attention each patient deserves. Your appointment time in this office will be reserved exclusively for you. We respect your time and make every effort to keep you from waiting. **We request you provide us with at least 48 hours notice if you need to reschedule your appointment. Without at least 24 hours notice of cancellation you will be subject to a $75.00 broken appointment fee. After three (3) broken appointments, you will be dismissed from the practice.**

FEES and PAYMENTS

Payment is expected at the time of service unless arrangements have been made prior to your scheduled appointment. We accept the following methods of payment:

CASH, MONEY ORDERS, CHECK, VISA, MASTERCARD, AMERICAN EXPRESS & DISCOVER

RETURNED CHECKS:

There will be a $35.00 charge applied to your account for any checks returned for non-sufficient funds.

INSURANCE

As a courtesy to our patients, we will file your dental insurance claims and bill your dental insurance company for treatments you receive. However, in the event the insurance company, for any reason does not pay the estimated portion of the bill, the balance will become the patient's responsibility and will be billed directly to you. Balances unpaid by your insurance will be billed to you and should be paid within 30 days. Accounts 90 days past due may be turned over to a collections agency with no further notice.

Please take the time to read and understand your insurance policy and benefits. In most cases, dental insurance is a contract between your employer and a dental insurance company. The benefits you receive are based on the terms of the contract that were negotiated between your employer and the dental insurance company, and not our dental office. Our goal is to help you achieve and maintain optimal dental care. Our office will do everything possible to help you understand and make the most of your dental insurance benefits.

If you should have any questions regarding our policies, please do not hesitate to ask. Once again, we would like to thank you for choosing our office. Please sign and date below certifying that you have read and agree to the above office policies.

_____ _____

SIGNATURE **DATE**

PATIENT NAME

PATIENT NAME _____ TODAY'S DATE _____
HOME ADDRESS _____ DATE OF BIRTH _____
_____ HOME PHONE _____
E-MAIL _____ CELL PHONE _____
EMPLOYER _____ BUSINESS PHONE _____
INSURANCE CO. _____ SS#/SIN _____

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 serious illness?	☐	☐
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐
If yes, what medication(s) are you taking? _____		
4. Have you ever taken Fen-Phen/Redux?	☐	☐
5. Do you use tobacco?	☐	☐
6. Do you use alcohol, cocaine or other drugs?	☐	☐
7. Are you wearing contact lenses?	☐	☐

8. Are you allergic to or have you had any reactions to the following?

YES	NO		YES	NO		YES	NO	
☐	☐	Local anesthetics (eg. novocaine)	☐	☐	Barbiturates	☐	☐	Aspirin
☐	☐	Penicillin or other antibiotics	☐	☐	Sedatives	☐	☐	Other _____
☐	☐	Sulfa Drugs	☐	☐	Iodine			_____

9. WOMEN ONLY:

	YES	NO
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking birth control pills?	☐	☐

10. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? ☐ ☐

11. 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/High Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma
☐	☐	Epilepsy / Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss
☐	☐	Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease
☐	☐	Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Mitral Valve Prolapse
☐	☐	Kidney Diseases	☐	☐	Hepatitis / Jaundice	☐	☐	Respiratory Problems
☐	☐	AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Other _____
☐	☐	Thyroid Problem	☐	☐	Stomach Troubles / Ulcers	☐	☐	_____

COMMENTS

_____

_____

_____

_____

_____

_____

Signature of Dentist Date

PATIENT DENTAL HISTORY

	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 teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to 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?		
a) Clicking?	☐	☐
b) Pain (joint, ear, side of face)?	☐	☐
c) Difficulty in opening or closing?	☐	☐
d) Difficulty in chewing?	☐	☐
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 had any orthodontic treatment?	☐	☐
13. Have you ever had prolonged bleeding following extractions?	☐	☐
14. Have you ever had instruction on the correct method of brushing your teeth?	☐	☐
15. Have you ever had instructions on the care of your gums?	☐	☐

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE X _____ _____

PATIENT, PARENT OR GUARDIAN DATE

REGISTRATION AND TREATMENT

Date_____ Home Phone (_____)_____

Cell Phone (_____)_____

PATIENT INFORMATION

Name _____ SS/HIC/Patient ID #_____
Last Name First Name Middle Initial

Address _____ E-mail _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age_____ Birthdate _____ ☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone (_____)_____

Whom may we thank for referring you?_____

In case of emergency who should be notified? _____ Phone (_____) _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Middle Initial

Relation to Patient _____ Birthdate _____ ID#/Soc. Sec. # _____

Address (If different from patient's)_____ Phone (_____) _____

City _____ State _____ Zip _____

Person Responsible Employed By _____ Occupation _____

Business Address_____ Business Phone (_____) _____

Insurance Company_____

Contract #_____ Group #_____ Subscriber #_____

Names of other dependents covered under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name_____ Relation to Patient _____ Birthdate _____

Address (If different from patient's) _____ Phone (_____) _____

City _____ State _____ Zip _____

Subscriber Employed by_____ Business Phone (_____)_____

Insurance Company _____ Soc. Sec. #_____

Contract #_____ Group #_____ Subscriber #_____

Names of other dependents covered under this plan _____

Please Complete Above Information and Next Page

NOTICE OF PRIVACY PRACTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPPA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, or paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPPA" provides penalties for covered entities that misuse person health information. As required by "HIPPA", we prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. We may use and disclose your medical records only for each of the following purposed: treatment, payment and health care operations.

- **Treatment** means providing, coordination, or managing health car and related services by one or more health care providers. An example of this would include teeth cleaning services.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your health insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information. We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable request to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosure of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. This notice is effective as of April 14, 2003 and we are required to abide by the terms of this Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office. You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information

Steven R. Bates, D.M.D.
8535 Dorchester Road
North Charleston, SC 29418
(843) 767-1809

For more information about HIPPA
Or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Steven R. Bates, D.M.D.
8535 Dorchester Road
North Charleston, SC 29418
(843) 767-1809

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy Reqarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and physician certifications.

I acknowledge that I have received you Notice Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I amy contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used of disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Patient/Guardian Signature: _____

Relationship to Patient: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date:	Initials:	Reason: