

Welcome To Cauthen Family Dental Care

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us.

PATIENT INFORMATION

Date _____

First Name _____ Last Name _____ Middle _____

Birthdate _____ SSN _____ Email address _____

Address _____ City _____ State _____ Zipcode _____

Home Number _____ Cell Number _____

Please check one:

Sex M F

Please check one:

Married Widowed Single Separated Divorced

Employer/School _____ Employer/School Phone _____

Employer/School Address _____ City _____ State _____ Zipcode _____

Spouse or Parent's First Name _____ Last Name _____

Employer _____ Work Number _____

Person to contact in case of emergency _____ Phone _____

RESPONSIBLE PARTY

Person responsible for this account _____ Relation to Patient _____

Address _____ City _____ State _____ Zipcode _____

Birthdate _____ SSN _____ Home Number _____ Cell _____

Are you currently a patient in our office? Yes No

INSURANCE INFORMATION (please give insurance cards to receptionist)

Name of Insured _____ Relation to Patient _____

Birthdate _____ SSN _____ Insurance Company Name _____

Employer Name _____ Work Number _____

Address _____ City _____ State _____ Zipcode _____

SECONDARY INSURANCE

Name of Insured _____ Relation to Patient _____

Birthdate _____ SSN _____ Insurance Company Name _____

Employer Name _____ Work Number _____

Address _____ City _____ State _____ Zipcode _____

OVER

Whom may we thank for referring you? (check below)

AT&T Phonebook Newspaper Friend/
 Comporium Phonebook York County Magazine Family _____
 Welcome Wagon Other _____ Name

DENTAL HISTORY

Reason for today's visit _____ Date of last dental care _____

Former Dentist _____ Date of last X-rays _____

Address _____

Please check if you have had problems with any of the following:

Bad breath Grinding teeth Sensitivity to hot
 Bleeding gums Loose teeth or broken fillings Sensitivity to sweets
 Clicking of popping jaw Periodontal treatment Sensitivity when biting
 Food collection between the teeth Sensitivity to cold Sores or growths in mouth

How often do you floss? _____ How often do you brush? _____

AUTHORIZATION AND RELEASE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. Cauthen all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient

Payment is due in full at time of treatment unless prior arrangements have been approved.

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

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.

- Are you under a physician's care now? 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 explain: _____
- 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 Local Anesthetics Acrylic Metal Latex Sulfa drugs
 Other If yes, please explain: _____

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

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

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 _____ DATE _____



1015 Creekside Medical Drive, P.O. Box 734
York, SC 29745
803-684-9220 Fax: 803-684-0910

NOTICE OF PRIVACY PRACTICES

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

Understanding your Dental Record/Health Information

Your dental record is the physical property of this practice, however the information it contains belongs to you. You have the following rights and we request that you notify the Privacy Officer of the Practice of your request for any of these actions:

1. Request Restrictions: You have a right to request restrictions on the use of your information.
2. Obtain a Paper Copy of this Notice: You have a right to receive a paper copy of this notice.
3. Inspect and Copy: You have a right to inspect and receive a copy of your dental information. If you request a copy of your information, you may be charged a reasonable fee for photocopying, retrieval, labor, postage and supplies used.
4. Amend: You have the right to request that we amend your dental information.
5. Obtain an Accounting of Disclosures: You have the right to request an accounting of certain disclosures of information that have been made about you. This listing includes disclosures of your information for other than treatment, payment or dental care purposes and is within a specified period of up to six years. The first listing of disclosures is provided as a complimentary service to you, but you may be charged a reasonable fee for additional request within a twelve-month period.
6. Request Communications of your Dental Information: You have the right to request that you receive communications regarding your information in a certain manner or at a certain location.
7. Revoke Your Authorization for Disclosure: You have the right to revoke an authorization for disclosure of information that was previously given.

Our Responsibilities

Our practice is required to:

1. Confidentiality: Maintain the privacy of your dental information.
2. Provide a copy of this notice: We will provide you with a copy of this notice of our legal duties and privacy practices with respect to the information we collect and maintain about you.
3. Abide by the terms of this notice.
4. Unable to restrict: We will notify you if we are unable to agree to a requested restriction of your information.
5. Provide alternative means or alternative locations: We will accommodate reasonable request you may have to communicate dental information by alternative means or at alternative locations. We reserve the right to change our privacy practices and to make new provisions effective for all protected dental information we keep. Should our information practices change, we will notify you of these changes when you return to our office. We will not use or disclose your dental information without your authorization, except as described in this notice.

For More Information

1. If you have a question or would like additional information, you may contact our privacy officer.
2. If you have a concern about the privacy of your information, you may contact our privacy officer. Your concerns will be responded to by our practice, but you may also file a complaint with the secretary of Health and Human Services in the U.S. Office of Civil Rights. The privacy officer will supply information about this procedure.

Examples of Disclosures of Information

1. Treatment: We will use your dental information for treatment purposes. As an example, information given to a receptionist, dental assistant, hygienist or dentist will be recorded in your dental record and used to determine the best treatment for you. Members of the dental care team will document your treatment goals, actions taken and clinical observations. We will provide your other dental care providers with copies of various reports that will help them to treat you for any subsequent conditions that may arise.
2. Payment: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, your diagnoses, treatments and supplies used.
3. Dental care operations: The dentist and members of your dental care team may use the information to evaluate the quality of care you received as well as the care received by others similar to you. This information will be used to improve the effectiveness of the dental care operations and services we provide.

Financial Policy

We feel that everyone benefits when there is a definite and clear understanding of our financial policy prior to treatment.

- Payment is due at time of service. An estimate of your total fee will be outlined in detail with you at the time of your initial visit.
- On treatment involving laboratory fees (crowns, bridges, dentures, etc.) you will be required to pay your responsibility before treatment is started.
- We offer 2 Payment Plans: Automatic Payment Plan and Care Credit.
- Patients with insurance: As a courtesy, our office will file your insurance if you provide us with the proper information. You are expected to pay your deductible and any out-of-pocket portions at the time services are rendered. In the event your insurance pays more than expected we will credit your account or send you a refund. If your insurance company does not make a payment within 60 days, you will be notified. If payment is not received within 90 days, you are immediately responsible for the remaining balance.
- Finance Charge: If an account, which is the patient's responsibility, is not paid in full within 30 days, a 1 1/2% service charge will be added to the account balance per month.
- Collection Charge: If an account, which is the patient's responsibility, is not paid in full within 90 days the account may be turned over to our Collection Agency. If this occurs, there will be a fee of 35% of your account balance charged to your account for collection fees.
- Missed Appointment Fee: We would appreciate your consideration in giving us at least 24 hours notice should you need to reschedule your appointment. If you do not show up to an appointment, or cancel with less than 24 hours notice, a fee of \$35.00 will be charged.
- Returned Checks: There will be a fee of \$30.00 for any check returned by the bank.

For your convenience, we accept Cash, Personal Checks, Visa, Mastercard and Discover. We can also assist you in obtaining financing through Care Credit.

I have read and agree to the above Financial Policy.

Patient Name

Signature of Patient or Responsible Party

Date

Effective 12/2/2010

**Cauthen Family Dental Care
Dr. Lewis J Cauthen, DMD**

**Receipt of Notice of Privacy Practices
Written Acknowledgement Form**

I, _____ have received a copy of the
Cauthen Family Dental Care Notice of Privacy Practices.

Signature of Patient/Legal Guardian

Date