



Keowee Smiles

Kenneth C. Dobson, DMD
Charles Garabadian, DDS
KeoweeSmiles.com

241 Stork Way
FAX: 864-888-3124

Seneca, SC 29678 864-888-3102

Keowee Smiles
General and Cosmetic Dentistry

PATIENT INFORMATION

DATE: _____

PATIENT'S NAME: _____
Last First MI (Preferred Name)

Street: _____

City: _____ State _____ Zip Code _____

Date of Birth: _____

SS #: _____

Email: _____ Home Phone: _____

Work Phone: _____ Cell Phone: _____

Employed at: _____

PERSON RESPONSIBLE FOR PAYMENT: *Self* **OR** *Other*
IF OTHER THAN PATIENT:
 Name: _____ Phone _____

Street: _____ City _____ State _____

Zip Code _____ Employed at: _____

Male Female
 Married Single
 Child Other

Emergency Contact Name & Phone

(relationship)

Phone: _____

Male Female
 Married Single Other

Date of Birth: _____

SS #: _____

PRIMARY DENTAL INSURANCE PLAN: _____

PLEASE PROVIDE CARD TO FRONT DESK FOR SCANNING. THANK YOU

If not patient: Subscriber's Name _____

Subscriber's address _____

Subscriber's Date of Birth: _____ Subscriber's SS# OR ID#: _____

Is this insurance through an Employer?
 Yes No

Employer: _____

Patient's relationship to subscriber:
 Self Spouse Child Other

SECONDARY DENTAL INSURANCE PLAN: _____

PLEASE PROVIDE CARD TO FRONT DESK FOR SCANNING. THANK YOU

If not patient: Subscriber's Name _____

Subscriber's address _____

Subscriber's Date of Birth: _____ Subscriber's SS# OR ID#: _____

Is this insurance through an Employer?
 Yes No

Employer: _____

Patient's relationship to subscriber:
 Self Spouse Child Other

REFERRAL INFORMATION

Whom may we thank for referring you to our practice? : _____

HEALTH INFORMATION

Have you ever had any of the following? Please mark those that apply:

<input type="checkbox"/> Compromised Immune System (Lupus, Radiation Immune Problems, etc.) <input type="checkbox"/> AIDS/HIV <input type="checkbox"/> Art. Heart Valve <input type="checkbox"/> Active Sexually Transmitted Disease (STD) <input type="checkbox"/> Anemia <input type="checkbox"/> Angina or Chest Pain <input type="checkbox"/> Arthritis <input type="checkbox"/> Artificial Joints, Joint Surgery, or Prosthesis <i>If yes, What joint, area & surgery date: _____</i> <input type="checkbox"/> Asthma <input type="checkbox"/> Atherosclerosis <input type="checkbox"/> Blood Transfusion <input type="checkbox"/> Blood Disease <input type="checkbox"/> Cancer (any form)	<input type="checkbox"/> Chemotherapy <input type="checkbox"/> Cold Sore/Fever B. <input type="checkbox"/> Congenital Heart Defects <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Coronary Artery Disease <input type="checkbox"/> Diabetes or Blood Sugar Problems <input type="checkbox"/> Dizziness/Fainting <input type="checkbox"/> Epilepsy or other Seizure Disorder <input type="checkbox"/> Excessive Bleeding <input type="checkbox"/> Emphysema <input type="checkbox"/> Glaucoma/Eye Disease <input type="checkbox"/> Growths/Tumors <input type="checkbox"/> Hay Fever <input type="checkbox"/> Head/Jaw Injuries <input type="checkbox"/> Heart Disease <input type="checkbox"/> Heart Murmur <input type="checkbox"/> Hemophillia	<input type="checkbox"/> Hepatitis A, B or C <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Jaundice <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Liver Disease <input type="checkbox"/> Heart Valve(s) Damage/ Mitral Valve Prolaps <input type="checkbox"/> Heart Attack <i>Date _____</i> <input type="checkbox"/> Heart Surgery <i>Type & Date _____</i> <input type="checkbox"/> Any Mental Disorders <input type="checkbox"/> Nervous Disorders <input type="checkbox"/> Organ Transplant <input type="checkbox"/> Osteoporosis (Boniva) <input type="checkbox"/> Pacemaker <input type="checkbox"/> Current Pregnancy <i>Due date: _____</i> <input type="checkbox"/> Pain in Jaw Joints	<input type="checkbox"/> Pre-Medication <input type="checkbox"/> Psychiatric Treatment <input type="checkbox"/> Radiation Treatment <input type="checkbox"/> Respiratory Problems <input type="checkbox"/> Rheumatic Heart Disease /Rheumatic Fever <input type="checkbox"/> Rheumatism <input type="checkbox"/> Sinus Problems <input type="checkbox"/> Skin Problems <input type="checkbox"/> Sore or Wound that bleeds easily/doesn't heal <input type="checkbox"/> Stomach Problems <input type="checkbox"/> Stroke or CVA <input type="checkbox"/> Thyroid Problem <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Ulcers or Acid Reflux <input type="checkbox"/> Venereal Disease Other Allergies: _____
---	---	---	--

Name of Physician: _____ Phone: _____

Other Physicians & Specialists
 Name: _____ Specialty: _____ Phone: _____

1. Have you been hospitalized or had surgery within the last 3 years? Yes No If yes, list reason and dates

2. Have you ever been instructed to take ANY medications or ANY special precautions before a dental appointment?
 Yes No If yes, please explain:

3. Are you taking ANY drugs, medications, or treatments at this time? Yes No (Provide list to front desk or write below)

Prescribed: _____

Over-the-counter (OTC) medications (such as Aspirin, Advil, Allergy medication, sleeping aids, etc):

Vitamins, natural or herbal preparations or chemotherapy treatments? Yes No

If yes, for how long? _____ Name of Facility performing the treatment: _____

4. Are you taking or have you ever taken/been treated with Bisphosphonate (Fosamax)? Yes No

5. Are you allergic to or have you ever experienced an unusual reaction to:

- | | | |
|--|--|--|
| <input type="checkbox"/> Latex | <input type="checkbox"/> Metal or jewelry | <input type="checkbox"/> Dental anesthesia (local) |
| <input type="checkbox"/> Fluoride | <input type="checkbox"/> Halcion (Sedation Medication) | <input type="checkbox"/> General Anesthesia |
| <input type="checkbox"/> Penicillin (or related drugs) | <input type="checkbox"/> Tranquilizers (Valium) | <input type="checkbox"/> Tetracycline |
| <input type="checkbox"/> Aspirin/Ibuprofen (Advil, Motrin, Nuprin) | <input type="checkbox"/> Keflex (Cephalexin) | <input type="checkbox"/> Sulfa Drugs |
| <input type="checkbox"/> NSAID (Celebrex, Vioxx, Anaprox) | <input type="checkbox"/> Clindamycin (Cleocin) | <input type="checkbox"/> Erythromycin |
| | | <input type="checkbox"/> Codeine |
| | | <input type="checkbox"/> Iodine |

6. Do you have any other conditions, diseases, or medical problems, or is there ANY other information that you would like us to know about, or that we should be made aware of? Yes No If Yes, Please Explain:

To the best of my knowledge, all of the information provided are true and correct. Should I have any changes in my health, I will inform the doctors at the next appointment without fail.

Date: _____

Signature of patient, parent or guardian

Consent for Services at Keowee Smiles

Payment: I agree to accept full responsibility for the payment of all fees associated with procedures performed and all costs incurred in the collection of these fees. As a courtesy, Keowee Smiles will file insurance, but the patient is still responsible for the charges incurred. The patient is required to pay all insurance deductibles, and all non-covered costs at the time services are rendered. We will file your insurance at the time of service. Keowee Smiles will refile the claim one time. After 30 days if your insurance company has not paid, the patient is responsible for balance.

A courtesy savings of 10% is offered for treatment prepaid in full (regardless of insurance coverage) 48 hours in advance of appointments. PLEASE NOTE: prepayment savings are not offered with other payment plans, and are valid only for procedures paid in full prior to appointments.

Authorization of insurance payment: I authorize the release of any information relative to dental claims and also authorize all insurance payments to the provider.

Web Consent: I hereby give permission to the office of Keowee Smiles to review my patient information from the website of keoweesmiles.com. I understand that this allows me to view my patient and/or family information by logging in under a username and password. Initial _____

Treatment Plan Estimates are provided as a courtesy to you. PLEASE NOTE: treatment estimates are valid for 90 days from the date of the patient examination. Fees are subject to change due to treatment changes.

I agree to allow designated staff members of Keowee Smiles the right to perform dental treatment, take necessary x-rays, photographs and structure my dental treatment according to my best interest for optimum dental health. I grant my permission to Keowee Smiles to telephone me at home or at my work to discuss matters related to this form, my appointments and/or my dental treatment.

By signing below I have read the above conditions of treatment and payment and agree to their content.

SIGNED: _____ DATE: _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION HIPPA

Notice of Privacy Practices: You have the right to read our [Notice of Privacy Practices](#) before deciding whether to sign this Consent. Our Notice provides a description of our treatment and payment activities, the uses and disclosures we may make of your protected health information, and other important matters about your protected health information including use of intra-oral and extra-oral pictures. **A copy of our Notice is available for your review.**

We reserve the right to change our privacy practices as described in our [Notice of Privacy Practices](#). If we change our privacy practices a revised [Notice of Privacy Practices](#) will be issued. Changes may apply to any of your protected health information that we maintain. A copy of our [Notice of Privacy Practices](#), including any revisions, may be obtained at any time by contacting our office at 864-888-3102.

Purpose of Consent: By signing this form, you consent to our use and disclosure of your protected health and dental information for treatment and payment activities. **You are entitled to a copy of this consent after you sign it.** We can opt to decline treating you in the event you refuse to sign this Consent.

Right to Revoke: This Consent can be revoked at any time by submitting a written notice of your revocation to our office. Revocation of this Consent will not affect any action we took in reliance of this Consent before receiving your revocation. We can opt to decline treating you in the event you revoke this Consent.

I have had full opportunity to read the [Notice of Privacy Practices](#) before signing this Consent form. By signing this Consent form, I consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship of Patient: _____

Please specify the exact reason why patient chose not to sign the Consent for Use and Disclosure Form:

