TYLAN CREEK FAMILY DENTISTRY, P.A.

DARRYL L. HALBERT, D.M.D.
JOSHUA A. BURNS, D.D.S.
WILLIAM M. FORRESTER, D.M.D.
LANCEN W. HALBERT, D.M.D.

PATIENT INFORMATION:

Name: _____

Address: _____ City & Zip: _____

SS#_____ -_____ -_____ Birthday: _____/_____/_____ Sex: _____

Marital Status: Single Married Divorced Widowed

Phone: _____ Cell: _____ E-mail: _____

We confirm through electronic emails and texts prior to making phone calls. Please check any/all boxes that you would like to receive confirmation reminders: ***text*** ☐ ***email*** ☐ ***cell*** ☐

Responsible Party **(if minor)**: _____ Relationship to Patient: _____

In Case of Emergency (closest relative or friend):

Name: _____ *Phone:* _____

Ins. Policy Holder Information:

Dental Ins. Co. _____ Policy #_____

Employer: _____

Employer Address: _____

City & Zip: _____ Phone: _____

Name of Policyholder **(if different from above)**:_____

Address: _____ City & Zip: _____

Phone: _____ Cell: _____ E-Mail:_____

SS# _____ -_____ -_____ Birthday: _____/_____/_____

Whom may we thank for referring you to our office? _____

Time 1:34 PM | Tylan Creek Family DentistrySimpsonville | Date 1/30/2015

Updated 2015

Patient Name: | Birth Date: | Date Created:

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
Have you ever been hospitalized or had a major operation?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Are you taking any medications, pills, or drugs?	Yes No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Are you on a special diet?	Yes No	
Do you use tobacco?	Yes No	
Do you use controlled substances?	Yes No	
Do you presently or have you ever been informed that you need to premedicate prior to dental	Yes No	If yes

Women: Are you...

- Pregnant?
- Nursing?
- Taking oral contraceptives?
- Trying to get pregnant?

Are you allergic to any of the following?

- Aspirin
- Penicillin
- Codeine
- Acrylic
- Metal
- Latex
- Sulfa Drugs
- Local Anesthetics

Other Allergy/Allergies not listed above:

Do you have, or have you had, any of the following?

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

Have you ever had any serious illness not listed Yes No If yes

Signature of Patient, Parent or Guardian:

X Date:_____

Tylan Creek Family Dentistry
330 Harrison Bridge Road
Simpsonville, South Carolina 29680

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of privacy Practices, which will contain the changes. Those changes may apply to any or your protected information that we maintain.

You may obtain copy or our Notice of Privacy Practices, including any revisions of our Notice at any time by contacting:

Telephone: (864) 962-6671
Address: 330 Harrison Bridge Rd., Simpsonville, S.C. 29680

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contract Person listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____Date: _____

CONSENT TO TREAT

Patient's Name: _____ DOB: _____

I give consent for myself/child to receive dental treatment deemed necessary by the providers at Tylan Creek Family Dentistry. These procedures include, but are not limited to; examinations, oral prophylaxis (cleanings), fluoride treatments, sealants, restorations (amalgam or composite fillings and crowns), periodontal (gum) treatments, endodontic (root canal) treatments, extractions, and the use of local anesthetics and nitrous oxide (upon request). I understand that the use of local anesthetics carries a small risk of swelling, bruising, allergic reaction, changes in pain perception, or prolonged anesthesia. This consent shall be considered in effect until rescinded or revoked.

_____	_____	_____	_____
(Printed Name)	(Signature)	(Relationship)	(Date)

YOU ARE ENTITILED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT

RELEASE OF INFORMATION

The following individuals are authorized to obtain information in regards to my medical information (including, but not limited to, treatment given and/or diagnosed, account information, and scheduled appointments. This signed release shall be considered in effect until rescinded or revoked. If the patient is a minor, parents will need to list themselves as well.

_____	_____	_____
Name	Relationship to Patient	Date
_____	_____	_____
Name	Relationship to Patient	Date

Financial Arrangement

While we understand that it is often uncomfortable to discuss payment for our services, it is essential that our patients are aware of associated fees and various options of payment that are available. *It is important to understand that our primary concern is our relationship with our patients, not their insurance companies.* We feel strongly that our use of the finest procedures, combined with extensively trained staff members, allows us to provide the highest level of care available anywhere in the country. Fortunately our practice offers several payment options that make this highest level of care affordable for everyone.

1. **Pay In Advance**-It is certainly preferred for full payment to be made prior to the time services are rendered. If restorative services are proposed at your appointment, we offer an 8% courtesy fee reduction for payment made at time of proposal. In exchange for offering this discount, we ask that you pledge to keep your scheduled appointment. If you do not provide us with at least 48 hours notice of cancellation or rescheduling of appointment, the 8% discount will be nullified.

2. **Pay over Time-** If you choose not to take advantage of the discounted option, we can help make arrangements for you to make regular monthly payments. Such payments can be stretched out over a 6 to 12 month period, interest free. All it takes is a quick credit application which we process here in our office.

3. **Pay At Time Services Are Rendered**- If you have insurance we will collect payment of your estimated portion at the time services are rendered and will accept assignment of benefits from your insurance company to cover the balance. You will, of course, be responsible for paying any balance that may remain after your insurance claim is settled.

   We file insurance as a courtesy to our patients. Please be aware that some, or perhaps all of the services provided may be non-covered services and not considered reasonable and usual by your insurance company. Also, some insurance companies will deny receipt of your claim. We recommend that you follow-up with your insurance company within the next 14 days and advise us if there is a problem. Additionally, some insurance companies will request additional information such as dental records, x-rays, etc., which usually delays payment. We respond to each request as quickly as we reasonably can. We ask that you do the same if your insurance company is requesting information directly from you. If for any reason we have not received payment from your insurance company within 90 days, you will be responsible for paying the existing balance immediately and any future payments by the company will go directly to you.

   ***Some Delta Dental Insurance Policies will not pay the provider directly and full payment must be made before services are rendered. We will still file your claim for you however the insurance payment is sent directly to the Policy Holder**.

   ***Return checks will be subject to a $30.00 returned check charge and any other collection fees that may be incurred**

If you should have any questions regarding our financial policy, please feel free to discuss any concerns with us. Thank you and we look forward to providing you with outstanding care.

_____	_____	_____
Print Name	Signature	Date

WARRANTY INFORMATION

We believe in our work and want you the patient to believe in it as well. Therefore we offer a warranty on all work we do*.

- Fillings & Sealants are under warranty for one (1) year.
- Crowns, Root Canals & Bridges are under warranty for three (3) years.
- Cerec Restorations are under warranty for two (2) years.
- Dentures are under warranty for one (1) year from seat date.
- Partials are under warranty for two (2) years from seat date. This does not include temporary partials.

* Warranty is only valid if patient continues on six (6) month recall appointments (for denture placement the patient must come in for six (6) month periodic oral evaluations). We monitor the progress/condition of all work done at these appointments, as well as your overall health and oral hygiene. It is important to realize that even the best restoration will fail if optimal gum health is not maintained. Warranty includes replacement at no charge or amount charged for original work credited towards other work that might need to be done.

APPOINTMENT AGREEMENT

At Tylan Creek Family Dentistry, we pride ourselves in respecting our patients' busy schedules and on completing their scheduled treatment in a timely manner. You will always be seated within 10 minutes of your scheduled arrival and you will always be dismissed by your scheduled completion time. We spend hours every month refining ways to insure that your scheduled time with us will never cause disruption in the remainder of your daily schedule. We take this task seriously, and that is why our patients have never had lengthy waits and never will. We have discovered that in nearly every single instance that we have failed in this commitment, it is due to a patient failing to show up for scheduled treatment without giving us 48 hours' notice. The result is a scramble to work someone into a time slot, whose needs don't quite fit with the time and resources allotted. We consider our appointment time to be a verbal contract. We require you to give us 48 hours' notice of any changes to this contract. Doing so will allow us to get in another patient whose needs precisely fit into that available schedule slot, and prevent that time from being permanently lost. That way we continue to always be on time, and more importantly so will you.

_____ _____

Patient Signature Date