DENTAL HEALTH HISTORY
(Confidential)

Today's Date_____

Patient Name _____ Birthdate_____

Last First Initial

DENTAL HISTORY

Reason for Today's Visit _____

Former Dentist _____

Address _____

Date of last dental care_____ Date of last X-rays _____

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 or popping jaw	☐ Periodontal treatment	☐ Sensitivity when biting
☐ Food collection between teeth	☐ Sensitivity to cold	☐ Sores or growths in your mouth

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

MEDICAL HISTORY

Physician's Name_____ Date of Last Visit _____

Have you had any serious illnesses or operations? _____ If yes, describe _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates _____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (√) if you have or have had any of the following:

☐ AIDS	☐ Cortisone Treatments	☐ Hepatitis	☐ Rheumatic Fever
☐ Anemia	☐ Cough, Persistent	☐ High Blood Pressure	☐ Scarlet Fever
☐ Arthritis, Rheumatism	☐ Cough up Blood	☐ HIV Positive	☐ Shortness of Breath
☐ Artificial Heart Valves	☐ Diabetes	☐ Jaw Pain	☐ Skin Rash
☐ Artificial Joints	☐ Epilepsy	☐ Kidney Disease	☐ Stroke
☐ Asthma	☐ Fainting	☐ Liver Disease	☐ Swelling of Feet or Ankles
☐ Back Problems	☐ Glaucoma	☐ Mitral Valve Prolapse	☐ Thyroid Problems
☐ Blood Disease	☐ Headaches	☐ Nervous Problems	☐ Tobacco Habit
☐ Cancer	☐ Heart Murmur	☐ Pacemaker	☐ Tonsillitis
☐ Chemical Dependency	☐Heart Problems	☐ Psychiatric Care	☐ Tuberculosis
☐ Chemotherapy	Describe_____	☐ Radiation Treatment	☐ Ulcer
☐ Circulatory Problems	☐ Hemophilia	☐ Respiratory Disease	☐Venereal Disease

MEDICATIONS

List medications you are currently taking:

_____

_____

Pharmacy Name _____

Phone _____

ALLERGIES

☐ Aspirin	☐ Penicillin
☐ Barbiturates (Sleeping pills)	☐ Sulfa
☐ Codeine	☐Other _____
☐ Local Anesthetic	_____

SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date _____ Signature _____

PATIENT REGISTRATION

(PLEASE PRINT)

Date_____ Home Phone_____

Email Address: _____ Cell Phone_____

Patient_____

Last Name First Name Initial Preferred Name

Street Address_____ City_____ State_____ Zip_____

Sex: ☐ M ☐ F Age_____ Birthdate_____ ☐Single ☐Married ☐Widowed ☐ Separated ☐ Divorced

Employed by_____ Occupation _____

Business Phone _____

Spouse Name _____ Spouse Birthdate _____

Spouse Employed by _____ Occupation _____

Business Phone _____

Who is responsible for this account? _____ Relationship to Patient _____

Social Security # _____ Spouse Social Security # _____

Name of Dental Insurance Company _____ Group Number _____

In case of emergency, who should be notified? _____ Phone _____

Whom may we thank for referring you? _____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance with _____

Name of Insurance Company(ies)

and assign directly to Dr. _____ all 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

_____ _____

Date *Signature*

MINOR/CHILD CONSENT

I, being the parent or guardian of _____ do hereby request

Name of minor/child

and authorize the dental staff to perform necessary dental services for my child, including but not limited to X-rays, and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

_____ _____

Date *Signature of Insured/Guardian*

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges not covered by insurance.

_____ _____

Date *Signature of Insured/Guardian*

SmileCare

-Payment Options
For
Dr. James J. Swick, II

Dr. Swick strives to offer convenient payment options while at the same time maintaining the high standard of comprehensive dental care that our patients deserve. Please take a moment to review the financial options offered and indicate your choice of payment.

- ***Plan A: Payment in full on the day of each visit.***

- ***Plan B: You may use your credit or debit card to make payment. We gladly accept Master Card or Visa.***

- ***Plan C: We are pleased to offer our patients another extended monthly payment plan option through a dental financing company called Care Credit. Please see the office manager prior to treatment for more details and to receive a loan application.***

- ***Plan D: Our goal is to help you maximize your dental insurance benefits. As a courtesy, we are happy to bill your dental plan for services. Please remember that the contract itemizing your dental benefits is between you, and your employer, and your insurance carrier. Regardless of coverage, your estimated co-payment is due in full the day of treatment. If your dental plan does not pay within 60 days of treatment, you must pay the outstanding balance and seek reimbursement from your dental plan. Also remember that dental insurance plans are not designed to cover all of your dental needs. Rather, the amount your dental plan contributes towards your dental care is based on the plan selected and purchased by your employer.***

Again feel free to contact the office manager if you have questions regarding the payment options described above. We thank you for trusting us with your dental care needs and hope that you will let us know if we can improve our service to you in any way.

I, _____, have chosen option _____ (above) and accept full financial responsibility for this account and for all dentistry performed upon my dependents in this dental office. I understand that it is up to me to confirm my insurance eligibility, waiting periods, and benefits. I also understand that this office cannot guarantee my insurance status in any of these areas. Any insurance estimate or information given to me by this office is not a guarantee of actual insurance payment. I also understand that any insurance claim not paid in full after 60 days will become my responsibility to pay at that time.

_____	_____	_____
Patient Signature	***Staff Signature***	***Date***

SmileCare

Authorization for Release of Information

Name of Patient _____ Date of Birth _____

James J. Swick, II DDS or any employee acting on Dr. Swick's behalf, is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
❑ Voice Mail	❑ Results of lab tests/x-rays ❑ Other_____
❑ Spouse	❑ Financial ❑ Medical as follows:_____ _____
❑ Parent (provide name) _____	❑ Financial ❑ Medical as follows:_____ _____
❑ Other (provide name) _____ _____	❑ Financial ❑ Medical as follows _____ _____

Patient Information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

_____ Date_____

Signature of Patient or Personal Representative

Description of Personal Representative's Authority (attach necessary documentation):

_____

Authorization to Release Health Information

Expires upon one time release

Patient Information:

Name of Patient _____ Date of Birth _____

Address_____

City, State, Zip _____

I authorize the practice below to release my health information:

_____

_____

_____

Please forward/release my health information to:

SmileCare

James J. Swick, II D.D.S, P.A.
9353 Two Notch Road
Columbia, SC 29223
788-5360 - office
788-9953 - fax

The information below is provided at the request of the patient. (Describe PHI needed)

_____

_____

This authorization shall be in effect until the information has been forwarded as requested.

Patient Information

I understand that my treatment will not be conditioned on signing this authorization and that I have the right to refuse to sign this authorization. *I understand that information disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.*

I understand that I have the right to revoke this authorization by sending a written notification to the address below and that a revocation is not effective if the information has already been disclosed but will be effective going forward.

I understand that I have the right to inspect or copy the protected health information as described in this document. I can do this by written notification to _____

_____.

_____ Date _____

Signature of Patient or Personal Representative

SmileCare

James S. Swick, II D.D.S

Acknowledgement of Receipt
Of Notice of Privacy Practices

I, _____, have received a copy of this office's Notice of Privacy Practices.

Print Patient Name _____

Patient Address _____

_____

_____

_____ _____

Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ❑ An emergency existed & a signature was not possible at the time.
- ❑ The individual refused to sign.
- ❑ A copy was mailed with a request for a signature by return mail.
- ❑ Unable to communicate with the patient for the following reason:
  _____
- ❑ Other:_____
  _____

Prepared By _____

Signature _____

Date _____

Notice Of Privacy Practices
for the office of

SmileCare

James J. Swick, DDS
9353 Two Notch Rd.
Columbia, SC 29223
803-788-5360

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.

Uses and disclosures to carry out treatment, payment, and health care operations

Treatment- This practice may use or disclose your protected health information in consultation between health care providers relating to your treatment or for your referral to another health care provider for your treatment.

Payment- This practice may use or disclose your protected health information for billing, claims management, collection activities, or obtaining payment.

Health care Operation- This practice may use or disclose your protected health information for reviewing the competence or qualifications of health care professionals, or for conducting training programs in which students, trainees, or practitioners participate. This practice may use or disclose your protected health information for accreditation, certification, licensing, or credentialing activities. This practice may use or disclosure your protected health information to our business associates who participate in our healthcare operations. These disclosures will only be made after we have satisfactory assurances in the form of a Business Associates Agreement from the business associate. These assurances will include their agreement to comply with the HIPAA rules and the compliance of any subcontractor with which they do business.

Authorized Uses or Disclosures:

The following uses or disclosures require a valid authorization as defined by the HIPAA standards.

Uses or Disclosures for Psychotherapy Notes- Not applicable to this practice

Uses or Disclosures for Marketing Purposes- Not applicable to this practice

Disclosures for a Sale of Protected Health Information- This practice will require an authorization for any disclosures that would constitute a sale of protected health information.

For any other use or disclosure you wish us to make, you can give us a written, valid authorization. Your authorization must have specific instructions for the use and disclosure you want us to make. You will have the right to revoke the authorization in writing at any time before the information is used or disclosed.

Uses or disclosures requiring an opportunity for the individual to agree or object

For disclosures to others involved with your health care or payment, we will inform you in advance and give you the opportunity to agree or object. These disclosures will be limited to the information necessary to help with your health care or payment. These disclosures will only be made if you do not object.

Uses and disclosures for which an authorization or opportunity to agree or object is not required

The following uses or disclosures do not require an authorization or the opportunity for you to agree or object.

Uses and disclosures required by law-This practice may use or disclose protected health information to the extent required by law. The use or disclosure will comply with and be limited to the relevant requirements of such law.

Uses and disclosures for public health activities-This practice may use or disclose protected health information for the purpose of preventing or controlling disease, injury, or disability, including, but not limited to, the reporting of disease, injury, and vital events such as birth or death.

Disclosures about victims of abuse, neglect or domestic violence This practice may disclose protected health information about an individual whom this practice reasonably believes to be a victim of abuse, neglect, or domestic violence.

Uses and disclosures for health oversight activities-This practice may disclose protected health information to a health oversight agency for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations, inspections, licensure, or disciplinary actions.

Disclosures for judicial and administrative proceedings- This practice may, in response to an order of a court or administrative tribunal, provide only the protected health information expressly authorized by such order or a subpoena.

Disclosures for law enforcement purposes- This practice may disclose protected health information as required by law including laws that require the reporting of certain types of wounds or other physical injuries.

Uses and disclosures about decedents- This practice may disclose protected health information to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law. We may disclose protected health information to a funeral director, as authorized by law, to carry out their duties. This disclosure will be made in reasonable anticipation of death.

Uses and disclosures for cadaveric organ, eye or tissue donation purposes- This practice may use or disclose protected health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of cadaveric organs, eyes, or tissue for the purpose of facilitating organ, eye or tissue donation and transplantation.

Uses and disclosures for research purposes- This practice may use or disclose protected health information for research, when the research has been approved by an institutional review board or privacy board, to protect your protected health information.

Uses and disclosures to avert a serious threat to health or safety- This practice may, consistent with applicable law and standards of ethical conduct, use or disclose protected health information, in good faith, if we believe the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Uses and disclosures for specialized government-This practice may use and disclose the protected health information of individuals who are Armed Forces personnel for activities deemed necessary by appropriate military command authorities to assure the proper execution of the military mission, if the appropriate military authority has published by notice in the Federal Register.

Disclosures for workers' compensation-This practice may disclose protected health information as authorized by and to the extent necessary, to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

Patient rights under HIPAA

The following information describes your rights under the HIPAA Standards. This practice requires that all requests for the various rights be made in writing and we will provide our decision on your request in writing. You should be aware that there may be some situations when there could be limitations placed on your rights. We are required to permit you to request these rights, but we are not required to agree to your request, except as discussed in the Right of Restriction section.

Right of an individual to request a restriction of uses and disclosures
This practice will permit an individual to request that we restrict uses or disclosures of protected health information about the individual to carry out treatment, payment, or health care operations or to others involved in your care or in payment. We will consider these requests, but we are not required to agree to them, except as discussed in the next section.

Under your right of restriction, you may restrict certain disclosures of protected health information to a health plan for payment or healthcare operation, where payment in full is made out of pocket for a healthcare item or service

Confidential communication requirements
This practice will permit an individual to request and will accommodate reasonable requests to receive communications of protected health information from our practice by alternative means or at an alternative location.

Access of individuals to protected health information
An individual has a right of access to inspect and obtain a copy of protected health information about the individual in a designated record set except as prohibited by state or federal law or certain other exemption. Your access may be provided in electronic form if producible at your request or in another form or format. As permitted by state and federal law, we may charge you a reasonable cost based fee for a copy of your record. Questions about the fee should be addressed to our Privacy Officer at the phone number listed at the end of this document.

Amendment of protected health information
An individual has the right to ask to have this practice amend protected health information or a record about the individual in a designated record set for as long as the protected health information is maintained in the designated record set.

Accounting of disclosures of protected health information
An individual has a right to receive an accounting of disclosures of protected health information made by this practice in the past six years but not before April 14, 2003. The accounting will not include disclosures made for treatment, payment, or operations, as well as authorized disclosures or disclosures made for which you had an opportunity to agree or object. You may receive one free accounting in a 12 month period. There will a reasonable cost based fee for additional requests.

Right of Breach Notification
An individual has the right to and will receive a notification of any breach of their unsecured protected health information as defined by the Breach Notification Rule. We will fulfill our obligation to provide notice in accordance to HIPAA standards.

Copy of this notice
You have a right to a copy of this notice. Even if you agreed to receive an electronic copy, you may request and receive a paper copy.

Our Duties

This practice is required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information.

This practice is required to abide by the terms of the notice currently in effect.

This practice is required to notify you of any change in a privacy practice that is described in the notice to protected health information that we created or received prior to issuing a revised notice. We reserve the right to change the terms of our notice and to make the new notice provisions effective for all protected health information that we maintain.

Complaints

If at any time you feel we have violated your HIPAA rights, please contact our Privacy Officer or the Secretary of Health and Human Services. This practice will not retaliate against any individual for filing a complaint.

Contact

You have the right to file a complaint with our Privacy Officer at the address and phone number at the top of this notice, or with the Office of Civil Rights, US Department of Health and Human Services, 61 Forsyth St., SW, Suite 3B70, Atlanta, GA 30323.

Effective Date of the Notice is September 23, 2013