PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

IF THIS APPOINTMENT IS FOR YOU START HERE

DATE			1
LAST NAME	FIRST		M.I.
PREFERS TO BE CALLED BY			
ADDRESS			
CITY	STATE		ZIP
HOME PHONE NO.		FAX	
CELL		EMAIL	
BIRTHDATE	AGE	MALE	FEMALE
MARRIED	SINGLE	DIVORCED	WIDOWED
SOCIAL SECURITY NO.			

IF THIS APPOINTMENT IS FOR YOUR CHILD START HERE

DATE			
LAST NAME	FIRST		M.I.
ADDRESS			
CITY	STATE		ZIP
HOME PHONE NO.			
BIRTHDATE	AGE	MALE	FEMALE
SCHOOL			GRADE
SOCIAL SECURITY NO.			

IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO

DENTAL INSURANCE	2
PRIMARY CARRIER	
INSURANCE COMPANY	
GROUP NO.	
EMPLOYER NAME	
INSURED'S NAME	
DATE OF BIRTH	RELATIONSHIP TO PATIENT
INSURED'S I.D. NO.	
INSURED'S SOCIAL SECURITY NO.	
SECONDARY CARRIER	
INSURANCE COMPANY	
GROUP NO.	
EMPLOYER NAME	
INSURED'S NAME	
DATE OF BIRTH	RELATIONSHIP TO PATIENT
INSURED'S I.D. NO.	
INSURED'S SOCIAL SECURITY NO.	

GETTING TO KNOW YOU		3
IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?		
NAME:		
RELATIONSHIP:		
YOU WERE REFERRED TO US BY		
NAME:		
PERSON TO CONTACT FOR EMERGENCY		
NAME:		
CELL NUMBER		
HOME NUMBER		
ADDRESS		
CITY	STATE	ZIP

ACCOUNT INFORMATION		4
PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT		
NAME		
RELATIONSHIP TO PATIENT	SOCIAL SECURITY NO.	
ADDRESS		
CITY	STATE	ZIP
PHONE NO.		
YOU		
NAME		
OCCUPATION		
EMPLOYER'S NAME		
ADDRESS	CITY	
PHONE NO.	FAX NO.	
YOUR SPOUSE		
NAME		
OCCUPATION		
EMPLOYER'S NAME		
ADDRESS	CITY	
PHONE NO.	FAX NO.	

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) ________________________'s dental needs.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

6 Cell Phone: ☐ I consent to the dental practice using my cell phone number to (choose one or both) ☐ call or ☐ text regarding appointments and to call regarding treatment, insurance, and my account. I understand that I can withdraw my consent at any time. My cell phone number is (include area code) ________________________

Patient's Signature________________________ Date ____________ Witness ________________

Parent/Responsible Party's Signature ________________________ Relationship to Patient ____________

MEDICAL HISTORY

Patient Name ______________________ Birth Date ______________

Patient SS# ______________________ Medical Alert ______________

1. Have you ever been under the care of a medical doctor during the past two years? Yes No
   If yes, for what? ______________________
2. Physician's Name ______________________ Phone ______________
   Address ______________ City ______________ State ________ Zip ________
3. Have you taken any medication, herbs, supplements or drugs during the past two years? Yes No
4. Do you use Viagra or any other similar drugs? Yes No
5. Are you taking any medication, herbs, supplements regular doses of aspirin or drugs now? Please list: ______________
6. I am aware that street drugs (including alcohol) may cause life-threatening reactions with dental procedures. (please initial) ________
7. Have you ever taken any prescription drugs for weight loss, including Fen-Phen; Pondimen; or Redux Yes No
   If yes, did you have a medical exam for heart issues? Yes No
8. Are you aware of having an allergic (or adverse) reaction to any medication or substance? Yes No
   If yes, please list ______________________
   Have you ever taken antibiotics before any dental treatment? ***Yes*** ***No***

Indicate which of the following you have had, or have at the present. Circle "Y" (yes) or "N" (no) to each item.

Heart (surgery, disease, attack)	Y N	Ulcers	Y N	Hepatitis	Y N
Chest Pain	Y N	Diabetes	Y N	Sexually Transmitted Disease	Y N
Congenital Heart Disease	Y N	Thyroid Problems /or / Parathyroid	Y N	AIDS / or HIV Positive	Y N
Heart Murmur / Irregular Heartbeat	Y N	Glaucoma	Y N	Stomach or Intestinal Disease	Y N
High / Low / Blood Pressure	Y N	Cold Sores / Fever Blisters	Y N	Mitral Valve Prolapse	Y N
Emphysema / or other Lung Disease	Y N	Blood Transfusion	Y N	Artificial Heart Valve	Y N
Hemophilia	Y N	Heart Pacemaker	Y N	Tuberculosis	Y N
Sickle Cell Disease / or Trait	Y N	Anemia	Y N	Rheumatic Fever	Y N
Asthma / or Breathing Problems	Y N	Arthritis / Rheumatism	Y N	Hay Fever	Y N
Liver Disease / Yellow Jaundice	Y N	Latex Sensitivity	Y N	Neurological Disorders / Shingles	Y N
Allergies or Hives	Y N	Epilepsy or Seizures	Y N	Stroke	Y N
Sinus Trouble	Y N	Fainting or Dizzy Spells	Y N	Radiation Therapy / or Chemotherapy	Y N
Nervous / Anxious	Y N	Artificial Joints (hip, knee, etc)	Y N	Excessive Thirst / or Dry Mouth	Y N
Psychiatric/Psychological Care	Y N	Kidney Trouble	Y N	Cancer	Y N
Sensitivity to Dental Anesthetic	Y N	Frequent Headaches	Y N	Bruise Easily	Y N
Contact Lenses	Y N	Hepatitis A B C (circle)	Y N	Chronic Cough	Y N
Alzheimer's Disease	Y N	Tonsillitis	Y N	Hypoglycemia	Y N

9. Do you have or had any disease, condition, or problem not listed? Please list. ______________
10. Do you use more than 2 pillows to sleep? Yes No
11. **WOMEN:** Are you Pregnant? Yes No Month ________ Nursing? Yes No Taking birth control pills? Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency who may release such information to you. I will notify the dentist of any change in my health or medication.

Patient / Guardian Signature ______________________ *Date* ________

Dentist Signature ______________________ Date ________

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General Dentistry

GENERAL OFFICE POLICIES

IN ORDER for us to continue to provide you with outstanding customer service and care, please review and sign the following policies of our office.

Vista Smiles is a general dental practice that employs general dentists.

Payment is due when services are rendered. We accept cash, checks, Visa, Master Card and Discover. Additional financing may be available pending approval.

Insurance: We accept assignment of many dental plans. However, we do require the **estimated** co-payment portion of your bill to be paid at the time of service. The balance is your responsibility whether your dental plan pays or not. Your policy is a contract between you and the insurance company. We are not a party to that contract. If your dental plan has not paid your account in full within 45 days, the balance must be paid once you receive your statement. Please be aware that some, and perhaps all of the services provided, may be non-covered services and are not considered reasonable and customary *under your dental plan*. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Please be advised that if your treatment is not covered under your specific plan, full payment is due at the time of service. *We are not a Medicare Provider and neither this office nor its patients can file dental claims to/with Medicare.*

Additional Insurance Information: We are reiterating our General Office Policy regarding **dental benefits** this includes all PPO in which we participate (ex BCBS-SC PPO). Dental benefits Fees Allowance are based on the least costly alternative. Members are responsible for amounts exceeding the PPO allowance.

EXAMPLE: Tooth colored composite restoration on molars or use of precious materials rather than non-precious.

Adult/Minor Patients: Adult patients are responsible for full payment of their portion at the time of service. The adult accompanying a minor (parents or guardian of the minor) are responsible for full payment of their portion at the time of service. Children under the age of 16 must be accompanied by a parent or guardian at all times.

Guarantee of Work: Vista Smiles guarantees restorative work for up to five years depending upon you maintaining your individual homecare needs. This is also contingent upon you keeping your recommended treatment and preventative care appointments. The non-compliance of the above will make this guarantee null and void.

____ Date________________

Signature of Patient or Responsible Party

515 Richland Street Columbia, SC 29210 P: 803-779-9666 F: 803-779-4622

Vista Smiles of Columbia

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

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

____

{Please Print Name}

____

{Signature}

____

{Date}

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

Personal Representative's name______________________________

Relationship to Patient______________________________

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

____

____

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VISTA SMILES OF COLUMBIA

NOTICE OF PRIVACY PRACTICES

APPOINTMENT REMINDERS: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, letters or E-mails).

PATIENT RIGHTS

ACCESS: You have the right to look at or get copies of your health information with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $25.00 for staff time to locate and copy your health information. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

DISCLOSURE ACCOUNTING: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you requested this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

RESTRICTION: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions but if we do, we will abide by our agreement (except in an emergency).

ALTERNATIVE COMMUNICATION: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **(You must make your request in writing).** Your request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

AMENDMENT: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

ELECTRONIC NOTICE: If you receive this Notice on our Web site or by electronic mail (E-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our Privacy Practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your Privacy Rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Anne Kay
Address: Vista Smiles of Columbia
515 Richland Street
Columbia, SC 29201
Phone: 803-779-9666
FAX: 803-779-4622

Video/Picture Release Form

Vista Smiles of Columbia
515 Richland Street
Columbia, SC 29210

The undersigned patient (or representative of the patient on behalf of the patient) hereby grants, conveys and releases to Vista Smiles of Columbia, LLC and its successors, affiliates, and assigns the unrestricted right and license to use, reproduce or otherwise publish recordings of my voice and/or copies of my photo or likeness as may have been recorded, or obtained by or for Vista Smiles, by any means and in any format, to be used or not used in its sole and absolute discretion, whether such use is in print, television, or as part of an Internet posting, webpage or other media, such as to be limited, however, to those informational services, marketing, or promotional activities of Vista Smiles or its affiliated companies.

Patient Name______________________________

Name: (print)______________________________

Signature:______________________________ Phone:__________________

Address:____

Date:________________

I am 18 years of age or older ☐

I am the parent or guardian of the minor named above, and I hereby grant consent on behalf of the minor and myself ☐

VISTA SMILES OF COLUMBIA

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our Privacy Practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provide such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

TREATMENT: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

PAYMENT: We may use and disclose your health information to obtain payment for services we provide to you.

HEALTHCARE OPERATIONS: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

YOUR AUTHORIZATION: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except for those described in this Notice.

TO YOUR FAMILY AND FRIENDS: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

PERSONS INVOLVED IN CARE: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of health information.

MARKETING HEALTH-RELATED SERVICES: We will not use your health information for marketing communications without your written authorization.

REQUIRED BY LAW: We may use or disclose your health information when we are required to do so by law.

ABUSE OR NEGLECT: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

NATIONAL SECURITY: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.