Hilton Head Dental, PA
Experience the Difference

Thank You for Selecting Our Dental Team

To help us meet all your healthcare needs, please fill out this form completely in ink.
If you have any questions or need assistance, please ask us and we will be happy to help.

Patient Information (Confidential)

Patient Number _____

Name _____ Date _____

Soc. Sec. # _____ Birthdate _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

EMail _____ Fax _____ Cell Phone _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If Student, Name of School / College _____ City _____ State _____ ☐ Full Time ☐ Part Time

Patient's or Parent's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone _____

How did you hear about our office (√ all that apply) ☐ Yellow Pages ☐ Magazine ☐ Radio ☐ Website ☐ Location

☐ Cable ☐ Mail Invitation Referral _____ Other _____

Person to Contact in Case of Emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Driver's License # _____ Birthdate _____ Financial Institution _____

Employer _____ Work Phone _____ SSN# _____

Is this Person Currently a Patient in our Office? ☐ Yes ☐ No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

☐ Cash ☐ Personal Check Credit Card ☐ VISA ☐ MasterCard ☐ Amer. Express ☐ Discover

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company - Please fill out attached Insurance Questionnaire

---

Do You Have Any Additional Insurance? ☐ Yes ☐ No If Yes, Complete the Following

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____

Over Please

Be Fit For Life ■ Eat Healthy ■ Schedule Regular Exams ■ Be Fit For Life

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	☐	☐
If yes, please explain _____		
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐
If yes, what medication(s) are you taking? _____		
4. Have you ever taken Phen-Fen/Redux?	☐	☐
5. Do you use tobacco?	☐	☐
6. Do you use controlled substances?	☐	☐
7. Are you wearing contact lenses?	☐	☐

9. Are you allergic to or have you had any reactions to the following:

	Yes	No
Local Anesthetics (e.g. novocain)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other _____	☐	☐

10. Women Only:

	Yes	No
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

8. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever / Allergies	☐	☐
Fainting / Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy / Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble	☐	☐
Kidney Diseases	☐	☐	Hepatitis / Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Mitral Valve Prolapse	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles / Ulcers	☐	☐	Other _____	☐	☐

Patient Dental History

Name of Previous Dentist _____ Date of Last Exam _____

Previous Dentist's Location _____ Date of Last Cleaning _____

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐

	Yes	No
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials?	☐	☐
If yes, date of placement _____		
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16. Do you like your smile?	☐	☐

Authorization and Release

The health information that I have given is correct to the best of my knowledge. All information is strictly confidential and it is my responsibility to inform this office of any changes in my medical status. I am fully aware of HILTON HEAD DENTAL'S payment policy. Payment is due in full at the time of treatment, unless prior arrangements have been approved. Our office will be happy to file your insurance, having the insurance company responsible to you.

_____ _____

Signature Date

Hilton Head Dental, PA

Experience the Difference

INSURANCE QUESTIONNAIRE

DATE: _____ PATIENT NAME: _____

SS# _____ DOB _____

INSURANCE SUBSCRIBER'S NAME: _____

SS# _____ DOB _____

PATIENT'S RELATIONSHIP TO SUBSCRIBER: _____ Self _____ Spouse _____ Child _____ Other

Employer's Name: _____

Dental Insurance Co: _____ Group #: _____

Insurance Claims Address:

PLEASE CONTACT YOUR BENEFIT PLAN ADMINISTRATOR OR INSURANCE REPRESENTATIVE IF YOU NEED ASSISTANCE IN COMPLETING THE FOLLOWING SECTION:

PLEASE ASK YOUR INSURANCE REPRESENTATIVE THE FOLLOWING QUESTIONS:

What is the Policy Effective Date? _____ Is coverage: Single? _____ Spouse? _____ Family? _____

What is the Maximum Benefit Amount? _____ Is there a deductible? _____ If yes, what is the dollar amount? _____

What does the deductible apply to? _____

At what percentage are the following services paid? Preventive? _____ % Basic? _____ % Major? _____ %

How often are preventive cleanings allowed? _____

Is exam included? _____

How often are X-rays allowed? Bitewings? _____ Full Mouth Series? _____ Panorex? _____

Is there a Missing Tooth Clause? _____

Are there any Waiting Periods? _____

Are Periodontal Services covered? _____ If yes, under Basic? _____ Under Major? _____

For Scaling/Root Planing? _____ For Gross Debridement? _____ For Fine Scale/Periodontal Maintenance? _____

Are Endodontic Services covered? (Root Canal Therapy) _____ If yes, under Basic? _____ Major? _____

Is replacement of Prosthesis covered? (Crowns, Bridges and/or Partials/Dentures)_____ If yes, after how many years? _____

Is there Orthodontic coverage? _____ If yes, what is the age limit? _____ What is the dollar amount limit? _____

Does this include removable orthodontic appliance? _____

Is Pre-Determination necessary? _____ If yes, what is the dollar amount? _____

Electronic Submission? _____ If yes, Payor ID# _____

THANK YOU FOR YOUR ASSISTANCE IN PROVIDING THIS INFORMATION. FILING INSURANCE CLAIMS IS A SERVICE HILTON HEAD DENTAL, P.A. IS PLEASED TO PROVIDE FOR OUR PATIENTS WITHOUT CHARGE.

FORM 207239 R/03/01 ITEM 8101 COLWELL SYSTEMS 1.800.637.1140

■ Be Fit For Life ■ Eat Healthy ■ Schedule Regular Exams ■ Be Fit For Life ■

SMILE QUESTIONNAIRE

1. HOW HIGH ON YOUR LIST OF PRIORITIES IS YOUR DENTAL CARE?
   HIGH MEDIUM LOW

2. IS YOUR MAIN REASON FOR COMING TO THE DENTIST.....
   HYGIENE COSMETIC TOOTHACHE

3. DO YOU LIKE THE APPEARANCE OF YOUR TEETH, YOUR SMILE?
   YES NO IF NOT, PLEASE EXPLAIN_____

_____

4. DO YOU LIKE THE COLOR OF YOUR TEETH? YES NO
   IF NOT, PLEASE EXPLAIN_____

_____

5. DO YOU LIKE THE SHAPE OF YOUR TEETH? YES NO
   PLEASE EXPLAIN_____

_____

6. DO YOU HAVE SPACES THAT YOU DO NOT LIKE? YES NO
   PLEASE EXPLAIN_____

_____

7. ARE THERE OLD FILLINGS OR DENTAL WORK THAT YOU DO NOT LIKE?
   YES NO PLEASE EXPLAIN_____

_____

8. IS THERE ANYTHING SPECIFIC YOU WOULD LIKE TO CHANGE IN THE
   APPEARANCE OF YOUR TEETH?_____

_____

9. HOW WOULD YOU LIKE YOUR TEETH TO LOOK?_____

_____

10. HOW COMFORTABLE ARE YOU COMING TO THE DENTIST?
    SCALE 1 TO 10 _____

Hilton Head Dental Dr Daniel P Lawless 222 Pembroke Dr., Ste 102 HHI, SC 29926 843-681-6200

PAYMENT POLICY

- As a courtesy, we will file in-network insurance claims, therefore we will request a copy of your insurance card at the time of each visit.
- Patients are responsible for any deductible, co-payment, or charges not reimbursed or allowed by insurance.
- If the patient is a minor (18 years or younger), the parent or guardian is responsible for payment of the account, in accordance with the outlined policy above.
- You will receive statements. Any account not paid in full within 45 days, will be considered past due and will be subject to 8% interest charges, added every 45 days. If past due accounts are not paid, they will be subject to court, or collections, where there will be additional fees, such as administration, court fees, collection fees and you will be responsible for all Hilton Head Dental attorney fees.
- You will be required to either maintain a credit or have a credit card on file with us. For insured patients, your credit card will be charged once your EOB arrives and there is a balance.
- Please be aware we will add a $100 fee for returned checks.
- Patients having dental insurance will be expected to contact their insurance carrier if there is a delay in payment. Please understand that insurance is a contract between you and your carrier, therefore, you are responsible for your bill.
- If you have difficulty paying your account, please contact our billing department.
- Credit Card payments made over the phone are subject to a 5% processing fee and if a signature is required on the merchant receipt, the below signature signifies you agree to pay the total amount in accordance with the issuers agreement. (Visa, MasterCard)
- In case of divorce, the parent who brings the child/children in for treatment is responsible for payment; There are no exceptions.
- Patient is responsible for maintaining current address and phone number with our office.

ACKNOWLEGEMENT AND AUTHORIZATION

I have read, understand and agree to the above policies. I understand the charges not paid by my insurance company, for any reason as well as co-payments and deductibles are my responsibility. I authorize and assign my insurance benefits to be paid directly to Hilton Head Dental. I authorize Hilton Head Dental to release any dental or other information to my insurance company when requested.

_____

Patients Signature Todays Date

MULTIPLE INSURANCES

If there are multiple insurances, in network or not, the primary insurance company will be the only insurance company that has any “write-offs / adjustments” if applicable. We will then file the second insurance claim for you at that time. The remaining balance will be the patients’ responsibility.

_____

Patients Signature Todays Date

INSURANCE CLAIM APPEAL

We provide as a courtesy to our patients, the initial submission of a claim at no cost to you. However, if insurance companies need a re-submission of a claim, a $36 service fee may be required to cover each appeal we send to the insurance company. You may also decide to deal directly with the insurance company yourself. Please check either box and provide a signature stating that you have read the above policies and agree to follow them accordingly.

_____ YES, I agree to pay a $45 service fee for each claim appeal that is sent to my insurance company

_____ NO, I choose not to pay a $45 service fee for claim appeals and will deal directly with my insurance company.

MISSED APPOINTMENT POLICY

Should you need to cancel your appointment, please notify our team 48 hours prior to your scheduled appointment. Our office policy requires a $75 fee be charged to you for missed appointments without this notice.

_____

Patients Signature Todays Date

Hilton Head Dental Dr Daniel P Lawless 222 Pembroke Dr., Ste 102 HHI, SC 29926 843-681-6200

X-ray DUPLICATING POLICY

X-rays will be provided to a single email address, only after a signed records release has been received. We will include a nominal fee of $25.00 for the duplication of x-rays to any and all additional email addresses. This office is not responsible for X-rays sent to unencrypted email addresses. Any x-rays provided in the form of films from other dentists will be returned to you, if necessary.

_____

Patients Signature Todays Date

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICE

I have reviewed a copy of the notice of privacy practices for HHD.

_____

Patients Signature Todays Date

CREDIT CARD AUTHORIZATION

Please Sign ,stating that you have read the below policies and agree to follow them accordingly.

I will keep a credit card on file with Hilton Head Dental. I authorize Hilton Head Dental to generate charges to my credit card for any unpaid balance without further permission or notice should my account fall into a 45 day or later(after the date of service)category. A receipt with detail explanation for any charges will be mailed to me at my home address. All personal information is protected by HIPAA and can only be used for purpose of treatment, payment or healthcare operations.

_____

Patients Signature Todays Date

EMERGENCY NUMBER

Emergency Number does NOT send or receive Texts. This line is ONLY monitored after business hours for phone calls, only

_____

Patients Signature Todays Date