Riverwalk Smile Dentistry
998 Riverwalk Pkwy, Ste 203, Rock Hill SC 29730, Website: www.riverwalksmiledentistry.com Tel: (803) 639-7676 Fax: (803) 639-7677

Patient Registration Form

First Name: _____ Last Name: _____ Middle Initial: _____

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name: _____

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City: _____ State / Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: _____ Age: _____ Soc Sec: _____ Drivers Lic: _____

E-mail: _____ ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg: _____

Section 3

Referred By _____

Previous Dentist _____

Emergency Contact _____

Emergency Contact # _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Rem. Benefits: _____ Rem. Deduct: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Rem. Benefits: _____ Rem. Deduct: _____

Note: Out of courtesy to other patients, we do require a 48 hour notice to change an appointment _____**(Initials)**

Riverwalk Smile DENTISTRY

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

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, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

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 Problem ◯ 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	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

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Authorization for Release of Information – Compound Release

Name of Patient _____ Date of Birth _____

Riverwalk Smile Dentistry is authorized to release protected health information about the above named patient in the following manner to identified persons.

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	☐ Appointment Reminders
☐ Other person(s) (provide name and phone number)(i.e. Spouse, Parent, Friend, Stepparent, Grandparent etc) ☐ _____ ☐ _____	☐ Financial
☐ Email communication-Provide email address* *For email communication to occur, please accept the disclosure below	☐ Financial ☐ Treatment/Treatment Plans ☐ Appointment reminders ☐ Breach notification
☐ Text communication-Provide number* _____ *For text communication to occur, please accept the disclosure below	☐ Appointment reminder ☐ Other_____
☐ For email and/or text communication, I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected	
☐ Photo of patient received by patient or legal guardian Spouse, Parent, Friend, Stepparent, Grandparent etc) ☐ Photo taken by staff (example: pre/post procedure)	☐ May be posted in office/on website ☐ Other_____

Patient Rights:

- I have the right to revoke this authorization any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- I have right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient

Signature of patient or representative_____ Date:_____

*Description of representative's authority (attach necessary documentation)

Riverwalk Smile DENTISTRY

VELScope Vx Exam authorization form

Our practice continually looks for advances to ensure that we are providing the optimum level of oral health care to our patients. We are concerned about oral cancer and look for it in every patient.

One American dies every hour from oral cancer. Late detection of oral cancer is the primary cause that both the incidence and mortality rates of oral cancer continue to increase. As with most cancers, age is the primary risk factor for oral cancer. Tobacco and alcohol use are other major predisposing risk factors but more than 25% of oral cancer victims have no such lifestyle risk factors. Studies also suggest that human papillomavirus (HPV 16/18) plays a role in more than 20% of oral cancer cases. Oral cancer risk by patient profile is as follows:

Increased Risk: patients age 18-39 (both genders); sexually active patients any age (HPV 16/18)

High Risk patients age 40 and older (both genders) tobacco users (ages 18-39, any type with 10 years)

Highest Ris: patients age 40 and older (both genders) with lifestyle risk factors (tobacco and/or alcohol use); patients with history of oral cancer or other cancers

We have incorporated **VELScope Vx** into our oral screening standard of case. We find that using **VELScope Vx** along with a standard oral cancer examination improves the ability to identify suspicious areas at their earlier stages. **VELScope Vx** is similar to proven early detection procedures for other cancers such as mammography, Pap smear and PSA. **VELScope Vx** is a simple and painless examination that gives best chance to find any oral abnormalities at the earlier possible stage. Early detection of precancerous tissue can minimize or eliminate the potentially disfiguring effects of oral cancer and possible save your life. The **VELScope Vx** exam will be offered to you annually.

This enhanced examination is recognized by the American Dental Association code revision as CDT-2007/08 procedure code D0431; however, this exam might not be covered by your insurance. The fee for this enhanced examination is $20.00

☐ **YES**: *I authorize the clinician to perform the VELScope Vx exam along with the standard oral cancer examination. I accept financial responsibility for this enhanced examination.*

Print Name: _____

Signature: _____ Date:_____

☐ **No**: *I would prefer not to have the VELScope Vx exam at this time.*

I hereby release from liability Dr. Anjali Seth, her hygienists, employees or agents from any injury I may currently, or in the future suffer as a result of my refusal to proceed with this enhanced oral cancer examination.

Print Name: _____

Signature: _____ Date:_____

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ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

Acknowledgement

I,_____, hereby acknowledge that I have received and reviewed a copy of Riverwalk Smile Dentistry's *HIPAA Notice of Privacy Practices*.

I understand that Riverwalk Smile Dentistry 's *HIPAA Notice of Privacy Practices* may change periodically and that I am entitled to receive a copy of Riverwalk Smile Dentistry's revised *HIPAA Notice of Privacy Practices* upon request.

I understand that, if I have questions about Riverwalk Smile Dentistry's *HIPAA Notice of Privacy Practices*, I may contact Riverwalk Smile Dentistry (803) 639-7676.

I understand that it is my right to refuse to sign this Acknowledgement should I so choose, and that Riverwalk Smile Dentistry will not refuse treatment to me if I refuse to sign this Acknowledgement.

I further understand that I may contact the Secretary of the U.S. Department of Health and Human Services should I have concerns regarding Riverwalk Smile Dentistry's privacy policies and procedures. For information on how to contact the U.S. Department of Health and Human Services, please ask the office administrator at Riverwalk Smile Dentistry, for assistance.

_____ Patient Signature	_____ Date
_____ Signature of Personal Representative	_____ Print Name of Personal Representative
	_____ Relationship of Personal Representative to Patient

FOR OFFICE USE ONLY

Riverwalk Smile Dentistry made a good-faith effort to obtain Acknowledgement, from the patient noted above, of receipt of its *HIPAA Notice of Privacy Practices*. In spite of these efforts, Riverwalk Smile Dentistry was unable to obtain a signed Acknowledgement for the following reason(s):

- ☐ Refusal to sign Acknowledgement on _____, 20_____.
- ☐ Communications barriers prohibited us from obtaining a signed Acknowledgement.
- ☐ An emergency situation prohibited us from obtaining a signed Acknowledgement.
- ☐ Other (Describe):_____

Date Received	By	Patient ID