Consent for Treatment

1. I hereby authorize doctor or designated staff to take radiographs, study models, photographs, and other diagnostic aids appropriate by doctor to make a thorough diagnosis of ________________________________dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon my/me and to employ such assistance as required to provide care.
3. I agree to the use of anesthetics sedative and other medication as necessary. I fully understand that using anesthetic agent embodies certain risk. I understand that I can ask for a complete recital of any possible complication.
4. I give consent to the doctor's or designated staff's use and disclosure of any oral, written, or electronic health record that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operation. 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. *I authorize the doctor/staff to give/leave information to _________________ and they can leave a message on my answering machine: yes _____ or no ______.*

Patient's
Signature___________________________________Date_____________Witness______

Patient/Responsible Party' Signature________________________________
Relationship to Patient______________________________

Do you take Viagra or any other similar
drugs?______YES_______________NO__________

I am aware that street drugs (including alcohol) may cause life threatening reaction with dental procedures. Please Initial__________

Have you taken any weight loss drugs including Fen-Phen, Pondimen or
Redux?_____YES______NO_______

Do you take any Herbs, supplements____YES____________NO_________________

Crescent Beach Dentistry

602 17th Avenue South
North Myrtle Beach, South Carolina 29582
843-272-1121
888-310-6058 Fax

Office Policies

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

Regular office hours: Our office is open Monday through Thursday from 8:00am until 5:00pm. We close from 12:00 to 1:00pm for lunch.

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

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. We cannot bill your dental plan unless you give us the correct information. Your policy is a contract between you and the insurance company; we are not a party of 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 usual customary to 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.

Adult/Minor Patients: Adult patients are responsible for full payment of their portion at the time of service. The adult accompanying a minor and the parent (or guardian of the minor) is 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. For unaccompanied minors, non-emergencies treatment will be denied unless changes have been pre-arranged.

Guarantee of work: Dr. Riley guarantees restorative works for five years depending upon you maintaining your individual home care 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 in void.

Missed Appointments: We certainly understand that scheduling conflicts occur. ***In order to prevent assessing a broken appointment fee of $35.00***, **we require a full business day's notice for cancellations.** For an appointment on Monday, please call Thursday morning as our office is closed on Fridays. This time is reserved exclusively for and not shared with others, please help us by keeping your reserved appointment time.

Interest: We reserve the right to charge interest in the amount of 1 1/2% (18% APR) as provided by state law.

I have read and understand this financial policy and agree to all terms stated above.

X____**Date**______________

Signature of Patient or Responsible Party

Crescent Beach Dental

602 17th Ave. South
North Myrtle Beach, SC 29582
843-272-1121 office
888-310-6058 fax

Welcome!!!

As a new patient in our office, we will need to take X-rays. X-rays allow us to see in and around a tooth that the Dentist can not see with his/her naked eye.

If you have had a full mouth or Panorex X-ray within the last 3 to 5 years at another dental office we will have them transferred to our office; your insurance will only pay for these X-rays once every 3 to 5 years depending on your plan.

Date: _______________

Past Dentist Name: _________________________

Fax: _____________ Phone: _______________

Address: ____________________________ City:_____________
State:________

Patient Name: ______________________________ DOB:
____

Patient Signature: ___________________________

The above mentioned patient has requested that you transfer their record/X-rays.

Crescent Beach Dental

843.272.1121
602 17th Avenue South,
North Myrtle Beach, SC

Patient Information

Date ____________________

SS/HIC/Patient ID# ____________________

Patient Name ____________________
Last Name

____
First Name Middle Initial

Address ____________________

Email ____________________

City ____________________

State ____________ Zip ____________

Sex ☐ M ☐ F Age ________ Birthdate ____________

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for ________ years

Patient Employer/School ____________________

Occupation ____________________

Employer/School Address ____________________

____

Employer/School Phone ____________________

Spouse's Name ____________________

Birthdate ____________________

SS# ____________________

Spouse's Employer ____________________

Whom may we thank for referring you? ____________________

Dental Insurance

Who is responsible for this account? ____________________

Relationship to Patient ____________________

Insurance Co. ____________________

Group # ____________________

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name ____________________

Birthdate ____________ SS# ____________

Relationship to Patient ____________________

Insurance Co. ____________________

Group# ____________________

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with ____________________ and assign directly to
Name of Insurance Company(ies)

Dr. ____________________ all insurance 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 authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

____
Signature of Patient, Parent, Guardian or Personal Representative

____
Please print name of Patient, Parent, Guardian or Personal Representative

____________ ____________
Date Relationship to Patient

Phone Numbers

Home ____________ Work ____________ Ext ______ Alt. Phone ____________

Spouse's Work ____________ Best time and place to reach you ____________

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name ____________ Relationship ____________

Phone ____________ Alt. Phone ____________

Dental History

Reason for today's visit ____________________

____

Former Dentist ____________________

City/State ____________________

Date of last dental visit ____________________

Date of last dental X-rays ____________________

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath ☐ Yes ☐ No
Bleeding gums ☐ Yes ☐ No
Burning sensation on tongue ☐ Yes ☐ No
Chewing on one side of mouth ☐ Yes ☐ No
Cigarette, pipe, or cigar smoking ☐ Yes ☐ No
Clicking or popping jaw ☐ Yes ☐ No
Dry mouth ☐ Yes ☐ No
Fingernail biting ☐ Yes ☐ No
Food collection between the teeth ☐ Yes ☐ No
Foreign objects ☐ Yes ☐ No
Grinding teeth ☐ Yes ☐ No
Gums swollen or tender ☐ Yes ☐ No
Jaw pain or tiredness ☐ Yes ☐ No
Lip or cheek biting ☐ Yes ☐ No
Blisters on lips or mouth ☐ Yes ☐ No
Loose teeth or broken fillings ☐ Yes ☐ No
Mouth breathing ☐ Yes ☐ No
Mouth pain, brushing ☐ Yes ☐ No
Orthodontic treatment ☐ Yes ☐ No
Pain around ear ☐ Yes ☐ No
Periodontal treatment ☐ Yes ☐ No
Sensitivity to cold ☐ Yes ☐ No
Sensitivity to heat ☐ Yes ☐ No
Sensitivity to sweets ☐ Yes ☐ No
Sensitivity when biting ☐ Yes ☐ No
Mouth sores or growths ☐ Yes ☐ No

How often do you floss? ____________ How often do you brush? ____________

Crescent Beach Dental

843.272.1121
602 17th Avenue South,
North Myrtle Beach, SC

Health History

Physician's Name ______________________ Date of last visit ____________

Have you ever used a bisphosphonate medication? Common brand names are: Fosamax, Actonel, Atelvia, Didronel, Boniva. ☐ Yes ☐ No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
AIDS/HIV	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Fainting or dizziness	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Artificial Heart Valves	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Heart Problems	☐ Yes	☐ No	Skin Rash	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	Hepatitis Type ______	☐ Yes	☐ No	Special Diet	☐ Yes	☐ No
Bleeding abnormally with extractions or surgery	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Swollen Feet or Ankles	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No	Swollen Neck Glands	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	Jaw Pain	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Congenital Heart Lesions	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Tumor or growth on head or neck	☐ Yes	☐ No
Cortisone Treatments	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No	Ulcer	☐ Yes	☐ No
Cough, persistent or bloody	☐ Yes	☐ No	Nervous Problems	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Weight Loss, unexplained	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No			
Do you wear contact lenses?	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No			

Women:

Are you pregnant? ☐ Yes ☐ No — Due Date ____________ — Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

Medications

List any medications you are currently taking and the correlating diagnosis:

____

____

Pharmacy Name ______________________

Phone ______________________

Allergies

☐ Aspirin
☐ Local Anesthetic
☐ Barbiturates (Sleeping Pills)
☐ Penicillin
☐ Codeine
☐ Sulfa
☐ Iodine
☐ Other ____________
☐ Latex

Updates (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? ______________________

Are you taking any new medications? ☐ Yes ☐ No If so, what?

____

Patient's Signature ______________ Date ________

Doctor's Signature ______________ Date ________

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? ______________________

Are you taking any new medications? ☐ Yes ☐ No If so, what?

____

Patient's Signature ______________ Date ________

Doctor's Signature ______________ Date ________