Dental and Medical History Intake

Premise Health.

Patient Registration *(Please Print)*

Patient's Name: _____ Date of Birth: _____

Patient's Employer: _____ Work Phone Number: _____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed Gender: ☐ Male ☐ Female

Social Security Number: _____ Email: _____

Home Phone Number: _____ Cell Phone Number: _____

Primary residency (address): _____

(City, State and Zip): _____

Primary Care Physician's Name: _____Office Phone Number: _____

Date of Last Physical: _____ How would you describe your health? _____

Are you currently under a physician's care? ☐No ☐Yes

If yes, for what? _____

Have you been hospitalized in the last two years? ☐No ☐Yes

If yes, for what reason? _____

Do you take any medications, drugs, pills or supplements on a regular basis? ☐No ☐Yes

If yes, list all medications and dosages below:

Name of Medication	Dosage		Name of Medication	Dosage

Do you use any form of tobacco (Cigarettes, Cigars, e-Cigarettes, Smokeless/Chew)? ☐No ☐Yes

If yes, type of tobacco used: _____ How often? _____

How much? _____

Women Only:

Are you pregnant? ☐No ☐Yes Date of last menstrual period (LMP): _____

Are you nursing? ☐No ☐Yes

Are you taking any kind of hormone therapy including birth control pills or shots? ☐No ☐Yes

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PATIENT'S CURRENT OR PREVIOUS HEALTH CONDITIONS

Please select any of the following if you currently have, or has ever had, any of the conditions listed:

Allergies to:

☐Penicillin ☐Aspirin ☐Codeine ☐Erythromycin ☐Iodine ☐Latex ☐Novocaine

☐Sulfa Drugs ☐Tetracycline ☐Valium ☐Xylocaine ☐Other: _____

Medical Conditions:

	Heart related conditions (attack, surgery, murmur, etc.)		Behavior Health		Lung Disease
	Artificial Heart Valve		Attention Deficit (ADD/ADHD)		Shortness of Breath
	Congenital Heart Defect		Extreme nervousness		Asthma
	Stroke		Gastrointestinal disorders		Tuberculosis
	Pace Maker		Autoimmune disorders		Frequent Cough
	Chest pain		Ulcers		Sinus Trouble
	High/Low Blood Pressure		Acid Reflux		Hay Fever
	Blood Disease		Chemical Dependency		Emphysema
	Deep Vein Clot		Arthritis/Gout		Kidney Disease
	Blood Transfusion		Joint Replacement		Parathyroid Disease
	Anemia		Glaucoma		Cancer
	Hemophilia		Scarlet Fever		☐ Chemotherapy ☐ Radiation
	Excessive bleeding when cut		Rheumatic Fever		Osteoporosis (bisphosphonates)
	Sickle cell disease		Hives		Liver Disease
	Swelling feet/ankles		Venereal Disease		Yellow Jaundice
	Hepatitis (☐ A, ☐ B, ☐ C)		Herpes		Thyroid Disease
	HIV/AIDS		Rheumatism		X-ray or Cobalt Treatments
	Diabetes		Fainting/Dizziness		Other:
	Excessive thirst		Cortisone Treatment		Other:
	Hypoglycemia		Epilepsy or Seizures		Other:

Explain any Medical Conditions checked above: _____

_____

Dental History Conditions:

☐Brush teeth daily ☐Flosses teeth daily

☐Excessive bleeding after a tooth extraction ☐Previous problems with dental care

☐Mouth sores that take a long time to heal ☐Teeth sensitive to hot, cold, pressure or sweets

☐Dry mouth ☐Gums that are tender and/or bleed

☐Periodontal (gum) treatments ☐Regular headaches, earaches or neck pains

☐Clenching or grinding of teeth ☐ "Clicking" sound when opening/closing mouth

☐Jaw gets "stuck" ☐ Mouth breathing

☐ Injuries to teeth, mouth, head or jaws – (list): _____

Would you like your smile to look better? ☐Yes ☐No

Dental and Medical History Intake

Premise Health.

Employee Guarantor information:

Guarantor Name: _____ Employer: _____

Relation to Patient: _____

Pediatric Patient Parent information if different from Guarantor:

Name: _____ Employer: _____

Relation to Patient: _____

Emergency Contact:

Full Name: _____

Phone Number: _____ Relation: _____

Primary Dental Insurance Company – Subscriber and Insurance Company Details:

Insurance Company: _____ Employer: _____

Subscriber Name: _____ Subscriber Date of Birth: _____

Subscriber ID: _____

Secondary Dental Insurance Company – Subscriber and Insurance Company Details:

Insurance Company: _____ Employer: _____

Subscriber Name: _____ Subscriber Date of Birth: _____

Subscriber ID: _____

I hereby certify that the information provided on this form is accurate and complete and that I will notify the office of any changes in a timely manner. I will not hold my dentist, or any member of his/her staff, responsible for an errors or omissions that I may have made in the completion of this form.

_____ _____

Signature of Parent/Self Date

Office use only:

Reviewed by (dental assistant): _____

Reviewed by (dental hygienist): _____

Reviewed by (dentist): _____

Patients < 12 years: □ Yes □ No If yes, Weight: _____

Blood Pressure: _____ Pulse: _____

Health History Form to be completed on initial visit. Review medical and allergy history every visit in EHR.

Dental Consent for Treatment – Minor

Dental Center:_____

Patient Name: _____

Date of Birth: _____

Address: _____

PLEASE READ CAREFULLY Consent to Treatment:
I, the undersigned, consent to and authorize the dental provider(s) and dental Center professionals and staff who may be involved in the care of my child to provide such examinations, diagnosis, care and treatment considered necessary or advisable by my dental provider.

EXAMINATIONS AND XRAYS

I understand that the initial visit may require radiographs in order to complete the examination, diagnosis and treatment plan.

TREATMENT PLAN

I understand that I will be presented with a written treatment plan and will be given the opportunity to authorize or refuse the recommended treatments for my child after receiving a description of the benefits and risks of each treatment.

CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change or add procedures to the treatment plan because of conditions found while working on the teeth that were not discovered during examination, the most common being pulp capping (a medication to protect the nerve) or root canal therapy following routine restorative procedures. I give my permission to the Dentist to make changes and additions as necessary.

DENTAL PROPHYLAXIS (CLEANING)

I understand this treatment involves the removal of plaque and calculus above the gum line and will not address gum infections below the gum line called periodontal disease. I understand bleeding could last several hours. Should it persist, particularly if it is severe in nature, it should receive attention and this office must be contacted.

FILLINGS

I understand that a more extensive restoration than originally diagnosed may be required due to additional decay or unsupported tooth structure found during preparation. This may lead to other measures necessary to restore the tooth to normal function, including a root canal, a crown, or both. I understand that care must be exercised in chewing on fillings during the first 24 hours to prevent breakage. I understand that sensitivity is a common after effect of a newly placed filling.

ADDITIONAL TREATMENTS

I understand that in addition to the above treatments the following may also be recommended for my child. By my initials and the date signed, I am in agreement for the provision of the indicated treatments.

- Sealants
- Fluoride Treatment

Dental Consent for Treatment – Minor

Premise Health

BEHAVIOR CONTROL OR MODIFICATION

I understand that the continuation of a treatment is dependent on the cooperation of my child with the dentist or dental hygienist. To encourage this cooperation a parent or previously identified temporary guardian will be present at each dental appointment for this child. I also agree by initial and date that in addition to positive reinforcement the following behavior modification methods may be used by the dental staff.

- Tell-Show-Do – The dentist, dental hygienist, or assistant explains to the child what is to be done using simple terminology and repetition. Demonstration with instruments will be shown on a model or the child's finger. The procedure is then performed in the child's mouth as described.
- Hand Holding / Passive Restraint – The assistant may hold the child's hand during a procedure or lay their hands over the child to remind him/her not to reach up to his/her mouth.
- Voice Control – The attention of an uncooperative child is gained by changing the tone or increasing the volume of the dentist's or dental hygienist's voice. The content of the conversation is less important than the abrupt or sudden nature of the command.

LOCAL ANESTHESIA: I understand that certain dental procedures require the use of local anesthetic agents (infiltrate or nerve block). It is normal for the numbness to take time to wear off after treatment, usually two or three hours. However, it can take longer and rarely the numbness is permanent if the nerve is injured. Infection, swelling, allergic reactions, discoloration, headache, tenderness at the needle site can occur. Other symptoms may include but not limited to palpitations, dizziness, nausea, vomiting; also, cheek, tongue, or lip biting can occur.

Assignment and Release:

I, the undersigned, certify that my child/dependent is eligible to receive services at _____ Dental Center. I understand that I am financially responsible for the co-payment, charges not paid by insurance and for non-covered services for which it is determined my child was ineligible to receive. I also authorize the provider to release all information necessary to secure the payment of benefits and to use or disclose health information necessary to carry out treatment, payment or health care operations.

I have read, understand, and agree to each of the statements contained in this document.

Signature:_____ Date: _____
(Patient / Personal Representative)

Relationship: _____

Witness: _____

South Carolina

BlueCross BlueShield of South Carolina is an independent licensee of the Blue Cross and Blue Shield Association

Visit our website at:
www.SouthCarolinaBlues.com

OTHER HEALTH/DENTAL COVERAGE QUESTIONNAIRE

Your contract contains a Coordination of Benefits (COB) provision to ensure we provide correct benefits on claims for members with more than one health/dental coverage plan. We need information about possible other health/dental coverage, including Medicare, to process your claims correctly.

_____ ID Number: _____

_____

_____ Date: _____

1. Do you or any dependents have any other group health, dental or Medicare coverage? ☐ No ☐ Yes

IF NO, PLEASE SIGN, DATE AND RETURN THIS FORM OR CALL US AT OUR COB HOTLINE (800-931-3401) AND WE WILL PROCESS THIS INFORMATION IMMEDIATELY. IF YOU ANSWERED YES, PLEASE PROCEED TO QUESTION #2.

Your Signature: _____ Date: _____

2. Please list the family members covered by the other policy and the type of coverage you have.

_____	☐ Medical	☐ Hospital	☐ Drug	☐ Dental	☐ Medicare
_____	☐ Medical	☐ Hospital	☐ Drug	☐ Dental	☐ Medicare
_____	☐ Medical	☐ Hospital	☐ Drug	☐ Dental	☐ Medicare
_____	☐ Medical	☐ Hospital	☐ Drug	☐ Dental	☐ Medicare
_____	☐ Medical	☐ Hospital	☐ Drug	☐ Dental	☐ Medicare

For additional family members, attach a separate sheet with the information.

* **If you checked Medicare, answer question #7 on page 2.**

3. Name of Other Policyholder: _____

Other Policyholder's Date of Birth: _____ Relationship to You: _____

4. Employer's Name, If Coverage is Provided Through an Employer: _____

5. Name of Other Insurance Company and Effective Date of Policy: _____ Effective Date: _____

If policy is now terminated, please give termination date: _____ ID#: _____

6. The Other Insurance Company's Address: _____
7. The Payor ID for the Other Insurance Company (if known): _____
8. If there is a divorce or separation, please list who is responsible for the health care expenses: _____

If there is a copy of a divorce decree, please forward a copy to us.
If there is not a court decree, who has custody of the children? _____

* * * * * **SECTION PERTAINS TO MEDICARE COVERAGE ONLY** * * * * *

9. Are you actively working? ☐ Yes ☐ No Start Date: _____ Last Day of Active Employment: _____

10. Are you or any family members covered by Medicare? ☐ No ☐ Yes
If No, please sign and date below. If Yes, please complete the information below.

- Name: _____ Date of Birth: _____

Medicare Number: _____ Part A Effective Date: _____

Part B Effective Date: _____

Reason for Medicare (check one):
☐ Age
☐ Disability
☐ ESRD Date of First Dialysis: _____

- Name: _____ Date of Birth: _____

Medicare Number: _____ Part A Effective Date: _____

Part B Effective Date: _____

Reason for Medicare (check one):
☐ Age
☐ Disability
☐ ESRD Date of First Dialysis: _____

Your Signature: _____ **Date:** _____

Please mail or fax this form to the correct plan:

- **State Health Plan ("ZCS" and "ZCK" Prefix)**

State Health Plan: AX-B10
ATTN: COB
P.O. Box 100605, Columbia, SC 29260-0605
Fax: 803-264-4204

- **Federal Employee Plan/FEP ("R" Prefix)**

Federal Employee Customer Service: AX-B05
P.O. Box 100603
Columbia, SC 29260-9982
Fax: 803-736-8341

- **Small Group and Individual ("ZCY" Prefix)**

Group and Individual: AX-F25
ATTN: COB
P.O. Box 100246, Columbia, SC 29202-3246
Fax: 803-264-0172

- **Preferred Blue® and All Other BlueCross Plans (Include name of health plan.)**

BlueCross BlueShield of South Carolina
P.O. Box 100300
Columbia, SC 29202

Check your member ID card for Service Center location:
Piedmont (Greenville) Service Center: Fax: 803-264-9128
Columbia Service Center: Fax: 803-264-6572

REQUEST TO RESTRICT USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

THE PURPOSE OF THIS REQUEST FORM

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you may request that we restrict the use and disclosure of your protected health information. You have been given this form in case you would like to request such a restriction. This federal law allows you to make such a request, but do not require us to agree to your request. Please see our Notice of Privacy Practices for further information.

Clinic Name/Location: _____

Patient Name: _____

Date of Birth: _____

Patient Mailing Address: _____

City, State, ZIP _____

YOUR REQUESTED RESTRICTION

In the space provided below, please describe what restrictions on the use and disclosure of protected health information you are requesting. Please be as detailed as possible, and if you have any questions, please feel free to seek our help. (Please circle, if you wish, what categories are would be applicable).

Home phone #	Visit notes	Office address
Home address	Hospital notes	Office phone #
Occupation	Prescription information	Spouse's name
Name of employer	Patient history	Spouse's office phone #

Other: _____

How would you like (or disclosure of) your PHI restricted? Be as specific as possible.

_____

_____

_____

OTHER INFORMATION CONCERNING YOUR REQUEST

This request is governed by the HIPAA. Even if we agree to your requested restriction, that agreement will not prevent us from making uses or disclosures that are permitted or required under HIPAA or our Notice of Privacy Practices. Also, if our Privacy Officer agrees to your requested restriction, we may later end that agreement by informing you that the restriction has ended. If you have any questions about your request, the HIPAA, or our Notice of Privacy Practices that apply to this request, please call our Privacy Officer at: 615-628-9317.

REQUEST TO RESTRICT USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Signature of Patient: _____ Date: _____

Name of Patient (please print):_____ Date of Birth: _____

If applicable, Name of parent, legal guardian, or personal representative (please print):

_____

If applicable, Signature of parent, legal guardian, or personal representative, if patient is younger than 18

_____

Relationship to patient (mother, father, legal guardian)

_____

Office Use Only

Privacy Officer Agree _____ Disagree _____ Length of Time for Restriction _____

Medical Record Number: _____

Premise Health.

Consent for Treatment and Patient Acknowledgment of the Notice of Privacy Practices

CONSENT FOR TREATMENT

I consent to all necessary and reasonable medical examinations, testing, and treatment by Premise Health. I voluntarily request the provider to explain the nature, risks, and purpose of a medical examination, testing, and treatment, including possible alternatives if I do not consent to treatment. I understand that I can change my mind about treatment. If I have any questions about my examination, testing, or treatment, Premise Health and the provider will not proceed, unless it is an emergency, until such questions have been answered so that I am fully informed.

I acknowledge that it is important to give all relevant medical information to Premise Health and my provider and to the extent that additional examinations, testing, or treatment are needed and recommended, it may be necessary for me to read and sign additional consents.

I am aware that no guarantee is made concerning a final medical result, outcome, or cure.

To better serve patients, Premise Health offers some health care services with combinations of asynchronous, interactive video communications, telephone, and/or by the electronic transmission of information. This may assist in the evaluation, diagnosis, management and treatment of certain health conditions. This process is referred to as “telemedicine” or “telehealth.” In a telehealth encounter, you may be evaluated and treated by a health care provider from a distant location. Since this may be different than the traditional evaluation, it is important that you read, understand, and agree to the following:

- At my option, Premise Health may provide some services via telehealth. Telehealth offers convenient, timely access to healthcare services but is not always a substitute for face-to-face consultations. I understand that, as with any technology, telehealth has limitations. Though unlikely, it is possible some information may be lost due to technical failures. Ultimately, my healthcare provider may determine that telehealth is not an appropriate means of addressing my condition(s). I understand the appropriate use of telehealth is a decision that can only be made by my provider.

- I understand that I can withdraw my permission at any time and that I do not have to answer questions that I consider to be inappropriate or am unwilling to have heard by other medical professionals in the room with the provider. Nonetheless, I am aware healthcare confidentiality standards apply to telehealth sessions just as they would to any other healthcare encounter. While any communications may be recorded, and may be added to my medical records, these recordings and records remain confidential. Premise Health's electronic communications portal encrypts all data transmissions and authenticates all users prior to accessing any healthcare data. I recognize that despite these security measures, data compromises remain possible, though unlikely.

- By executing this consent, I authorize this electronic transmission of information. I understand that if I do not choose to participate in a telehealth session, no action will be taken against me that will cause a delay in my care and that I may still pursue face-to-face consultation. I also authorize the information from a telehealth encounter to be forwarded to my primary care provider, if my primary care provider is different from the telehealth provider. I MAY DECLINE TO AUTHORIZE FORWARDING TO MY PRIMARY CARE PROVIDER IF NOT A PREMISE HEALTH PROVIDER.

I have read this Consent for Treatment or have had it read to me, and it has been explained to my satisfaction. I understand that this Consent for Treatment is valid from the date that I sign it until: the physician-patient relationship is terminated; a new healthcare representative is appointed; or I revoke consent. I understand that any proposed invasive diagnostic or treatment procedure will require separate informed consent.

"Premise Health" means Premise Health Employer Solutions, LLC along with its affiliated entities and professional organizations, including its professional, technical, and administrative staff providing services as part of the Premise Health clinic.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES:

I have received the Premise Health Notice of Privacy Practices either today or at a past visit and acknowledge that I can receive a copy at my request or from the Premise Health website (www.premisehealth.com).

By signing below, I consent to treatment by Premise Health, including any treatment I choose to receive via telemedicine, and I acknowledge receipt of the Premise Health Notice of Privacy Practices:

_____ _____

Patient/Personal Representative Signature Date

_____ _____

Patient/Participant Name (please print) Date of Birth

Relationship of Personal Representative (parent/legal guardian): _____

FOR SITE USE ONLY

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

_____Patient did not sign or refused to sign

_____Communication barriers prohibited obtaining the acknowledgement

_____An emergency prevented us from obtaining acknowledgement

_____Other (Please describe:_____)

Health Center Services and Patient Financial Responsibility

Premise Health is the provider of the health care services offered at the Associate Family Health Center (AFHC). It is our pleasure to be able to provide health care services to you and your family.

Paying for Services:

After you have received heath care services, your claim processes, and you receive a bill (patient statement) from Premise. It is your responsibility to pay for the services that were provided. Premise Health provides health services at a lower fee structure than community negotiated rates.

The Claims and Billing process:

After you have been seen at the AFHC, Premise will file a claim with your insurance carrier, and then will bill you a balance based on the result of that claims process.

No-Show Fees and Late Arrivals:

A patient who has scheduled an appointment with the AFHC and is unable to make their scheduled appointment, is expected to contact the health center to cancel or re-schedule their visit. A patient who is more than 10 minutes (15 minutes for Physical Therapy) late for a scheduled appointment, and/or who does not call 24 hours in advance to cancel or re-schedule their appointment will be charged a $20 "no-show" fee. Late fees must be paid in full before you can be seen for next scheduled appointment.

__Before dental treatment can be provided patients payment responsibility is due.__

For your convenience there are several ways to make a payment:

- In-person at the Associate Family Health Center
- Over the phone by calling:
  - For **Primary Care:** 864-989-1432 ext. 1
  - For **Vision**: 864-989-1432 ext. 2
  - For **Dental**: 864-989-1432 ext.3
  - For **Physical Therapy**: 864-989-1432 ext.4

- By mailing your payment to:
  Premise Health
  PO Box 3288
  Brentwood, TN 37024

Acknowledge and Agree:

By signing below, I acknowledge that I have read this policy and that I understand that it is my responsibility to pay for services received at the AFHC, if there is a remaining balance after my insurance has been processed. I also understand that failure to pay could affect my rights to receive services at AFHC in the future.

_____ _____

(Signature) (Date)

Sincerely,
Premise Health

Rev: 09/18/2019