P. Spencer Witkin, D.M.D.

415-A Robertson Boulevard
Walterboro, South Carolina 29488

Thank you for visiting our office. We want your visit to be pleasant and comfortable. Please help us by completing this form.

Patient Information:

Name _____
LAST FIRST MIDDLE INITIAL PREFERRED NAME

Address _____
STREET APT #

_____
CITY STATE ZIP

Birth Date _____ ❑ Male ❑ Female
Employer _____

Height _____ Weight _____ ❑ Married ❑ Single ❑ Other
Phone: Home (_____) _____ Social Security # _____

Work (_____) _____

Cell (_____) _____ Email _____

Emergency Contact: Name _____ Phone (_____) _____

If Patient Is Under 18 Years Old:

Responsible Party _____ Phone: (_____) _____ Relationship to Patient _____

How Did You Hear About Us? ❑ Phone Book ❑ Google ❑ Yahoo ❑ Yelp ❑ Walk in/Drive by

Referred By: _____ Other: _____

Insurance:

Please give a copy of your card to the front desk along with your driver's license.

The information on this page is correct to the best of my knowledge: (SIGN AND DATE)

X_____ _____
PATIENT OR PARENT/GUARDIAN SIGNATURE **DATE**

Health History

Primary Physician's Name:_____

Have you had a serious illness or operation? Y ❑ N ❑ If yes, please describe: (Anything that would hinder dental treatment)

_____

Are you currently under physician care? Y ❑ N ❑
If yes, please describe:

_____

Do you Smoke or use Tobacco? Y ❑ N ❑

Are you pregnant? Y ❑ N ❑ if yes, # of weeks _____ Are you nursing? Y ❑ N ❑

Please circle those conditions that have ever applied to you:

Conditions

Abnormal Bleeding
Allergies
Anemia
Angina Pectoris
Arthritis
Artificial Heart Valve
Asthma
High Cholesterol
Cancer
Chemotherapy
Heart Attack
Congenital Heart Defect
Diabetes
Difficulty Breathing
Drug Abuse
Emphysema
Epilepsy
Fainting Spells
Fever Blisters
HIV+Aids
Joint Replacement, year_____
Heart Murmur
Heart Surgery
Hepatitis A, B, C
High Blood Pressure
Kidney Problems
Liver Disease
Pace Maker
Radiation Therapy
Seizures
Sexually Transmitted Disease
Shingles
Sickle Cell
Sinus Problems
Stroke
Thyroid problems
Tuberculosis
Ulcers

Allergies

***Aspirin**
***Codeine**
***Erythromycin**
***Latex**
***Metals**
***Penicillin**
***Sulfa**
***Morphine**
***Other: _____**
*** None**

Do you take a blood thinner? Y ❑ N ❑

Please list any medications you are currently taking:

_____

The information on this page is correct to the best of my knowledge. I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary or advisable including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my medical condition.

X_____ _____

PATIENT OR PARENT/GUARDIAN SIGNATURE **DATE**

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Please Check All That Matter To You:

- ❑ Complete and comprehensive exam showing every problem that exists
- ❑ One problematic area looked at and addressed
- ❑ Continual cleanings
- ❑ Bleaching
- ❑ Porcelain veneers
- ❑ Wisdom teeth removal
- ❑ Stop pain in teeth or gums
- ❑ Invisalign/Orthodontic Treatment
- ❑ Dentures/partials
- ❑ Implants
- ❑ I want to improve my smile and teeth
- ❑ I like the way my smile looks

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003.
What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care..

2. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

3. We agree to provide patients with access to their records in accordance with state and federal laws.

4. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

FINANCIAL POLICY

Payment is expected **at time of service**. We will accept cash, check, credit card and Care Credit. We do not accept temporary checks.

Past due accounts may be turned over to a collection agency. Any fees incurred due to this, will be added to the outstanding balance. This may include late fees, collection agency fees, court fees etc.

We are an out of network provider but do accept insurance. We will file your claims at no charge. It is the patient's responsibility to provide us with current insurance information prior to date services are performed.

Verification of eligibility and benefits payable by your insurance does not constitute a guarantee of claim payment. Final determination of benefits payable will be made at the time a claim is submitted and processed.

Not all services are covered by insurance. In the event that your insurance carrier determines a service "not covered" you will be responsible for the complete charge. If your insurance provides coverage for alternate services or downgrades any service, you will be responsible for whatever portion is not covered due to the modification made by your insurance. We will file pre-treatment estimates **AT YOUR REQUEST ONLY**. Please be aware that some insurance companies may not honor a pre-treatment estimate or may alter it. In all cases, it may delay important dental care.

Insurance limitations and regulations vary with all insurance plans. We do not base your treatment plan on what your insurance plan covers or does not cover. It's ultimately your responsibility to be aware of your dental plan coverage, regulations and limitations to avoid confusion and any surprises.

APPOINTMENT POLICY

Due to the high number of patients requiring dental care, certain appointment times might not be readily available. Because of this**, we enforce a missed appointment policy to ensure that all patients receive care as soon as possible.**

I do hereby consent and acknowledge my agreement to the terms set forth in the FINANCIAL POLICY, HIPAA, & APPOINTMENT POLICY FORM and any subsequent changes. I understand that this consent shall remain in force from this time forward.

Signature X_____ **Date** _____