Registered by: ____________

Data Verified & Entered By: ____________

Patient #: ____________

SEXTON DENTAL CLINIC INC.

Date: ________________

****All patients requesting partial dentures and/or extractions will be required to have x-rays.****
I fully understand the purpose of x-rays and their diagnostic value in dental medicine and surgery. If the dentist requires an x-ray prior to treatment, I give my permission to have the x-rays taken.

Signature of Patient: ________________________ Date: ____________

Patient Requested Dental Treatment: (please circle)

Complete Upper Denture | Upper Partial | Extractions | Consultation
Complete Lower Denture | Lower Partial | Reline/Adjustment
Consultation | Were you scheduled for IV Sedation_______?

Patient's Initials __________

PATIENT INFORMATION (Photo identification is required.)

Name ______________________________ Age ____ Date of Birth___/___/___Sex:_____Male_____Female
First MI Last

Street Address: ____________________ City____________ State___ Zip_______Telephone # (____)____-_____

Height:_______Weight ________ Email: ______________________________ Cell # (____)____-_____

Social Security No.____-____-_____(for identification purposes only) Marital Status___Single___Married___Widowed___Divorced___Separated

Occupation: __________________ Employer ____________________

Is this your first visit to Sexton Dental Clinic?___If not, please list the approximate date of your last dental visit and the name of the dentist you were treated by: ____.

Why did you come to our office today? **(Chief dental complaint.)** ________________________

Date of last dental examination____________________Name of dentist____________________

Do you have SC Medicaid?______If yes, please list your Medicaid ID Number ____________________

How did you hear about our office?___Phonebook ___Internet ___Friend(____________) ___Other(____________)

MEDICAL HISTORY

Please answer all questions, (circle Yes or No), and fill in all blank spaces where indicated. Answers to these questions are for our records only and are kept confidential.

Do you have or have you ever had any of the following Diseases or Conditions?

Heart Murmur	Yes	No	Epilepsy or Seizures	Yes	No	Asthma or Hay Fever	Yes	No
Heart Attack	Yes	No	High/Low Blood Pressure	Yes	No	Diabetes	Yes	No
Hepatitis	Yes	No	Stomach Ulcers	Yes	No	Kidney Trouble	Yes	No
Tuberculosis	Yes	No	Venereal Disease	Yes	No	Respiratory Trouble	Yes	No
Anemia	Yes	No	Sickle cell Disease	Yes	No	Cancer	Yes	No
Radiation/Chemotherapy	Yes	No	Stroke	Yes	No	Sinus Problems	Yes	No
Psychiatric Problems	Yes	No	HIV/AIDS/ARC	Yes	No	Blood Transfusion	Yes	No
Drug/Alcohol Abuse	Yes	No	Thyroid Problems	Yes	No	Herpes	Yes	No
Orthopedic Surgery	Yes	No	Mitrovalve Prolapse	Yes	No	Glaucoma	Yes	No
Are you Pregnant?	Yes	No						

Do you have any drug allergies or have you ever had an adverse reaction to any medication?______If so, please list all drug allergies and describe the adverse reaction. ____
____.

Are you allergic to Latex? Yes No (please circle)

Are you currently taking any medications?______If yes, please list ALL medications. ____.

Are you taking any blood thinners (Aspirin, Plavix, Coumadin, etc)? ____Yes ____No. If yes, please list________________________

Are you taking or have you ever taken any bisphosphonates (Fosamax, Zometa, Didronel, Aredia, Actonel, Boniva, Reclast)? Yes No

Date of last physical examination____/____/____. Are you currently under the care of a physician? ____Yes ____No
If yes, what condition is being treated?________________________
Name of your physician:______________________________Physician's Telephone No. (______)______-________
Have you been hospitalized within the last five years? ___Yes ___No
If yes, please list the reason you were hospitalized ____.
Is there anything else we should know about your medical history? ____
____.

Is this office visit accident related?___Yes ___No
If yes, please list the date and nature of accident____.

CONSENT TO ACCURACY AND DISCLOSURE OF PATIENT INFORMATION

The information I have provided is accurate and complete to the best of my knowledge and is only for use in treatment, billing, and processing of insurance benefits I am entitled to. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of my personal health information.

Signature of Patient: ____________________________________Date: ______________________________

If a personal representative signs this authorization on behalf of the patient, please complete the following:

Personal Representative's Name: __________________________Relationship to Patient: __________________

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Sexton Dental Clinic, Inc. may only use and disclose your protected health information as follows:

1. Directly to you (the patient)
2. To carry our treatment, payment, or healthcare operations
3. In compliance with a patient authorization form
4. When you (the patient) is informed in advance of the proposed disclosure and has the opportunity to agree or disagree.
5. When the disclosure is required by law or for public health reason.

Therefore, Sexton Dental Clinic, Inc.'s doctors and staff are not permitted to discuss your dental treatment or any issues related to your dental treatment with your family members, friends, etc. without your written authorization.

If you wish to authorize such uses and disclosures, please ask a receptionist for a "Patient Authorization Form".

Signature of Patient: ____Date: ______________________

Dr. Terry Evaluation & Consent Forms

1. Why are you here today? ________________ Today's date ___________
2. Do any of your teeth hurt today? ______________________
3. Do you want to change your smile with Cosmetic dental work? ______
4. Have you heard of Lumineer Smile Makeovers? _________

Do Not Fill In Below

1. Medical History _________________________
2. TMJ _________________________
3. Cancer Screening _________________________
4. Treatment needed:

   Periodontal Condition _________________________

   Gingival Contour ________________

   Needs Prophy ________________

   Needs SRP ________________

   Needs Referral ________________

   Restorative Treatment needed ____________

Treatment Plan

Today's Date_______________

1. ___________
2. ___________
3. ___________
4. ___________
5. ___________
6. ___________
7. ___________
8. ___________
9. ___________
10. ___________
11. ___________
12. ___________
13. ___________
14. ___________
15. ___________
16. ___________
17. ___________
18. ___________
19. ___________
20. ___________
21. ___________
22. ___________
23. ___________
24. ___________
25. ___________
26. ___________
27. ___________
28. ___________
29. ___________
30. ___________
31. ___________
32. ___________

Informed Consent

1. With any dental treatment, there are different options to all dental procedures. Some options are better than others. Dr. Terry will discuss my options for optimal dental health. I understand that my consult is only an estimate and it can change.

Sign ____

2. I understand that it is important after treatment to have regular check ups. If I don't get my teeth cleaned every six months problems may arise. I understand that my over all treatment is important for my dental health.

Sign ____

3. With any dental treatment, complications may arise. Sometimes treatment plans change due to extensive decay, tooth fractures, cracks, pulp exposures and occlusion problems. If any of these issues arise, I understand that Dr. Terry will discuss my options.

Sign ____

4. With any Crown & Bridge work, impressions are taken and sent to the lab to have work fabricated. Problems may arise with work having to be redone to make sure there is an ideal fit. I understand that if it is redone it will take an additional appointment or appointments to fit, depending on the labs need.

Sign ____

5. I understand that with any dental treatment, that a tooth or teeth may need a root canal, or extraction after treatment. During treatment if unforeseen tooth decay extends to the pulp it will require a root canal or extraction. Tooth infections can arise days, months, or years after dental treatment that will require a root canal or extraction. I understand that Dr. Terry will discuss my options if this arises.

Sign ____

6. I will review or let Dr. Terry pick the shade of my restoration. I understand that once the shade is picked, it cannot be changed unless it is remade at my (patients) expense.

MY SHADE for restoration is __________________

Sign ________________________________ **Date** __________________

Date	Tooth #	Surface	Procedure	Dr.	Fee

SEXTON DENTAL CLINIC INC.

Patient Name: ______________________________ **Patient #** ________ **Date** ____________

PAYMENT INFORMATION

Payment is to be made at the time services are rendered,   We accept cash, Visa, Mastercard, Discover, American Express, and Debit cards. We do not accept dental insurance; however, if you have dental coverage, a claim may be submitted to your insurance carrier for your reimbursement. If interested, please see the insurance specialists for further information.

The claims processing fee is $8.

Person Responsible for Payment: ______________________________ Do you have dental insurance? ____Yes ____No

POST OPERATIVE CARE

I, ______________________________ , agree that should I need any denture adjustments, post-operative care and treatment, or should any complications occur, I will return to the office of Sexton Dental Clinic. I understand that I may have to make return visits for denture adjustments and/or receive post-operative surgical procedures. If I am unable to return to the office of Sexton Dental Clinic, I will accept full responsibility of any expenses that may occur by choosing to go elsewhere for treatment. I also understand that if additional dental treatment is needed during a follow-up visit, there may be a fee for this treatment as well.

Signature of Patient: ______________________________ Date: ____________________

NO REFUND POLICY

Due to the customized nature of dentistry, our services and products are non-refundable and non-returnable. The No Refund policy also applies to any restorative or cosmetic treatment that is in process or has been completed. Customer satisfaction is paramount to us, and complaints will be assessed on an individual basis.

Signature of Patient: ______________________________ Date: ____________________

IMMEDIATE DENTURES

I understand that when having teeth extracted that I am purchasing an Immediate Denture/partial that is neither aesthetically nor functionally perfect. I am aware that adjustments and a reline is necessary and at no additional cost if returned within 90 days. A reline can usually be done as early as two (2) weeks prior to the ninety (90) day return time. I also understand that this temporary denture/partial will need to be replaced in approximately one (1) year at my expense.

Signature of Patient: ______________________________ Date: ____________________

CTI: COSMETIC TRY-IN DENTURE (not for patients having extractions)

One of the main concerns of denture wearers is the appearance of their teeth. An impression is taken and a lab-technician will set the teeth on the models according to certain anatomical landmarks for that particular patient. These anatomical landmarks are the basis for determining the size and length of the denture, etc. However, this may not coincide with what the patient has in mind in regards to the appearance of the teeth. this is the purpose for the *Cosmetic Try-In Denture* (CTI). The CTI is a little more expensive; however, it is the only way to assure the patient satisfaction with the appearance of the denture.

With CTI, the teeth are set in a wax model and "Tried In" for the patient to see. At this time, the patient can make any requests for change in the way the teeth are set.

If a patient declines the option to have the CTI, there is no guarantee the patient will be satisfied with the appearance of the new denture.

I understand that by declining the option of having a try-in denture made, there will be no guarantee that I will be satisfied with the appearance of the denture.
I decline the option of having a "try-in" denture made and I understand that appearance satisfaction is not guaranteed.

Signature of Patient: ______________________________ Date: ____________________

Dental Assistant: ______________________________ Date: ____________________

SEXTON DENTAL CLINIC INC.

Privacy Officer: **Effective Date:**

This Notice describers how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We care about our patients' privacy and strive to protect the confidentiality of your medical information at this practice. Federal legislation requires that we issue this official notice of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that protected health information. This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this Notice, please contact the Privacy Officer at this practice.

Who Will Follow This Notice
Any health care professional authorized to enter information into your medical record, all employees, staff and other personnel at this practice who may need access to your information must abide by this Notice. All subsidiaries, business associates (e.g. a billing service), sites and locations of this practice may share medical information with each other for treatment, payment purposes or health care operations described in this Notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be shared.

How We May Use and Disclose Medical Information About You
The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category of uses or disclosures. Not every possible use or disclosure in a category is listed.

For Treatment. We may use and disclose medical information about you to provide you with medical treatment or services. Example: In treating you for a specific condition, we may need to know if you have allergies that could influence which medications we prescribe for the treatment process.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive from us may be billed and payment may be collected from you, an insurance company or third party. Example: We may need to send your protected health information, such as your name, address, office visit date, and codes identifying your diagnosis and treatment to your insurance company for payment.

For Health Care Operations. We may use and disclose medical information about you for health care operations to assure that you receive quality care. Example: We may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

Persons Involved in Your Care. We may disclose medical information about you to a relative, close personal friend or any other person you identify if that person is involved in your care and the information is relevant to your care. Example: if the patient is a minor, we may disclose medical information about the minor to a parent, guardian or other person responsible for the minor except in limited circumstances.

Required by Law. We will use and disclose medical information about you whenever we a required by law to do so. There are many state and federal laws that require us to use and disclose medical information. Example: state law requires us to report gunshot wounds and other injuries to the police and to report known or suspected child abuse or neglect to the Department of Social Services. We will comply with those state laws and with all other applicable laws.

National Priority Uses and Disclosures Made Without Your Consent or Authorization. When permitted by law, we may use or disclose medical information about you without your permission for activities that are recognized as "national priorities." The government has determined that under certain circumstances, it is so important to disclose medical information that it is acceptable to disclose medical information without the individual's permission. Some examples include:

- Law enforcement or correctional institution, such as required during an investigation by a correctional institution of an inmate;
- Threat to health or safety, such as to avert or lessen a serious threat;
- Workers' compensation or similar programs, such as for the processing of claims;
- Abuse, neglect or domestic violence, such as if you are an adult and we reasonably believe you may be a victim of abuse;
- health oversight activities, such as to a government agency to investigate possible insurance fraud;
- Court or legal proceedings, such as if a judge orders us to do so;
- Research organizations, such as if the organization has satisfied certain conditions about protecting the privacy of medical information;
- Coroner or medical examiner for identification of a body;
- Public health activities, such as required by the US Food and Drug Administration (FDA); and
- Certain government functions, such as using or disclosing for government functions like military and veterans' activities and national security and intelligence activities.

Uses and Disclosures of Protected Health Information Requiring Your Written Authorization
The following uses and disclosures of medical information about you will only be made with your authorization (signed permission) from you or your personal representative:

- Uses and disclosures for marketing purposes.
- Uses and disclosures that constitute the sales of medical information about you.
- Most uses and disclosures of psychotherapy notes, if we maintain psychotherapy notes.
- Any other uses and disclosures not described in this Notice.

You have several rights with respect to medical information about you. This section of the Notice will briefly mention each of these rights. If you would like to know more about your rights, please contact our Privacy Officer.

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you give us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will thereafter no longer use or disclose medical information about you for the reason covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care we have provided you.

Your Individual Rights Regarding Your Medical Information

Complaints. If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at this practice or with the Secretary of the Department of Health and human Services. All complaints must be submitted in writing. You will not be penalized or discriminated against for filing a complaint.

To file a written complaint with us, you may bring your complaint directly to our Privacy Officer, or you may mail it to the following address:

To file a written complaint with the federal government, please use the following contact information:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

Toll-Free Phone: 1-(877) 696-6775
Website: http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html
Email: OCRComplaint@hhs.gov

Right to Request Restrictions on Uses and Disclosures. You have the right to request that we limit the use and disclosure of medical information about you for treatment, payment and healthcare operations. Under federal law, we must agree to your request and comply with your requested restriction(s) if:

1. Except as otherwise required by law, the disclosure is to a health plan for purpose of carrying out payment of healthcare operation (and is not for purposes of carrying out treatment); and,
2. The medical information pertains solely to a healthcare item or service for which the healthcare provided involved has been paid out-of-pocket in full.

Once we agree to your request, we must follow your restrictions (except if the information is necessary for emergency treatment). You may cancel the restrictions at any time. In addition, we may cancel a restriction at any time as long as we notify you of the cancellation and continue to apply the restriction to information collected before the cancellation.

You also have the right to request that we restrict disclosures of your medical information and healthcare treatment(s) to a health plan (health insurer) or other party, when that information relates solely to a healthcare item or service for which you, or another person on your behalf (other than a health plan), has paid us for in full. Once you have requested such restriction(s), and your payment in full has been received, we must follow your restriction(s).

Right to Request Confidential Communications. You have the right to request how we should send communications to you about medical matters, and where you would like those communications sent. To request confidential communications, you must make your request to the Privacy Officer at this practice. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you with to be contacted. We reserve the right to deny a request if it imposes an unreasonable burden on the practice.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually this includes medical and billing records but does not include psychotherapy notes, information complied for use in a civil, criminal, or administrative action or proceeding, and protected health information to which access is prohibited by law. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer at this practice. If you request a copy of the information, we reserve the right to charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by this practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at this practice. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if the information was not created by us, is not part of the medical information kept at this practice, is not part of the information which you would be permitted to inspect and copy, or which we deem to be accurate and complete. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Statements of disagreement and any corresponding rebuttals will be kept on file and sent out with any future authorized requests for information pertaining to the appropriate portion of your record.

Right to an Accounting of Disclosures We Have Made. You have the right to receive an accounting (which means a detailed listing) of disclosures that we have made for the previous six (6) years. If you would like to receive an accounting, you may send us a letter requesting an accounting, fill out an Accounting Request Form, or contact our Privacy Officer. Accounting Request Forms are available from our Privacy Center.

The accounting will not include several types of disclosures, including disclosures for treatment, payment or healthcare operations. If we maintain your medical records in an Electronic Health Record (EHR) system, you may request inclusion of disclosures for treatment, payment or healthcare operations. The accounting will also not include disclosures made prior to April 14, 2003.

If you request an accounting more than once every twelve (12) months, we may charge you a fee to cover the costs of preparing the accounting.

Right to Request an Alternative Method of Contact. You have the right to request to be contacted at a different location or by a different method. For example, you may prefer to have all written information mailed to your work address rather than to your home address.

We will agree to any reasonable request for alternative methods of contact. If you would like to request an alternative method of contact, you must provide us with a request in writing. You may write us a letter or fill out an alternative Contact Request Form. Alternative Contact Request Forms are available from our Privacy Officer.

Right to Notification if a Breach of Your Medical Information Occurs. You also have the right to be notified in the event of a breach of medical information about you. If a breach of your medical information occurs, and if that information is unsecured (not encrypted), we will notify you promptly with the following information:

- ❑ A brief description of what happened;
- ❑ A description of the health information that was involved;
- ❑ Recommended steps you can take to protect yourself from harm;
- ❑ What steps we are taking in response to the breach; and,
- ❑ Contact procedures so you can obtain further information.

Right to Opt-Out of Fundraising Communications. If we conduct fundraising and we use communications like the U.S. Postal Service or electronic email for fundraising, you have the right to opt-out of receiving such communications from us. Please contact our Privacy Officer to opt-out of fundraising communications if you chose to do so.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy. To obtain a paper copy of the current Notice, please request one in writing from the Privacy Officer at this practice.

Changes To This Notice
We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice, with the effective date in the upper right corner of the first page.