Welcome to the Carolina Dental Group Family. We look forward to being your dental care provider and getting to know you professionally and personally.

It is our mission to be leaders in dentistry through clinical excellence and patient satisfaction. Our commitment is to our patients and to their health, happiness and improved self-worth.

Our office is a provider of exceptional dental care and patient education. We are dedicated to providing comprehensive and innovative dental treatment and we encourage our patients to seek non-compromising care. We will create an environment of honesty and professionalism, where you will feel comfortable, cared for, and welcome.

We know your time is valuable, so in order to expedite your check in process, please complete all forms and mail them back to our office as soon as possible. If time does not permit a return mailing, please bring your completed forms with you to your appointment.

We will make every effort to maintain our schedule and yours. Please assist us by calling our office 48 hours prior to your appointment, if you are unable to keep your reserved time.

We pledge to make every effort possible in providing preventative dental health and education in combination with highest quality restorative care.

Sincerely,

Drs. Kevin J. Stoller, and Scott H. Stoller

132 Milestone Way • Greenville, SC 29615 • 864-288-6404 phone • 864-288-2515 fax • CarolinaDentalGroup.com • info@carolinadentalgroup.com

Thank you for Selecting Carolina Dental Group for your dental healthcare. To help us meet all of your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, we will be happy to help.

PATIENT INFORMATION (confidential)

Name: _____ Sex: _____

Date of Birth: _____ Social Security Number: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____

Emergency Contact: _____ Phone: _____

Whom May We Thank For Referring You? _____

RESPONSIBLE PARTY

Name of Person Responsible for this Account: _____

Relationship to Patient: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____

INSURANCE INFORMATION

Name of Person Insured: _____

Date of Birth: _____ Social Security Number: _____

Name of Employer: _____ Date of Employment: _____

Insurance Company: _____

Group #: _____ Policy ID# _____

Insurance Co. Address: _____

City: _____ State: _____ Zip Code: _____

CAROLINA DENTAL GROUP, PA

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

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

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other?	☐	If yes
Do you use controlled substances?	◯ Yes ◯ No	If yes

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 Problems	◯ 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 ◯ Yes ◯ No If yes

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:

X Date:_____

PRIVACY POLICY

We believe that you have the right to know what we do with the financial and health information we gather during the course of processing, administering, and maintaining your personal information. We also want to assure you that we properly safeguard this confidential information. Because we value our relationship with our patients, we have prepared the following summary of our privacy policy, which is based on the federal law governing patient privacy, and on our own high standards of patient confidentiality.

As required by HIPAA, below is an explanation of how we maintain the privacy of your health information. We may use and disclose your dental records only for each of the following proposed treatment, payment, and healthcare operations.

- *TREATMENT* means providing, coordinating, or managing healthcare and related services by one or more healthcare providers. An example of this would include teeth cleaning services.
- *PAYMENT* means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending an insurance claim to your insurance company for payment of services.
- *HEALTH CARE OPERATIONS* include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example of this would be an internal quality assessment review.

We may also create and distribute de-identifiable health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your prior authorizations.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer.

- The right to request restriction on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. However, we are not required to agree to a requested restriction. If we do agree to a restriction, we must abide unless you agree, in writing, to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means, or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive your accounting disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

Signature: _____ Date: _____

Kevin J. Stoller, DMD and Scott H. Stoller, DMD

Financial Policy

Please read the following financial policy for Carolina Dental Group, and sign below stating that you have read, and understand it.

Payment and Payment Methods:

We will collect the patient's portion of services rendered, at the time of the appointment. We offer a 5% discount to patients without dental insurance, who pay in full with cash or check on the day of service.

We accept all major credit cards, and we offer 6 and 12 month, interest free financing for qualified individuals as well.

Warrantees on crowns, bridges, veneers, or fillings, are only valid for patients who maintain 2 or more recare visits per year.

Dental Insurance:

As a courtesy, we will file your insurance claim for you. Please keep in mind, it is the patient's responsibility to pay the portion of services not covered by insurance.

Insurance Agreement: "I am aware that it is my responsibility to read and understand my own dental insurance policy, including benefits, limitations, downgrades, and exclusions. I also understand that an estimated portion is due at time of service and estimated according to expected coverage, which may not be disclosed nor guaranteed, by my insurance company. I understand that my portion may be more if my insurance company does not pay the anticipated amount. Services are rendered independent of insurance reimbursement."

Assignment of Benefits/Authorization to release information: I understand my signature on file allows payments to be made to Carolina Dental Group, P.A., and authorizes release of information necessary to pay my claim.

Returned Checks:

There will be a $25.00 charge to the patients account in the case of a returned check.

Missed Appointments:

We certainly understand emergencies and other unexpected situations that may come up. We do ask for 48 hour notice if you are unable to keep your scheduled appointment, in order for us to accommodate another patient who may be able to take your appointment time. Failure to keep/reschedule your appointment without 24 hour notice, may result in a $25.00 fee, applied to your account.

Please let us know if you have any questions or concerns, as we are committed to serving you with the best possible dental care.

Patient or Responsible Party Signature: _____ *Date:* _____

Date of Birth of Responsible Party: _____