32dental
Shivani A. Patel, DMD

121 Wildewood Park Drive Columbia, SC 29223 | 803.736.5300 | info@32dentalsc.com | 32dentalsc.com

Patient Information

Name (Dr., Mr., Mrs., Ms., Miss.): _____
Gender: ☐ Male ☐ Female ☐ Prefer Not to Answer Social Security #: _____
Date of Birth: _____ ☐ Married ☐ Single ☐ Divorced ☐ Widowed
Address: _____ City/State/Zip: _____
Phone: Home _____ Cell _____ Work _____
E-mail Address: _____
How do you prefer to be contacted: ☐ Home phone ☐ Cell phone ☐ Work phone ☐ E-mail
Employer & Occupation: _____
Whom may we thank for referring you: _____

Person responsible for account:

☐ Check if patient is guarantor/responsible for account (if checked, continue to Insurance Information section)
Name: _____
Address: _____ City/State/Zip: _____
Phone: Home _____ Cell _____ Work _____
Relationship to patient: ☐ Spouse ☐ Parent ☐ Other _____

Insurance Information

(If you **DO NOT** have dental insurance, skip this section)
Insured's Name: _____ DOB: _____ SSN: _____
Relationship to patient: ☐ Self ☐ Spouse ☐ Parent
Primary Insurance Company: _____
Policy Number: _____
Group Number: _____
Insurance phone number: _____
Do you have secondary dental insurance? ☐ Yes ☐ No
If yes, please provide name, policy number and group number: _____

Please text or e-mail a copy of the front and back of your Driver's License and Insurance card if available to (803) 736-5300 or info@32dentalsc.com

☐ I understand that my insurance is an agreement between my insurance company and me. I understand that I am responsible for the balance of my dental account regardless of my insurance. I assign dental benefits to be paid directly to Shivani A. Patel, DMD from my insurance company. I give permission for Dr. Patel or her clinical team to take any necessary diagnostic films, photos, or study models to properly enable complete diagnosis and treatment.

Patient/Guardian's Signature: _____ Date: _____

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Health History

Patient name: _____

Medical Doctor's Name: _____ Phone Number: _____

Date of last physical examination: _____

1. Have there been any changes to your general health in the past year? ☐ Yes ☐No
   *If yes, please describe:_____
2. Previous operations/invasive procedures or surgeries? ☐ Yes ☐No
   *If yes, what kind:_____
3. Have you been hospitalized or had a serious illness in the past two years? ☐ Yes ☐No
   *If yes, please explain:_____
4. **Check if you have or have you had any of the following conditions:**

☐ Murmur/Mitral Valve Prolapse	☐ Kidney Disease	☐ Acid reflux or GERD
☐ Angina/Chest Pain	☐ Artificial joints (Hip/knee)	☐ Stomach ulcers
☐ High Blood Pressure	☐ Arthritis	☐ Venereal disease
☐ Stroke	☐ Osteoporosis	☐ Alcohol/Substance Abuse
☐ Heart Attack	☐ Thyroid disease	☐ Prolonged or abnormal bleeding
☐ Congestive heart failure	☐ Hepatitis or liver disease	
☐ Pacemaker	☐ High cholesterol	☐ Anemia/Bleeding disorder
☐ Artificial heart valve	☐ Asthma	☐ HIV or AIDS
☐ Seizures/Epilepsy	☐ Lung disease	☐ Cancer/tumor
☐ Diabetes	☐ Persistent Cough	☐ Chemotherapy
☐ Fever blisters/Herpes	☐ Sinusitis/seasonal allergies	☐ Head and neck radiation therapy
☐ Fainting spells	☐ Sleep apnea	
☐ Glaucoma	☐ Use CPAP	☐ Psychiatric treatment

5. Are you taking blood thinners? ☐ Yes ☐No
   If yes, please check all that apply ☐Aspirin ☐Coumadin ☐Other: _____
6. Women: Are you pregnant? ☐ Yes ☐No
   Are you taking birth control medication? ☐ Yes ☐No
7. Are you taking or have you taken medication for osteoporosis? ☐ Yes ☐No
8. Are you currently being treated by a physician for any other medical conditions? ☐ Yes ☐No
   If yes, please explain:_____
9. Please list all allergies:
   _____
10. Please list all medications you are taking, prescriptions and over the counter:
    _____
    _____
11. Do you smoke? ☐ Yes ☐No
    If yes: ☐Pipe ☐Cigarettes ☐Smokeless tobacco ☐Vape ☐Marijuana

Signature of patient or guardian: _____Date: _____

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Dental History

Patient Name:_____ Date of Birth: _____
What is the reason for your visit?
_____
Date of your last dental examination: _____
Do you have X-rays at another dental office? ☐Yes ☐ No
Previous Dentist's Name: _____ Address: _____ Phone #: _____
When was your last dental cleaning?
☐6 months ago ☐12 months ago ☐over two years
How often do you brush your teeth?
☐once a day ☐twice a day ☐once every few days
How often do you floss your teeth?
☐daily ☐occasionally (1-3 times a week) ☐rarely ☐never
What else do you use to clean your mouth and teeth?
☐mouthwash ☐waterpik ☐tongue scraper ☐other _____
Are your teeth sensitive to?
☐hot ☐cold ☐sweets ☐biting
Do you experience
☐Clicking or popping of the jaw?
☐Difficulty chewing on one side of your mouth?
☐Difficulty opening or closing your mouth?
☐Headaches, neck or shoulder pain?

Are your gums uncomfortable or bleed? ☐Yes ☐No
Have you noticed bad odors or tastes in your mouth? ☐Yes ☐No
Does food wedge between your teeth? ☐Yes ☐No
Do you clench or grind your teeth during the day or at night? ☐Yes ☐No
Do you currently wear a nightguard or bite splint? ☐Yes ☐No
Do you frequently get cold sores or blisters? ☐Yes ☐No
Are you satisfied with the appearance of your teeth? ☐Yes ☐No
*if no, please describe:
_____
Do you feel anxious about receiving dental care? ☐Yes ☐No
*If yes, what is your biggest concern:
_____
Have you ever had a frightening dental experience? ☐Yes ☐No
*If yes, please describe:
_____
Would you spend 10 minutes a day to keep your natural teeth: ☐Yes ☐No

Is there anything else you would like for us to know about your dental history?
_____
_____

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All Patients General Consent

Patient's Name: _____ *DOB:* _____

1. *I consent to this office performing as applicable: Dental treatment to include elective procedures i.e., whitening procedures and minor orthodontic treatment. This is to include anesthetics as may be necessary in accordance with the judgment of the authorized physicians and/or clinicians and dental team members.*
2. *I hereby grant permission to 32 Dental, LLC and its representatives, to take and use: photographs, audio, and video recordings and/or digital images of me for continuing education meetings, treatment planning, marketing, website, or social media outlets. I further agree that my name and identity may be revealed in text or commentary in connection with the image(s). I authorize the use of these images without compensation to me.* ◯ *Yes* ◯ *No*
3. *I give permission to share my electronic medical record among my health providers and obtain medication history which will follow state and federal laws regarding access by medical providers of any protected information. I may opt out and continue to receive care.*
4. *I consent to the use of the electronic prescription system, which allows prescription history and related information to be electronically shared between my providers and my pharmacy.*
5. *I understand that certain circumstances require mandatory disclosure to organizations such as the state health department and department of health and environmental control and that this entity participates in the South Carolina Dept. of Health's statewide immunization registry, which complies with federal health information privacy laws.*
6. *I acknowledge receipt of the Patient General and Financial Polices. If I fail to make payment or comply with payment arrangements, collection measures may be initiated.*
7. *I give permission to leave messages on my answering machine/voicemail.* ◯ *Yes* ◯ *No*
   I give permission to email and text appointment reminders ◯ *Yes* ◯ *No*
8. *Patient's Responsibilities:*
   I understand the use of tobacco and alcohol is detrimental to the success of my treatment. I agree to follow all instructions provided to me by this office before and after the procedure, take medication(s) as prescribed, practice proper oral hygiene, keep all appointments, make return appointments if complications arise, and complete care. I will inform my doctor of any post-operative problems as they arise. My failure to comply could result in complications or less than optimal results.

I FULLY UNDERSTAND AND AGREE TO THE CONDITIONS CONTAINED IN THIS FORM.

Signature of Patient or Legal Representative: _____

Printed Name of Patient or Legal Representative: _____

Date: _____

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Office and Financial Policies

We, the staff of 32 Dental, LLC. thank you for choosing us as your dental health provider. We consider it a privilege to serve your needs and we look forward to doing so. We are committed to providing you with the highest level of care and to building a successful provider/patient relationship with you and your family. We believe your understanding of our patients' financial responsibility is vital to that provider/ patient relationship and our goal is not only to inform you of the provisional aspects of that financial policy but also to keep the lines of communication open regarding them. If at any time you have any questions or concerns regarding our fees, policies, or responsibilities please feel free to contact our office at (803)736-5300.

We believe this level of communication and cooperation will allow us to continue to provide quality service to all of our valued patients. Please understand that payment for services is an important part of the provider/ patient relationship. If you do not have proof of current insurance coverage or if you participate in a plan that will not honor an assignment of insurance benefits, payment for services will be due at time of service.

Please be prepared to pay for your dental treatment on the day of service. We accept cash, check, Visa, Mastercard, Discover, American Express and Care Credit. A $35.00 service fee will be charged for all returned checks. For your convenience, you may authorize us to keep your credit card on file.

Interest

Interest may incur if a balance remains unpaid after 60 days.

Insurance

Please remember that your insurance policy is a contract between you and your insurance carrier. We will, as a courtesy, bill your insurance and help you receive the maximum allowable benefit under your policy. Despite our best efforts, insurance plans do not always pay the entire estimated amount. Please be aware that payment of the entire service fee is ultimately the responsibility of the patient. We have found that patients who are involved with their claims process are more successful at receiving prompt and accurate payment services from their insurance carrier. We do expect patients to be interactive and responsible for communicating with their insurance carrier on any open claims.

It is your responsibility to provide all necessary insurance eligibility, identification, authorization and referral information and to ***notify our office of any information changes when they occur****. Even a prior authorization of services does not guarantee payment from your insurance carrier. We also require photo identification when accepting insurance information. It is the patient's responsibility to know if our office is participating or non-participating with their insurance plan. Failure to provide all required information may necessitate patient payment for all charges. When insurance is involved, we are contractually obligated to collect co-payments, coinsurance, and deductibles, as outlined by your insurance carrier.*

Please be aware that out-of-network insurance carriers often prohibit assignment of benefits and may try to limit their financial liability with arbitrary limits, exclusions, or reductions such as reasonable and customary or usual and prevailing reductions.

Our fees are well within such ranges and although we will assist in the filing of an appeal if these limitations are imposed, you as the guarantor are responsible for all out-of-network fees. If we are not contracted with your carrier, we will not negotiate reduced fees with your carrier.

Miscellaneous Forms, Additional Information and Authorizations

We will provide all necessary information to have your benefits released. However, if it becomes necessary to submit redundant or unnecessary information for the completion of claim forms for school, sports, or extracurricular activities, there may be an administrative fee, not to exceed $35.00, for the additional information.

Missed Appointments

We require a twenty-four (24) hour minimum notice for all cancellations. This allows us to offer the appointment time to another patient. If you fail to keep your appointments without notifying us in advance: a missed appointment fee will apply. These fees are equal to 20% of the cost of your scheduled appointment. Repeated missed appointments without notification may cause you to be discharged from the practice so that we can provide care to other patients.

Medical Records Fees

Patients are entitled under federal law to have access to their protected health information and we follow all rules, guidelines, and exceptions to ensure compliance to patient rights. However, providers also have the right to compensation for records and our fees are a reasonable cost-based fee for copies including the copying, supplies, labor, and postage of the files, and or summaries.

Timeliness of Appointments

We try to see everyone in a timely manner but if we are taking too long, please let our receptionist know so we can best serve your needs and reschedule you if necessary. In order to stay on schedule and see all of our patients at their appointed times, we ask that you arrive on or before the time you have been scheduled. Patients arriving more than ten (10) minutes past their appointed time may be asked to reschedule and will be subject to the missed appointment fee described above.

Acknowledgment

I have read and understand the above policies. I agree to assign insurance benefits to 32 Dental, LLC. when applicable. I also agree, in addition to the amount owed, I will be responsible for the fee charged by the collection agency for costs of collections if such action becomes necessary.

*Signature of Patient or Guardian:*_____ *Date:*_____

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INDIVIDUAL PATIENT'S AUTHORIZATION

THIS FORM IS TO CONFIRM YOUR AUTHORIZATION TO DISCLOSE YOUR PROTECTED HEALTH INFORMATION

*Patient's Name*_____

*Address*_____

City _____ *State* _____ *Zip* _____

*Telephone Number*_____

Describe the protected dental information you are authorizing to be disclosed (Example: treatment, appointments, insurance, dental, all information)

_____

_____

List the names and dates of birth of the people you are authorizing to receive your protected dental information.

_____

_____

_____

I understand that I may revoke this authorization at any time by giving written notice. However, I understand that I may not revoke this authorization for any actions taken before receipt of my written notice to revoke this authorization. In addition, I understand that if I am giving this authorization as a condition of obtaining insurance coverage, and I revoke this authorization, the insurance company has a right to contest my claims under the insurance policy.

I understand that by signing this form I am confirming my authorization for the disclosure of the protected health information described in this form with the people named in this form.

YOU HAVE A RIGHT TO A COPY OF THIS FORM AFTER YOU SIGN IT

Signature: _____ *Date:* _____

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HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH CARE INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY

Our commitment at 32 Dental, LLC is to serve our patients with professionalism and care, being sure at all times to protect the privacy and security of all Protected Health Information. During the course of serving your interests, it may be necessary to share information with other health care providers or business associates. The following are examples of instances where information may be shared,
Please check all to confirm understanding:

- ☐ *During treatment, we may find it necessary to acquire a laboratory analysis.*
- ☐ *For payment purposes, we may use the services of a billing service.*
- ☐ *During health care operations, we may need a second opinion.*
- ☐ *We sometimes have to employ or contract with third-party Information Technology, Computer and Data Storage Vendors, in addition to our trained employees, who have the expertise to store, repair, modify or replace our data storage system and/or store the large amounts of patient and business information that we must maintain in order to operate the business and treat our patients.*

We at 32 Dental are committed to obeying all Federal, State and local laws and regulations regarding Privacy Practices and in good faith will do everything practical to maintain the security and confidentiality of all patient information. Not withstanding, at 32 Dental we shall have no responsibility or liability for any damages of any kind for the unauthorized access, hacking, misuse or misappropriation of information or theft of all such protected HIPAA information that are stored or organized by third parties or in the cloud. While we take all reasonable steps to preserve the confidentiality of our patient information sometimes information is compromised through no fault of our own not withstanding all protections in effect but due to others who do it for illicit purposes. If any other uses or disclosures than the ones listed above are needed, information will only be released with the written authorization of the individual in question. This written authorization may be revoked at any time by the individual, as provided for by law. If you have any questions or comments regarding your Protected Health Information, feel free to contact our Compliance Officer Dr. Patel at 803-736-5300 or info@32dentalsc.com.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices.

This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we must do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we usually will not ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- *when a state or federal law mandates that certain health information be reported for a specific purpose;*
- *for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;*
- *disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;*
- *uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;*
- *disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;*
- *disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;*
- *disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;*
- *uses or disclosures for health related research;*
- *uses and disclosures to prevent a serious threat to health or safety;*
- *uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;*
- *disclosures of de-identified information;*
- *disclosures relating to worker's compensation programs;*
- *disclosures of a "limited data set" for research, public health, or health care operations;*
- *incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;*
- *disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;*

  Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

APPOINTMENT REMINDERS

We may call, text or e-mail to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call, text or e-mail to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will call, text, e-mail or leave a message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.

If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- *Ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or e-Mail shown at the beginning of this Notice.*
- *Ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using email to your personal email address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or e-mail shown at the beginning of this Notice.*
- *Ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30-day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or e-mail shown at the beginning of this Notice.*
- *Ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30-day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or e-mail shown at the beginning of this notice.*

- *Get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include; disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without change. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30-day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or e-mail shown at the beginning of this notice.*
- *Get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or e-mail shown at the beginning of this notice.*

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office and have copies available in our office and post it on our website.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or e-mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

Patient/Guardian's Signature: _____ Date: _____

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Release of Records

I, _____ hereby authorize Dr. Shivani A. Patel to obtain my dental records from Dr. _____. These records may include x-rays, treatment notes, charting, medical and dental history, photographs or other notations relevant to my dental treatment.

These records may be obtained from:

Dental Practice: _____
Address: _____
City: _____
State: _____

Please e-mail x-rays to: info@32dentalsc.com

Signature: _____