BLUFFTON
DENTAL CARE
CENTER FOR IMPLANT & COSMETIC DENTISTRY

James G. Jenkins, DMD
25 Clark Summit Drive,
Suite 100
Bluffton, SC 29910
PHONE (843)706-3800
FAX (843)706-3802

Patient Registration

First Name / Initial / Last Name		Preferred Name	
Address		Birthdate	Social Security #
City / State / Zip Code		○ Male ○ Female	Driver's License #

O Married **O** Single **O** Divorced **O** Separated **O** Widowed

Home Phone	Work Phone	Cell Phone
Email	Would you like to receive text or email notifications? **O** Text **O** Email	

IF PATIENT IS A MINOR PLEASE FILL OUT

Parent or Guardian First Name / Initial / Last Name		Relationship	
Address		Birthdate	Social Security #
City / State / Zip Code		○ Male ○ Female	Driver's License #

Home Phone	Work Phone	Cell Phone

PLEASE PROVIDE ADDITIONAL CONTACT INFORMATION

Emergency Contact Person	Phone Number	Relationship
Address	City	State / Zip Code

OUR BIGGEST COMPLIMENT OUR PATIENTS GIVE US IS THE REFERRAL OF THEIR FAMILY AND FRIENDS…

Who may we thank for referring you?	Are they a patient here?

I WAS REFERRED BY ANOTHER SOURCE:

O Yellow Pages O Google O Newspaper/Magazine (Which One?)____________ O Social Media(Which one?)___________
O Website O Other__________

IF YOU HAVE DENTAL INSURANCE PLEASE PROVIDE:

PRIMARY		SECONDARY	
Insurance Company Name	Insurance Phone #	Insurance Company Name	Insurance Phone #
Employer Name	Employer Phone #	Employer Name	Employer Phone #
Insured's Name (If not Self)		Insured's Name (If Not Self)	
Birth Date of Insured	Relationship to Patient	Birth Date of Insured	Relationship to Patient
Insured's Insurance ID No.	Group Number	Insured's Insurance ID No.	Group Number
Insured Social Security # (If Not Self)		Insured Social Security # (If Not Self)	

FINANCIAL POLICY

Thank you for choosing Bluffton Dental Care. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

PAYMENT OPTIONS:

You can choose from:

-***Cash, Check, Visa, Mastercard or Discover.***

-NO INTEREST[1] Payment Plans[2] from CareCredit and Lending Club (Upon Credit Approval)

- Allow you to pay overtime with NO INTEREST[1]
- Convenient, low monthly payment plans[2] also available
- No annual fees or pre-payment penalties

PLEASE NOTE:

Bluffton Dental Care requires payment prior to the beginning of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case per this Financial Policy.

For patients with ***dental insurance*** we are happy to work with your carrier to maximize your benefits and directly bill them for reimbursement for your treatment. However, if we do not receive payment from your insurance carrier within 60 days, you will be responsible for payment of your treatment fees and collection of your benefits from your insurance carrier.

A FEE STARTING AT $50 IS CHARGED FOR PATIENTS WHO MISS OR CANCEL THEIR HYGIENE APPOINTMENT WITHOUT 24 HOURS NOTICE. SCHEDULED APPOINTMENTS WITH A DOCTOR WILL BE DETERMINED ON THE HOURS SET ASIDE FOR YOUR TREAMENT STARTING AT $600 AN HOUR.

Record Release fee for radiographs will be a charge of $150 and account balance must be paid in full.

BLUFFTON DENTAL CARE CHARGES $50 FOR RETURNED CHECKS.

If you have any questions, please do not hesitate to ask.

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Patient, Parent or Guardian Signature

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Patient Name (Please Print)

[1]If paid within the promotional period. Otherwise, interest assessed form purchase date. Minimum monthly payment required.
[2]Subject to Credit approval

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to myself or my dependent during the period of such dental care to third party payers and/or health practitioners.

I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

Patient Signature ____
(Of Guardian if patient is a minor)

OFFICE USE ONLY

Written Acknowledgement could not be obtained because:

_____Individual Refused to Sign
_____Communication Barriers prohibited obtaining the acknowledgement
_____An emergency situation prevented us from obtaining acknowledgement
____ Other (Please Specify)

____

PATIENT MEDICAL HISTORY

Physician's Name_____________________ Phone Number_____________ Date of Last Physical Exam__________

Have you ever been hospitalized or had a major operation? If yes, please explain

____

____

Have you ever had a serious head or neck injury? If yes, please explain______________________________

Please List All Medications you are currently taking, as well as over-the-counter medications, herbal remedies, vitamins, homeopathic remedies and please describe what they are being taken for:

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Do you take or have you taken Phen-Fen or Redux?	**O** YES	**O** NO
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	**O** YES	**O** NO
Have you ever used Botox or Dermal Fillers?	**O** YES	**O** NO
Are you on a special diet?	**O** YES	**O** NO
Do you use Tobacco?	**O** YES	**O** NO
Currently Taking Any blood thinners?	**O** YES	**O** NO

If yes, please list: _______________

WOMEN: ARE YOU?

Pregnant/ Trying to become Pregnant? **O** YES **O** NO **O** Nursing **O** Taking Oral Contraceptives

ALLERGIES OR REACTIONS TO ANY OF THE FOLLOWING?

O Aspirin	O Penicillin	O Codeine	O Acrylic
O Metal	O Latex	O Sulfa Drugs	O Anesthetics

OTHER (Please Specify):____

Please describe any impending operations, recent injuries or other information the dentist should be aware of:

____

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CHECK ALL THAT APPLY

O –AIDS/ HIV	O –Alzheimer's Disease	O –Anemia	O-Arthritis/Gout/Rheumatism
O- Angina/Chest Pain	O –Artificial Heart Valve	O –Artificial Joint	O –Asthma/Breathing Issues
O –Bruise Easily	O –Cancer	O –Chemotherapy/Radiation Treatment	O –Cold Sores/Fever Blisters
O –Convulsions/Seizures/Epilepsy	O –Cortisone Medicine	O –Diabetes	O –Drug Addiction
O – Excessive Bleeding	O –Excessive Thirst	O –Fainting Spells/Dizziness	O –Frequent Cough
O –Frequent Headaches/Migraines	O –GERF/Acid Reflux	O -Glaucoma	O –Hay Fever/Allergies
O –Heart Attack/Failure	O –Heart Murmur/Irregular Heartbeat	O – Heart Pacemaker	O –Heart Trouble/Disease
O –Hemophilia	O –Hepatitis	O –High Blood Pressure	O –High Cholesterol
O –Hives or Rash	O -Hypoglycemia	O –Kidney Disease/Kidney Problems	O –Liver Disease
O –Low Blood Pressure	O –Lung Disease	O –Mitral Valve Prolapse	O -Osteoporosis
O –Psychiatric Care	O –Renal Dialysis	O –Scarlet Fever	O –Sexual Transmitted Disease
O –Sickle Cell Disease	O Sinus Problems	O –Spina Bifida	O –Stomach/Intestinal Disease
O –Thyroid Disease	O –Tonsillitis	O –Tuberculosis	O –Tumors or Growths
O –Ulcers	O –Yellow Jaundice	O –Stroke	O –Renal Dialysis

PATIENT DENTAL HISTORY

What is the primary concern for today's visit? ____

When your last visit to a dentist and what was done? ____

Have past dental experiences been satisfactory? Please explain, ______________________________

Reason you left your last dental office? ____

I routinely see my dentist every:

O 3 mo. O 4 mo. O 6 mo. O 12 mo. O Not Routinely

Are you happy with the appearance of your teeth? O YES O NO

Explain:____

____

Do you snore or use a sleep device? O YES O NO

Would you like more information about sedation dentistry? O YES O NO

Would you describe yourself as having a fear of the dentist? O YES O NO

Are you interested in improving your fine lines and wrinkles? O YES O NO

Do you currently wear any removable oral appliances? O YES O NO

(Please Specify)______________________________

Do you or have you had any of the following? Check all that apply

O- Bleeding Gums	O- Grinding or clenching of teeth	O- Painful or Locking Jaw
O- Sensitive Teeth	O- Loose Teeth	O- Bad Taste/Bad Odor in Mouth
O- Periodontal Treatment	O- Orthodontic Treatment	O- Catching Food Between Teeth
O- Botox or Dermal Fillers	O- Dry Mouth	O- Missing Teeth
O- Migraines/Headaches	O- Spacing Between Teeth	O- Night Guard
O- Crooked or Crowded Teeth	O- Difficulty Opening or Closing	O-

OFFICE NOTES

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