RINEHART DENTISTRY

Welcome to Our Practice!

Thank you for selecting us as your dental health care providers. We believe that all patients deserve the very best dental care we can provide. The following information is provided to introduce you to our practice philosophy and policies.

Appointments

Our practice is dedicated to quality care and exceptional service. To serve you better and keep the costs of dental care down, we try to maintain an efficient appointment system. We make every effort to honor time commitments and we appreciate patients extending us the same courtesy. Patients are reminded of their appointments 2-3 days in advance by email, text, or phone. Patients are kindly asked to confirm their appointment at least 24 hours prior to their appointment through the reminder method employed.

New Patient Appointments

We reserve 60 minutes for each new adult patient visit and 30 minutes for each new child visit. This allows time for us to listen to patient concerns and to properly diagnose and develop appropriate treatment plans.

Continuing Care

Our practice is focused on prevention and maintaining optimum oral health. We recommend comprehensive treatment and continuing care on an appropriate recall schedule.

Urgent Care After Hours

We are committed to providing emergency dental services for our patients and our community. If you have a dental emergency, you can call the office number for information on how to contact the doctor on call. An after hours fee may be charged.

Children and Adolescents

We are happy to start seeing children at the age of three. Parents are welcome to accompany their children in the operatories. We require that parents remain in the office with children under the age of 12 for the entire appointment. Failure to comply may result in the appointment being rescheduled.

Cancellations and Missed Appointments

We require 24 hours advance notice of a cancellation. Patients who do not provide 24 hours notice of a cancellation or who do not present for a scheduled appointment will be charged a fee. Patients who fail to present for a second appointment may be dismissed from the practice.

Payments and Insurance

Payment for treatment is due the day services are rendered. It is our goal, however, to assist all of our patients in obtaining the dental treatment they deserve. As a result, we offer several payment options, including cash, check, credit card, and third party financing. For patients with dental insurance, we will file the appropriate claim forms. Please review our Financial Policy on Page 6 for more information regarding our financial agreement.

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Patient Information

Name:_____Preferred Name: _____

Home Address:_____City:_____State_____Zip_____

Home #:_____Work #:_____Mobile #: _____

Email: _____

Sex: M / F Birth Date:_____/_____/_____ SS#:_____

Family Status (circle): Single Married Divorced Child Spouse's Name: _____

How did you first hear about our office? (circle one):

Another Patient	Another Dental Office	Brochure	Online Search
Facebook	Work	School	Insurance Website
Sign –Drive by	Walk in	Other:_____	

Whom may we thank for referring you to our practice?_____

Person Responsible for Account

Name of responsible party: _____

Relationship to patient (Circle): Self Spouse Parent Other: _____

Home Address:_____City:_____State:_____Zip: _____

Home #:_____Work #:_____Mobile #: _____

Email: _____

Birth Date:_____/_____/_____ SS#:_____

Contact Information

What is the best way to communicate with you? Home Phone / Mobile Phone/ Text / Email

In the event of an emergency, whom should we contact? Name _____

Relationship_____Home #:_____Work #:_____Mobile #: _____

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Insurance Information (Primary)

Name of Insured:_____Relationship to patient: _____

Insured Birth Date:____/___/_____

Insurance Plan Name:_____Insurance Co Phone #: _____

Claims Address _____

City, State, Zip _____

Group #:_____ID #: _____

Insurance Information (Secondary)

Name of Insured:_____Relationship to patient: _____

Insured Birth Date:____/___/_____

Insurance Plan Name:_____Insurance Co Phone #:_____

Claims Address _____

City, State, Zip _____

Group #: _____ ID #: _____

Employment Information

Employer Name:_____Phone:_____

Address: _____

City, State, Zip: _____

Consent for Dental Care and Payment

1. I authorize the doctor or designated staff to take x-rays and/or use any other diagnostic aid deemed appropriate by the doctor to make a thorough diagnosis of my dental condition and needs.
2. Upon diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon.
3. I agree to the use of anesthetics and/or other medications as necessary. I fully understand that utilizing anesthetics entails certain risks. I understand that I can ask for a complete description of any possible complications.
4. I agree to have Rinehart Dentistry, Inc. share my dental and medical information with other specialists as necessary for my treatment.
5. I agree to keep my reserved dental appointments. If I must cancel an appointment, I agree to give at least 24 hours notice or a $50 cancellation charge will apply.

Patient Signature_____Date_____

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Medical History

Patient Name:_____Date of Birth: _____

1. Have you been under the care of a medical doctor during the past two years? Yes No
   If yes, what for? _____
2. Have you ever been hospitalized or had a major operation? (if yes, explain below)? Yes No

_____

3. Have you ever had a serious head or neck injury? Yes No
   If yes, what for? _____
4. Are you taking any medications, pills, or other drugs? Yes No
   If yes, please explain _____
5. Do you take, or have you taken, Phen-Fen or Redux? Yes No
   If yes, please explain _____
6. Are you taking or have you ever taken any of the following medications (please circle if yes):

Fosamax Actonel Boniva For how long? _____
Aredia Reclast Zometa When did you stop? _____

7. Are you on a special diet?
8. Do you use tobacco products?
9. **Women:** Are you pregnant/trying to get pregnant/breast feeding? Yes No

Pregnant/ Trying to get pregnant? Nursing? Taking oral contracpetinves?

10. Are you allergic to or have you had an allergic reaction to any of the following (please circle if yes):

Aspirin Penicillin Codeine Acrylic Other Antibiotic: _____
Metals Latex Sulfa Drugs Local Anesthetics

Do you use controlled substances? Yes No

If yes, please explain _____

Have you ever had any of the following?

AIDS/HIV+	Yes No	Cold Sores/Fever Blisters	Yes No	Hay Fever	Yes No
Alzheimer's Disease	Yes No	Convulsions	Yes No	Heart Attack/Failure	Yes No
Anaphylaxis	Yes No	Cortisone Medication	Yes No	Heart Murmur	Yes No
Anemia	Yes No	Diabetes	Yes No	Heart Pacemaker	Yes No
Angina	Yes No	Drug Addiction	Yes No	Heart Trouble/Disease	Yes No
Arthritis/Gout	Yes No	Easily Winded	Yes No	Hemophilia	Yes No
Artificial Heart Valve	Yes No	Emphysema	Yes No	Hepatitis A	Yes No
Artificial Joint	Yes No	Epilepsy or Seizures	Yes No	Hepatits B or C	Yes No
Asthma	Yes No	Excessive Bleeding	Yes No	Herpes	Yes No
Blood Disease	Yes No	Escessive Thirst	Yes No	High Blood Pressure	Yes No
Blood Transfusion	Yes No	Fainting Spells/Dizziness	Yes No	High Cholesterol	Yes No
Breathing Problems	Yes No	Frequent Cough	Yes No	Hives or Rash	Yes No
Bruise Easily	Yes No	Frequent Diarrhea	Yes No	Hypoglycemia	Yes No
Cancer	Yes No	Frequent Headaches	Yes No	Irregular Heartbeat	Yes No
Chemotherapy	Yes No	Genital Herpes	Yes No	Kidney Problems	Yes No
Chest Pains	Yes No	Glaucoma	Yes No	Leukemia	Yes No

Liver Disease	Yes No	Renal Dialysis	Yes No	Swelling of Limbs	Yes No
Low Blood Pressure	Yes No	Rheumatic Fever	Yes No	Thyroid Disease	Yes No
Lung Disease	Yes No	Rheumatism	Yes No	Tonsillitis	Yes No
Mitral Valve Prolapse	Yes No	Scarlet Fever	Yes No	Tuberculosis	Yes No
Osteoporosis	Yes No	Shingles	Yes No	Tumors or Growths	Yes No
Pain in Jaw Joints	Yes No	Sickle Cell Disease	Yes No	Ulcers	Yes No
Parathyroid Disease)	Yes No	Sinus Trouble	Yes No	Venereal Disease	Yes No
Psychiatric Care	Yes No	Spina Bifida	Yes No	Yellow Jaundice	Yes No
Radiation Treatments	Yes No	Stomach/Intestinal Disease	Yes No		
Recent Weight Loss	Yes No	Stroke	Yes No		

Dental History

1. Date of last dental exam:_____Date of last dental x-rays: _____
2. Previous dentist's name / location:_____
3. Are you having tooth or gum pain at this time? Yes No
4. Do you feel nervous about having dental treatment? Yes No
5. Have you ever had a bad experience in a dental office? Yes No
6. Do your gums bleed when brushing / flossing? Yes No
7. Have you ever seen a periodontist? Yes No
8. Have you ever had a "deep cleaning" (Scaling and Root Planing)? Yes No
9. Is there anything you would like to speak with the Doctor about in private? Yes No
10. Would you be interested in discussing ways to improve your smile? Yes No

If yes, please explain: _____

Do you have any of the following dental concerns?

Clicking in jaw joint	Yes No	Sensitivity to: Hot Cold Sweets Biting	
Pain in or around your ears	Yes No	Swelling	Bleeding Gums
Difficulty opening or closing	Yes No	Bad Taste	Bad Breath
Difficulty chewing	Yes No	Food Catching	Tooth Pain
History of trauma to jaw or face	Yes No	Clenching	Grinding
Diagnosis of TMJ/TMD	Yes No	Other: _____	

I understand the importance of a truthful health history and realize that incomplete information may have an adverse effect on my treatment. To the best of my knowledge, the information above is complete and accurate.

Signature:_____Date_____

Doctor's Signature_____

Doctor's Notes:

Financial Guidelines

Dental treatment is an excellent investment in an individual's medical and psychological well-being, and our primary goal is not to allow the cost of treatment to prevent you from benefitting from the quality care you need or desire. In our office, we strive to maximize your insurance benefits and make any remaining balance easily affordable. We encourage you to ask questions and to be involved in treatment discussions. This includes understanding your treatment plan as well as our financial policy.

Financial Agreement:
Our fees are based on the quality materials we use and the time, effort and skill required in performing your needed treatment. We charge what is usual and customary for our area. We also believe that everyone benefits when specific financial arrangements are agreed upon. Please understand that payment of your bill is considered a part of your treatment. We will be sensitive to your financial circumstances and do everything possible to help you achieve oral health.

Patients are expected to pay for our services at the time they are rendered. For your convenience, we offer the following payment options:

- Cash or Check – we offer a 5% courtesy discount to our uninsured patients who pay for their treatment with cash or check prior to completion of care with an out of pocket expense of $350 or more.
- Credit Cards – Visa, MasterCard, Discover, and American Express
- Debit Cards
- CareCredit – a patient payment program offering a full range of no-interest and extended payment plans with prior credit approval

Insurance Information:
All our doctors will diagnose treatment based on your dental health, not your insurance coverage. As a courtesy to our insured patients, we submit electronic claims to your insurance company free of charge.

We request that any co-payments, deductibles, and any services not covered by your insurance plan be paid at the time the service is provided. Ultimately, **you are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.** Please bring your updated insurance information with you to your consultation, so that we can expedite reimbursement.

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As such, we can make no guarantee of the estimated coverage payment. However, we will do everything possible to see that you receive the full benefits of your policy. In order to submit your insurance claims, you will be required to provide us with your social security and insurance identification numbers (if applicable). Failure to provide your social security number will result in full payment for all services rendered.

If your insurance company has not paid your account in full within 45 days, the balance will be automatically transferred to your account. After 45 days, the patient is responsible for pursuing payment from the insurance company. All current documentation will be provided by mail in order to assist your inquires. The insured has a better ability to deal with the insurance company and the employer responsible for the party.

Appointments:
Our practice is dedicated to quality care and exceptional service. To serve you better and keep the costs of dental care down, we try to maintain an efficient appointment system. Our doctors and team also spend extensive amounts of time preparing for your visit. However, our cost of providing care increases greatly when people fail to keep scheduled appointments or cancel at the last minute. **We require a minimum of 24 hours notice for any cancelled appointment.**

If proper notice is not received, a fee of $50 will be charged for every hour of allotted time cancelled to your account. Please help us serve you better by keeping your scheduled appointments. Two cancellations or no shows will result in termination of our treatment agreement and dismissal from our practice. A $100 fee will be charged for reinstatement.

Due to the extensive amount of time our staff and doctors devote to preparing and reserving uninterrupted time for reservations for major procedures, or exceeding an hour, we require a $100 deposit to make your appointment. This deposit will be applied to the account balance upon completion of your treatment. If the appointment is cancelled less than 24 hours prior to your visit, the deposit will be forfeited.

Billing and Collections:
Failure to pay your account upon it becoming due may result in your account being reported to credit rating bureaus or to a collection agency and/or legal action against you for full payment, including but not limited to all related reasonable attorney's fees, collection and/or court costs.

All payments returned due to non-sufficient funds will be subject to a $30 returned check fee.

I have thoroughly read and agree to the Financial Policy of Rinehart Dentistry, Inc. I also understand and acknowledge that I am financially responsible for the services provided for myself or my dependent(s), regardless of insurance coverage.

_____ _____

Signature of Patient or Responsible Party Date

RINEHART DENTISTRY

Acknowledgement of Receipt of Notice of Privacy Practices

Name of Patient_____Date of Birth_____

By signing below, you consent to the use and disclosure of your protected health information by Brandon K. Rinehart DMD, Blake Burnett DMD, our staff and our business associates for treatment, payment and health care operations. For a more detailed description of uses and disclosures for these purposes, please review our Notice of Information Practices (Notice). You have the right to review Notice prior to signing this consent. The terms of this Notice may change. If any terms do change you may obtain a revised Notice by simply contacting this dental office at (843) 545-1295 and requesting a revised Notice. We will also post any revised notice in the dental office and on our website.

You have the right to request that we restrict our uses or disclosures of your protected health information that we are otherwise permitted to make for treatment, payment, and health care operations, although we are not required to agree to these restrictions. However, if we agree to further restrictions, they are binding on us. Finally, you may refuse to consent to the use or disclosure of your protected health information, but this must be in writing. Under this law we have the right to refuse to treat you should you choose to refuse to disclose your Protected Health Information (PHI).

This form is also used to obtain acknowledgement of receipt of our notice of privacy practices or to document our good faith effort to obtain that acknowledgement.

I have reviewed, understand and agree to the content of the notice of privacy.

Patient/Guardian Signature _____

Patient Consent to Receive Mail, Email and/or Telephone Messages

I agree that the practice may communicate with me electronically at the following addresses:

_____ _____

Phone Number Email Address (please print)

I consent to receive calls and text messages related to my protected healthcare and other services at the phone number(s) above. I understand I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system.

Do we have your permission to:

- Send a recall appointment reminder to your home? Yes_____ No_____
- Leave appointment, billing or dental information on your answering machine/voicemail/email? Yes_____ No_____

----------FOR OFFICE USE ONLY----------

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- o Individual refused to sign
- o Communication barriers prohibited obtaining the acknowledgement
- o An emergency situation prevented us from obtaining the acknowledgement
- o Other (Please Specify)

Authorization for Release of Information to Family and/or Friends

Name of Patient_____Date of Birth_____

Rinehart Dentistry, Inc. is authorized to discuss my dental care and may release my confidential health information to the following:

_____	_____	_____
Name	**Phone Number**	**Email Address**
_____	_____	_____
Name	**Phone Number**	**Email Address**
_____	_____	_____
Name	**Phone Number**	**Email Address**

Rights of the Patient

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to **Rinehart Dentistry, 419 Wood Street, Georgetown, SC 29440.** I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing this authorization.

This authorization shall be in force and effective until revoked by the patient or representative signing the authorization.

_____ _____

Signature of Patient or Personal Representative Date

_____

Description of Personal Representative's Authority (attach necessary documentation)