Clinton Dental Care
Where your smile matters!
1208 Springdale Drive ~ Clinton, SC 29325 ~ 864.833.5400 ~ clintondentalcare.com

On behalf of our staff at *Clinton Dental Care*,

Welcome to our office!

We sincerely appreciate you choosing us for your dental care, and we look forward to getting to know you. If there is anything we can ever to do improve your experience with us, please do not hesitate to ask.

This ***Welcome Packet*** includes several important documents to read and complete. In addition, we will need your dental insurance card and driver's license/photo ID. Please remember to fill out these documents so we can update your dental records and bring with you to your dental appointment.

On your first visit we will take time to discuss your dental goals and any concerns you have. We will then perform a comprehensive exam and take any necessary radiographs and images. With this information we can develop a customized dental plan together.

We accept all dental insurance as an out-of-network provider and are only in network with Delta Dental. This means you will have a co-payment due at your time of service based on your insurance benefits plan.

Thank you and we look forward to seeing you soon!

Dr. Kristin R. Derrick, DMD, FAGD, and Team Tooth

REGISTRATION INFORMATION

PATIENT INFORMATION (please print):

FIRST NAME: _____ LAST NAME: _____
MIDDLE INITIAL: ____ PREFERRED NAME: _____

RESPONSIBLE PARTY ***(if patient is minor***): _____
ADDRESS: _____
CITY: _____ ZIP CODE: _____

BIRTHDAY: ___ /___/_____ SSN: _____ - _____ - _____ MALE/FEMALE
HOME PHONE: _____ CELL PHONE: _____
EMAIL: _____

DENTAL INSURANCE INFORMATION:

Do you have dental insurance coverage? □ Yes □ No

If yes, you must present your current insurance card and photo ID.

We file dental insurance as a courtesy to you. We accept all dental insurance as an out-of-network provider and are only in- network with Delta Dental. We do not accept Adult Medicaid. Dental insurance is not a guarantee of payment and your estimated deductibles and/or co-payments are due at the time of service based on your insurance benefits plan.

PRACTICE PREFERENCES:

We confirm through electronic emails and texts prior to making phone calls. Please check any/all that you would like to receive confirmation reminders:

___ Text ___ Email ___ Calls Only

Preferred Pharmacy: _____

Referrals to our practice are the best gifts we can receive. Whom may we thank for referring you to us?

_____

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INFORMED CONSENT FOR DENTAL PROCEDURES

You, the patient, have the right to accept or reject dental treatment recommended by your dentist. It is very important that you provide your dentist with accurate information before, during and after treatment. It is equally important that you follow the dentist's advice and recommendations regarding medication, pre and post treatment instructions, and referrals to other dentists or specialists.

By signing this form, I understand that dental treatment will be provided and that changes and updates to your treatment plan of services will be reviewed upon these changes. Please notify our staff of any drug and medications allergies and routines that you may be currently on. These should be updated on the medical history form that you filled out before services also.

By signing this form, I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give permission to the dentist to make any/all changes and additions as necessary. I give permission to the dental office to bill my dental insurance provider for the treatment provided.

_____ _____
Patient Signature Date

ACKNOWLEDMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of this office's Notice of Privacy Practices.

Please print name _____

Signature _____

Date _____

SOCIAL MEDIA CONSENT

Clinton Dental Care would like my permission to use images taken of you and/or family member to showcase extraordinary before and after smiles on our website, Facebook and/or Instagram pages. Permission granted for these by:

Patient Name (printed) _____
Patient Signature _____
Parent/Guardian or Representative of Patient: _____
Date: _____

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clintondentalcare@gmail.com

AUTHORIZATION FOR OBTAINING/RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient Name _____ **Patient DOB** _____

Responsible Party Name _____ **Contact No.** _____

I authorize the professional office of my dentist named above to **OBTAIN/RELEASE** health information identifying me, including copies of my dental record. The *American Dental Association* states that a ***dental record*** includes the patient chart and is the official office document that records all diagnostic information, clinical notes, medical health history, radiographs, treatment performed and patient-related communications/referrals that occur in the dental office, including instructions for home care and consent to treatment.

1. Details/Description of the information to be released: **Dental Record Accounting Other**_____
2. To whom may the information be released **TO/FROM**: _____

   _____
3. The purpose for release: **Referral Transfer of Records Other** _____

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization. When your health history is disclosed as provided in this authorization, the recipient often has no legal duty to protect his confidentiality. Sometimes, state or federal law changes this possibility.

NOTE: *For promotional/marketing authorizations, we will provide a separate* ***Social Media Form*** *for your approval*.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THIS DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Date: _____ **Patient Signature:** _____

PERSONAL REPRESENTATIVE/RESPONSIBLE PARTY AUTHORIZATION

To comply with HIPAA and local state law, if you are requesting that a person be allowed to discuss the above dental patients' ***dental record*** {as stated above}, including details of accounting/financial, appointments and diagnostic treatment, you will need to sign for them as your personal representative. *A source of authority may be required.*

Print Personal Representative Name _____
Relationship to Patient _____
Patient Signature _____
Source of Authority (if applicable) _____