SHANNON M. PYE DMD
FAMILY DENTISTRY
664 Hiers Corner Rd. Walterboro, SC 29488 (843) 549-5913

MEDICAL HISTORY

PATIENT NAME:_____ **DATE OF BIRTH:**_____

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	Explain:_____
Have you ever been hospitalized or had a major operation?	Yes	No	Explain:_____
Have you ever had a serious head or neck injury?	Yes	No	Explain:_____
Are you taking any medications, pills, or drugs?	Yes	No	Please List:_____
Do you take, or have you taken, Phen-Fen or Redux?	Yes	No	_____
Are you on a special diet?	Yes	No	_____
Do you use tobacco?	Yes	No	_____
Do you use controlled substances?	Yes	No	_____

Women: Are you pregnant/trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following? (Please circle all that apply)
Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Sulfa Drugs Other _____

Do you have, or have you had, any of the following?

AIDS/HIV	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Radiation Treatments	Yes	No
Alzheimer's	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/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	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 Disease	Yes	No
Breathing Problem	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	Yes	No	Heart Murmur	Yes	No	Pain in Jaw/Joint	Yes	No	Tumors or Growths	Yes	No
Congenital Heart	Yes	No	Pacemaker	Yes	No	Parathyroid	Yes	No	Venereal Disease	Yes	No
Convulsions	Yes	No	Heart Disease	Yes	No	Psychiatric Care	Yes	No	Yellow Jaundice	Yes	No

Have you ever had any serious illness not listed above? Yes No Explain:_____
_____

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 my medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ **DATE** _____

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ACQUAINTANCE FORM

Date:_____ Patient Name:_____

Date of Birth:_____ Social Security Number: _____

Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____ Cell:_____

Employer:_____ Occupation:_____

Insurance Company:_____ Policy Holder's Name:_____

Policy Holder DOB:_____ Policy Holder SSN:_____

Do you have any additional dental insurance? _____

How did you hear about Dr. Pye?_____ Whom may be thank for this referral?_____

These things are important to me about my dental health: (Please circle one for each)

1. My mouth is:
   a. Very Comfortable
   b. Moderately Comfortable
   c. Uncomfortable
2. I am:
   a. Happy with the appearance of my mouth
   b. Satisfied with the appearance of my mouth
   c. Dissatisfied with the appearance of my mouth
3. I:
   a. Will do anything to keep my natural teeth
   b. Want to keep my natural teeth but am limited in time and money
   c. Do not feel natural teeth are important
4. I:
   a. Have set goals for my oral heath with a previous dentist
   b. Want to set goals concerning my dental health
   c. Never set goals concerning my dental health
5. These are some of my primary concerns: _____

   _____

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Consent to Dental Treatment

Patient: _____ Date:_____ Time:_____

I hereby authorize Dr. Pye to perform upon me or the named patient the following procedure(s): exam, x-rays, clean teeth, fluoride, fillings, local anesthetic (shot to numb), and any other dental procedures as recommended by Dr. Pye.

Dr. Pye has fully explained to me the purpose of the procedure(s) and has also informed me of the expected benefits and complications (from known and unknown causes), attendant discomforts and risks that may arise, as well as possible alternatives to the proposed treatment, including no treatment. The attendant risks of no treatment have also been discussed. I have been given an opportunity to ask questions, and all my questions have been answered fully and satisfactorily.

I understand that during the course of the procedure(s), unforeseen conditions may arise which necessitates procedures different from those contemplated or proposed. I, therefore, consent to the performance of additional procedures(s) which Dr. Pye may consider necessary.
I acknowledge that no guarantees or assurances have been made to me concerning the results intended from the procedure(s).
I confirm that I have read and fully understand the above and hereby consent to the proposed dental treatment.

_____ _____
Signature of Patient or Guardian Date

_____ _____
Interpreter (if used) Date

_____ _____
Signature of Witness Date

Dentist Certification
I hereby certify that I have explained the nature, purpose, benefits, risks of, and alternatives (including no treatment and attendant risk(s), to the proposed procedures. I have offered answers to any questions and have fully answered all such questions. I believe that the patient/parent/guardian fully understands what I have explained and answered.

_____ _____
Dentist's Signature Date

Acknowledgement of Receipt of Notice of Privacy Practices

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

_____ _____
Signature Date

Appointment Commitment Policy

In our office we strive to deliver the highest quality dental care possible in a relaxing and nurturing environment. To meet this goal, we reserve appointment times for each patient and work diligently to keep our patients from waiting. In return, we expect our patients to be present for all scheduled appointments and require a 48 hour notice for all cancellations or schedule changes. A broken appointment fee of $50.00 will be applied in those situations in which proper notice is not received.

We do realize that sometimes situations arise that are beyond anyone's control. However, please understand that arriving late or missing an appointment is time lost that will delay your necessary treatment. It is also time that could have been used to serve other patients that may be waiting for an appointment. Your signature below indicates your understanding of this policy. We are so glad to have you as part of our dental family.

_____ _____
Patient or Guardian Signature Date

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Office Financial Policies

Dental treatment is an excellent investment in an individual's physical and emotional well being. Financial considerations should not be an obstacle to obtaining this important health service. We are proud that our fees reflect the time that the doctor spends with each patient as well as the overall quality of care and service that we provide in our practice. We know that people have different needs in fulfilling their financial obligations; therefore, we provide the following payment options so that full payment can be received at the time of service.

Cash or Check
Returned checks will be charged a $30.00 fee

Credit Card
We accept Mastercard, Visa, American Express, and Discover

CareCredit
CareCredit is a credit card designed exclusively for healthcare services. CareCredit lets you begin your treatment immediately and then pay for it over time with low monthly payments that fit into your budget. We will be happy to help you through the application process at our office or you may visit them on line at www.carecredit.com.

Dental Insurance
We gladly file all insurance claims as a courtesy to you. We do ask that any amount not expected to be covered by your insurance be paid in full at the time of your appointment. This includes any policy deductibles and co-payments. Please remember, the amount we collect is only an ESTIMATE of your insurance companies responsibility based on information that we have available to us at that time. It is not a guarantee of payment. You are responsible for the balance in the case that payment from the insurance company is not received.

Billing
When statements are required to be sent payment is expected within 15 days of receipt. Any account over 30 days past due will be assessed a monthly billing charge equal to 1.5% of the unpaid balance (18% annually).

I have read and understand the payment policy. I hereby authorize release of any information in relation to my insurance claim. I understand that the responsibility for payment for dental services provided in this office for myself or my dependents is mine. I agree to pay all collection fees, attorney fees or court costs required in the process of collecting a delinquent account.

_____ _____

Signature of Patient or Guardian Date