3416 Holmestown Rd.
Myrtle Beach, SC 29588

stjamesdentistry@gmail.com
saintjamesdentistry.com

P: 843.650.2000
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Financial, Insurance and Treatment Agreement

Welcome to **St. James Dentistry**, the office of **Dr. David Savage**. We know choosing a dentist can be a difficult decision so we are grateful to care for your dental health. Our goal is to provide quality dental care in a comfortable, friendly and relaxing atmosphere. We utilize the latest technologies for diagnosing and treating your individual dental conditions in order to recommend the best treatment options tailored for you.

1. We accept payment for services by cash, check, Mastercard ®, Visa®, and American Express ®, and our office participates in third party financing through CareCredit.
2. If you have dental insurance, we will be happy to file your claim(s) for you as a courtesy. We will always review fee's prior to any treatment and always help to maximize your benefits, however any unpaid portion from your insurance company is your responsibility.
3. You will receive an **estimate** of your fees prior to any appointments so that you will be financially prepared. Please remember that, regardless of insurance coverage, you are responsible for your account with our office. If your insurance benefits do not cover 100 percent of the charges, you will be billed any additional amount.
4. When treatment is rendered, our staff will fully brief you on the costs and ask that your estimated copayment and deductible be paid at time of service. We may require a deposit at the time of appointment for services that require use of a dental laboratory outside from our office. Our office will let you know of any required deposit in advance. We will file insurance claims for you, after receiving payment through your insurance, we will send a statement with any balances due or credits. We ask that payment be made within 14 days of the statement. In the event of a credit, we will promptly issue a refund. In the event that your insurance does not pay within 45 days, we ask that you make payment in full and contact your insurance company regarding reimbursement to you.
5. If you, do not have dental insurance, your insurance pays you, or you are over your insurance limit, payment in full is expected at the time of service unless arrangements have been made in writing prior to treatment.
6. In cases of extensive treatment for which full payment cannot be made at the initial appointment, you may qualify for in office financial arrangements.
7. Fees quoted will be accepted for 90 days. In the event that clinical conditions warrant a different treatment, or a change in fees, you will be notified of changes prior to the procedure.
8. In the event of default of payment after 90 days, accounts in which effort to pay is not made will be subject to collection proceedings.
9. We do **not** charge fees for broken appointment reservations because we understand emergencies and mistakes happen, but in fairness to our other patients' prepayment for reserved care or dismissal will be considered following three canceled appointments without 24 hour notice.

I have read, reviewed any questions, and been given the opportunity to receive a copy.

Patient Signature ____________________ Date ________________

St. James Dentistry

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name:____

Address:____

SECTION B: TO THE PATIENT-PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY:
Purpose of this Consent: By signing the form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you sign this consent. Our Notice of Privacy Practices provides a description of our treatment, payment activities, healthcare operations, of the use and disclosure we may make of your protected health information, and of other important matters about your protected health information. A copy of our notice of Privacy Practices is available at the front desk. We encourage you to read over it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in the Notice of Privacy Practices. If we change our privacy practice, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information we maintain.

You may obtain a copy of our Notice of Privacy Practices, including and revisions of your notice, at any time, by contacting:

St. James Dentistry
3416 Holmestown Road
Myrtle Beach, South Carolina 29588

Signature

I,____, have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations.

Signature of Patient or Representative:____

Date:________________________

If this consent is signed by a personal representative on behalf of the patient, please complete the following:

Personal Representative's Name:

Relationship to Patient:

Right to Revoke: You have the right to revoke this consent at any time by giving us written notice of your revocation, submitted to the contact person listed above. Please understand that the revocation of this consent will NOT affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue to treat you if you revoke this consent.

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

Referred By

Previous Dentist

Emergency Contact

Emergency Contact #

Medical Insurance

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

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Dental and Medical History

Patient name (first and last): ______________________ Preferred Name ______________

Date of Birth: ______________ Email: ______________________

What is the name of your primary care physician? ______________________

Are you allergic or have you reacted adversely to any of the following (check all that apply):

___ Aspirin
___ Codeine
___ Acetaminophen/Tylenol
___ Penicillin
___ Other antibiotics ______________
__ Ibuprofen
__ Sulfa Drugs, Sulfites, Sulfides
__ Tetracycline
__ Latex, Metals, Plastic
__ Local Anesthesia

Have you ever taken bisphosphonates (Fosamax, Boniva, Actonel, Aredia, Zometa?) ☐ Yes ☐No
If yes, when? ______________________

Check any of the following that you have had or have at the present:

___ Cardiac stent
___ High cholesterol or taking statin drugs
___ Heart murmur/mitral valve prolapse
___ History of infective endocarditis
___ Artificial heart valve
___ Joint replacements
___ High or low blood pressure
___ Stroke (taking blood thinner)
___ Radiation therapy
___ Asthma
___ Breathing or sleeping problems
___ Bleeding disorders
___ Liver disease
___ Drug Abuse
___ Taking birth control
__ Thyroid or parathyroid disease
__ Diabetes (hbA1c=_____)
__ Digestive or eating disorders
__ Osteoporosis/Osteopenia
__ Arthritis
__ Autoimmune disease __________
__ Glaucoma
__ Epilepsy, convulsions, seizures
__ Immosuppressive Medication
__ AIDS or HIV+
__ Hepatitis (Type _______)
__ Viral infections and cold sores
__ Chemotherapy
__ Pregnant/trying to get pregnant (if pregnant, what trimester? ___
__ Tobacco Use (including smokeless tobacco and vaping)

Please list all prescription medications and over-the- counter drugs. (If you have a list we can make a copy)

____

____

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When was your last dental exam? ______________________

How would you rate the condition of your mouth?
☐ Excellent ☐ Good ☐ Fair ☐Poor

I routinely see my dentist every:
☐ 3 months ☐ 4 months ☐ 6 months ☐ 12 months ☐ Not routinely

Which below best describes what you desire for your dental care?
☐ Complete comprehensive care
☐ Preventing negative consequences by proactive care.
☐ Address problems after they have occurred.
☐ Emergency dental care only

Yes	No	
☐	☐	Do your gums bleed or are they painful when brushing or flossing?
☐	☐	Have you ever been treated for gum disease or been told you have lost bone around your teeth?
☐	☐	Did you ever have braces, clear aligners, orthodontic treatment? What age? __________
☐	☐	Is there anyone in your family with a history of periodontal disease in your family?
☐	☐	Do you feel or notice any holes (i.e. pitting, craters) on the biting surfaces of your teeth?
☐	☐	Are any teeth sensitive to hold, cold, biting, sweets, or do you avoid brushing any part of your mouth?
☐	☐	Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?
☐	☐	Do you frequently get food caught between any teeth?
☐	☐	In the past five years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed?
☐	☐	Are your teeth becoming more crooked, overlapped, or crowded?
☐	☐	Do you clench or grind your teeth together in the past daytime or make them sore?
☐	☐	Do you have any problems with sleep (i.e. restlessness or teeth grinding) or do you wake up with a headache?
☐	☐	Have you ever been diagnosed with sleep apnea?
☐	☐	Do you wear or have you ever worn a sleep appliance?
☐	☐	Do you or have you been told you snore?
☐	☐	Do you wear a C-PAP?
☐	☐	Have you had a sleep study or been told to get one?
☐	☐	Is there anything about the appearance of your teeth that you would like to change? (shape, color, size)
☐	☐	Have you ever professionally whitened (bleached) your teeth?
☐	☐	Have you ever felt uncomfortable or self-conscious about the appearance of your teeth?
☐	☐	Have you ever been disappointed with the appearance of previous dental work?

Authorization: I have reviewed the information on this form and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropr and healthful dental treatment. Please inform of us of any future changes.

Signature: ______________________ Date: ____________