



Welcome! Thank you for selecting **Waccamaw Oral and Maxillofacial Surgery**.

We strive to provide you with the best possible care. To assist us in this effort, please fill out this form completely in ink.

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

PATIENT INFORMATION: (CONFIDENTIAL)

DATE: _____ PATIENT

NAME: _____

BIRTH DATE: _____ PATIENT SSN: _____ GENDER: ☐ MALE ☐

FEMALE

MAILING

ADDRESS: _____ CITY: _____ ST: _____ ZIP: _____

HOME PHONE#: _____ MOBILE
PHONE#: _____

EMAIL

ADDRESS: _____

PLEASE CHECK ALL APPROPRIATE: ☐ MINOR ☐ STUDENT ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐

WIDOWED

IF STUDENT, NAME OF SCHOOL OR
COLLEGE _____

IF A MINOR, PLEASE LIST PARENT OR
GUARDIAN _____

PERSON TO CONTACT IN CASE OF EMERGENCY: _____ PHONE
#: _____

NAME OF REFERRING PHYSICIAN:

PHARMACY & ADDRESS : _____ PHONE #:

GENERAL MEDICAL/DENTAL INFORMATION

PATIENT HEIGHT _____ PATIENT

WEIGHT _____

NAME OF DENTIST _____ CITY/STATE OF
DENTIST _____

NAME OF PHYSICIAN _____ CITY/STATE OF
PHYSICIAN _____

DATE OF LAST DENTAL VISIT _____ DATE OF LAST MEDICAL
VISIT _____

DO YOU NEED TO TAKE ANTIBIOTICS PRIOR TO RECEIVING DENTAL OR SURGICAL CARE? ☐ YES ☐ NO ☐ DON'T
KNOW

PATIENT DENTAL HISTORY

HAVE YOU EXPERIENCED ANY DIFFICULTY WITH ANY PREVIOUS DENTAL TREATMENT? ____	☐ YES	☐ NO
DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH?_____	☐ YES	☐ NO
HAVE YOU EVER WORN BRACES?_____	☐ YES	☐ NO
DO YOU WEAR DENTURES OR PARTIALS?_____	☐ YES	☐ NO
DO YOU CLENCH OR GRIND YOUR TEETH?_____	☐ YES	☐ NO
HAVE YOU BEEN TOLD THAT YOU HAVE PERIODONTAL DISEASE?_____	☐ YES	☐ NO
DO YOU HAVE A GAG REFLEX?	☐ YES	☐ NO
OTHER DENTAL CONCERNS_____	☐ YES	☐ NO

CHECK ANY OF THE FOLLOWING MEDICATIONS THAT YOU CURRENTLY TAKE OR HAVE TAKEN IN THE PAST:

☐ FOSAMAX PROLIA
☐ ZOMETA
☐ DIDRONEL
☐ RECLAST
☐ BONIVA
☐ ACTONEL
☐ ACLASTA
☐ AREDIA
☐ ATELVIA
☐

☐ OTHER BISPHOSPHONATE; PLEASE LIST_____

☐ CORTISONE/ STEROID USE; PLEASE LIST_____

MAJOR HOSPITALIZATIONS, SURGERIES AND BLOOD TRANSFUSIONS- PLEASE LIST BELOW

DATE (MONTH/YEAR)	REASON
_____	_____
_____	_____
_____	_____
_____	_____

ALLERGIC OR UNUSUAL REACTION TO ANY OF THE FOLLOWING?

☐ PENICILLINS	☐ OPIATES	OTHER DRUGS	OTHER SUBSTANCES-FOODS, METALS, ETC
☐ SULFA DRUGS	☐ IODINE	LIST:_____	LIST:_____
☐ ASPIRIN	☐ LATEX	_____	_____
☐ LOCAL ANESTHESIA	☐ SEDATIVES	_____	_____
☐ BARBITURATES	☐ SLEEPING PILLS	_____	_____

FEMALES ONLY

ARE YOU:
☐PREGNANT _____WEEKS?
☐ TRYING TO BECOME PREGNANT?
☐ NOT SURE IF YOU ARE PREGNANT?

☐ GOING THROUGH MENOPAUSE?
☐ POST-MENOPAUSAL?
☐ TAKING BIRTH CONTROL PILLS?

PRESCRIPTION/NON-PRESCRIPTION MEDICATIONS (LIST ALL MEDICATIONS AND HERBAL SUPPLEMENTS THAT YOU CURRENTLY TAKE)

NAME	FOR WHAT CONDITION?	DOSAGE/FREQUENCY OF USE
1) _____		
2) _____		
3) _____		
4) _____		
5) _____		
6) _____		
7) _____		

HABITS

SMOKE	☐ YES	☐ NO	☐ IN THE PAST	HOW MUCH? _____ HOW LONG? _____
USE SMOKELESS TOBACCO	☐ YES	☐ NO	☐ IN THE PAST	TYPE? _____ HOW MUCH? _____ HOW LONG? _____
USE RECREATIONAL DRUGS	☐ YES	☐ NO	☐ IN THE PAST	TYPE? _____
DRINK ALCOHOL	☐ YES	☐ NO	☐ IN THE PAST	HOW OFTEN? _____ TYPE? _____
DRUG DEPENDENCY	☐ YES	☐ NO	☐ IN THE PAST	
ALCOHOL DEPENDENCY	☐ YES	☐ NO	☐ IN THE PAST	

MEDICAL HISTORY- PAST AND PRESENT ILLNESS

<u>HEAD AND NECK CONDITIONS</u>		
INJURY TO FACE, JAW OR	☐ YES	☐ NO
TMJ DISORDER	☐ YES	☐ NO
SALIVARY GLAND PROBLEMS	☐ YES	☐ NO
SINUSITIS	☐ YES	☐ NO
FACIAL PAIN	☐ YES	☐ NO
JAW PAIN	☐ YES	☐ NO
NECK PAIN	☐ YES	☐ NO
NECK LUMP/SWELLING	☐ YES	☐ NO
JAW CLICKING	☐ YES	☐ NO
DIFFICULTY	☐ YES	☐ NO
<u>CHRONIC PAIN</u>		
BACK	☐ YES	☐ NO
ABDOMINAL	☐ YES	☐ NO
HEADACHE/MIGRAINE	☐ YES	☐ NO
OTHER:		
<u>INFECTIOUS DISEASES</u>		
RHEUMATIC FEVER	☐ YES	☐ NO
HEPATITIS	☐ YES	☐ NO
HIV/AIDS	☐ YES	☐ NO
OTHER:		
<u>GASTROINTESTINAL DISORDERS</u>		
ACID-REFLUX/HEARTBURN	☐ YES	☐ NO
ULCER/GASTRITIS	☐ YES	☐ NO
IRRITABLE BOWEL SYNDROME	☐ YES	☐ NO
COLITIS	☐ YES	☐ NO
CROHN'S DISEASE	☐ YES	☐ NO
YELLOW JAUNDICE	☐ YES	☐ NO
CIRRHOSIS	☐ YES	☐ NO
OTHER:		
<u>RESPIRATORY DISORDERS</u>		
EMPHYSEMA	☐ YES	☐ NO
PNEUMONIA	☐ YES	☐ NO
BRONCHITIS	☐ YES	☐ NO
ASTHMA	☐ YES	☐ NO
TUBERCULOSIS	☐ YES	☐ NO
HAY FEVER	☐ YES	☐ NO
COUGHING/WHEEZING	☐ YES	☐ NO
SLEEP APNEA	☐ YES	☐ NO
USE CPAP MACHINE	☐ YES	☐ NO
COPD	☐ YES	☐ NO
<u>EYES</u>		
GLAUCOMA OR CATARACTS	☐ YES	☐ NO
CONTACT LENSES	☐ YES	☐ NO
BLURRED VISION	☐ YES	☐ NO
OTHER:		

<u>CANCER & NEOPLASTIC DISEASE</u>		
CANCER	☐ YES	☐ NO
LEUKEMIA/LYMPHOMA	☐ YES	☐ NO
CHEMOTHERAPY	☐ YES	☐ NO
RADIATION THERAPY	☐ YES	☐ NO
<u>IMMUNE SYSTEM DISORDER</u>		
RHEUMATOID ARTHRITIS	☐ YES	☐ NO
LUPUS	☐ YES	☐ NO
OTHER:		
<u>HORMONAL OR METABOLIC DISORDERS</u>		
DIABETES	☐ YES	☐ NO
THYROID PROBLEMS	☐ YES	☐ NO
OTHER:		
<u>HEART DISORDERS</u>		
SWELLING OF ANKLES	☐ YES	☐ NO
ANGINA/CHEST PAIN	☐ YES	☐ NO
HIGH BLOOD PRESSURE	☐ YES	☐ NO
HEART ATTACK	☐ YES	☐ NO
HEART MURMUR	☐ YES	☐ NO
CONGESTIVE HEART FAILURE	☐ YES	☐ NO
ANEURYSM	☐ YES	☐ NO
PACEMAKER/DEFIBRILLATOR	☐ YES	☐ NO
ARRHYTHMIAS	☐ YES	☐ NO
MITRAL VALVE PROLAPSE	☐ YES	☐ NO
ENDOCARDITIS	☐ YES	☐ NO
OTHER:		
<u>BLEEDING DISORDERS</u>		
ANEMIA	☐ YES	☐ NO
HEMOPHILIA	☐ YES	☐ NO
EASY/EXCESSIVE BRUISING	☐ YES	☐ NO
SICKLE CELL DISEASE	☐ YES	☐ NO
SICKLE CELL TRAIT	☐ YES	☐ NO
BLOOD TRANSFUSION	☐ YES	☐ NO
SPLEEN REMOVED	☐ YES	☐ NO
OTHER:		
<u>NEUROLOGIC DISORDERS</u>		
EPILEPSY/SEIZURES	☐ YES	☐ NO
NEURALGIA	☐ YES	☐ NO
STROKE	☐ YES	☐ NO
NUMBNESS	☐ YES	☐ NO
FAINTING	☐ YES	☐ NO
ASPERGER OR AUTISM	☐ YES	☐ NO
OTHER:		
<u>MUSCULOSKELETAL DISORDERS</u>		
OSTEO ARTHRITIS	☐ YES	☐ NO
ARTIFICIAL JOINTS	☐ YES	☐ NO
OTHER:		



FINANCIAL POLICY

For your convenience, we accept: Visa, MasterCard, Discover, American Express, Care Credit, Cash, Check or Money Order. There is a convenience fee 3.5% for using credit and/or debit cards.

We deliver the finest care at the most reasonable cost to our patients; therefore payment is due at the time service is rendered unless other arrangements have been made in advance.

If a check is returned to us as insufficient funds there will be a \$50 returned check fee.

PATIENTS WITH INSURANCE

Waccamaw Oral Surgery ONLY participates with SC Medicaid, Delta Dental Premier, BCBS of SC (GRID), Humana and Cigna Dental PPO dental plans. Since our professional services are rendered to you, and not to the insurance provider, you are directly responsible for your financial obligations. If your insurance company has not made payment within 90 days of the date of service, the unpaid balance becomes your responsibility. Please note that the percentage collected at the time of service is only an ESTIMATE and may vary depending on your personal benefits. All remaining balances will be due within 90 days of the first statement or an 18% service charge will be assessed to the account monthly. Any unpaid balance after 90 days will be subject to collections, a 35% collection fee and reported to the credit bureaus.

MEDICARE Patients: Dr. Covington does not participate with Medicare or any Medicare supplements and therefore you are responsible for the balance in full.

Minor Patients: Parents and guardians are responsible for all charges for minor children. Please list the responsible party as the parent accompanying the patient today.

RESPONSIBLE PARTY:

(PATIENTS AGE 18 AND OLDER ARE THEIR OWN RESPONSIBLE PARTY)

Name: _____ Relationship: _____ Birthdate: ____/____/____ SS#: ____-____-____

Address: _____ City: _____ State: _____ Zip: _____

INSURANCE INFORMATION

(circle one) **Medical** **Dental** **NONE**

Name of Insured _____ Relationship: _____ Birthdate: ____/____/____

SS#: ____-____-____ Employer: _____

Insurance Company: _____ Policy/ID#: _____ Group #: _____

DO YOU HAVE ANY ADDITIONAL DENTAL OR MEDICAL INSURANCE: YES or NO

(circle one) **Medical** **Dental**

INSURANCE INFORMATION

(circle one) **Medical** **Dental** **NONE**

Name of Insured _____ Relationship: _____ Birthdate: ____/____/____

SS#: ____-____-____ Employer: _____

Insurance Company: _____ Policy/ID#: _____ Group #: _____

Thank you for understanding and complying with our financial policy; please let us know if you have any questions or concerns.

CONSENT: I HAVE READ, UNDERSTAND, AND AGREE TO THE ABOVE TERMS AND CONDITIONS OF THE FINANCIAL POLICY. I ATTEST THAT I HAVE COMPLETELY AND ACCURATELY COMPLETED ALL FORMS, INCLUDING HEALTH HISTORY, TO THE BEST OF MY KNOWLEDGE.

Signature (Patient or Responsible Party)

Date



ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

By my signature below, I, _____, acknowledge that I was given the opportunity to
(Printed name of Patient, Parent/Guardian, or Personal Representative)

read and accept the Privacy Practices for Waccamaw Oral & Maxillofacial Surgery.

- ☐ I authorize Waccamaw Oral & Maxillofacial Surgery to leave **voicemail messages** (on any given phone numbers) concerning my health information, appointments, and pre/post-operative instructions.
- ☐ I authorize Waccamaw Oral & Maxillofacial Surgery to contact me via **email** concerning my health information, appointments, and pre/post-operative instructions. Email: _____
- ☐ I authorize Waccamaw Oral & Maxillofacial Surgery to contact me via **text message** regarding my appointments.

I hereby designate the following individual(s) to receive communications from Waccamaw Oral & Maxillofacial Surgery that may include my personal health information:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

- ☐ At this time, I DO NOT authorize anyone to receive communications from Waccamaw Oral & Maxillofacial Surgery that may include my personal health information.

Signature of Patient, Parent/Legal Guardian or Personal Representative

Date

If this acknowledgment is signed by a Personal Representative, on behalf of the patient, please complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____



Cancellation/No Show/Late Arrival Policy

We understand that unplanned situations can arise and you may need to cancel an appointment. We ask that you give us 24-hour notice if you must change or cancel an appointment.

It is the policy of Waccamaw Oral Surgery to optimize the use of Dr. Covington and her staff's time by working to ensure that scheduled time blocks are filled by scheduled patients. **Patients who do not provide the office with at least 24 hours' notice of cancellation or do not follow pre op acknowledgement instructions will be charged a "No-Show" fee for missing a confirmed scheduled appointment.** This charge will not be covered by insurance and will be fully your responsibility. **This fee must be paid prior to being rescheduled. Appointments will be removed from the schedule if not confirmed 24 hours prior to the appointment. If we are not in the office, it is acceptable to leave a message, as long as it is 24 hours prior to your appointment time.**

You will be charged a same day cancellation fee if Dr. Covington is unable to perform the scheduled procedure due to patient non-compliance.

NO-SHOW/CANCELLATION FEES

Any procedure that requires sedation:	\$400
Any procedure that requires local anesthetic:	\$200
Any consultation, office visit or late visit:	\$50

Waccamaw Oral Surgery reserves the right to discontinue patient care when an established patient misses three (3) confirmed appointments without providing 24 hour notice of cancellation. Established patients will be notified in writing that a third missed appointment will result in termination of the physician/patient relationship.

When a new patient misses two (2) confirmed appointments, that patient will not be rescheduled. Thank you for your cooperation.

LATE ARRIVALS

We understand that delays can happen, however we must try to keep our patients and doctor on time to alleviate wait times. ***If a patient arrives 15 minutes, or more, past their scheduled appointment time, the appointment will need to be rescheduled and the no show fee will be applied.***

If you have any questions or concerns regarding this policy, please speak with any of our staff.

I, _____, have read, understand, and agree to abide by the above policy.
(PLEASE PRINT NAME)

Patient or Parent/Guardian's Signature

Date

Witness

Date



**REQUEST FOR, AND AUTHORIZATION TO RELEASE, MEDICAL
TREATMENT INFORMATION**

LUCIA COVINGTON, DMD

3635 Old Kings Hwy
Murrells Inlet, SC 29576
(843) 947-0017
(843) 947-0668 (Fax)
info@waccamawos.com

PATIENT'S NAME: _____

DOB: _____

Our mutual patient, _____, is a candidate for a surgical procedure in our office. We need the following information for medical clearance prior to performing the procedure.

OFFICE USE ONLY

Waccamaw Oral Surgery is requesting a copy of the following documents:

- ☐ Current H&P
- ☐ Current list of medications
- ☐ Recent blood work/laboratory results
- ☐ X-Rays
- ☐ Other: _____

Please fax information to (843) 947-0668.

My signature below signifies my request, and hereby indicates my authorization to release my medical information to Dr. Lucia Covington, DMD.

Patient's authorization for Release: _____
(Signature of Patient or Legal Guardian of Minor) (Date)

Thank you for your attention in this matter.

Sincerely,
Lucia Covington, DMD