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 ZOMETA DIDRONEL RECLAST BONIVA ACTONEL ACLASTA AREDIA ATELVIA PROLIA

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

HEAD AND NECK CONDITIONS		
INJURY TO FACE, JAW OR NECK	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 OPENING/CLOSING JAW	YES	NO
CHRONIC PAIN		
BACK	YES	NO
ABDOMINAL	YES	NO
HEADACHE/MIGRAINE	YES	NO
OTHER:		
INFECTIOUS DISEASES		
RHEUMATIC FEVER	YES	NO
HEPATITIS	YES	NO
HIV/AIDS	YES	NO
OTHER:		
GASTROINTESTINAL DISORDERS		
ULCER/GASTRITIS	YES	NO
ACID REFLUX/HEARTBURN	YES	NO
IRRITABLE BOWEL SYNDROME	YES	NO
COLITIS	YES	NO
CROHN'S DISEASE	YES	NO
YELLOW JAUNDICE	YES	NO
CIRRHOSIS	YES	NO
OTHER:		
RESPIRATORY DISORDERS		
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
EYES		
GLAUCOMA OR CATARACTS	YES	NO
CONTACT LENSES	YES	NO
BLURRED VISION	YES	NO
OTHER:		

CANCER & NEOPLASTIC DISEASE		
CANCER	YES	NO
LEUKEMIA/LYMPHOMA	YES	NO
CHEMOTHERAPY	YES	NO
RADIATION THERAPY	YES	NO
IMMUNE SYSTEM DISORDER		
RHEUMATOID ARTHRITIS	YES	NO
LUPUS	YES	NO
OTHER:		
HORMONAL OR METABOLIC DISORDERS		
DIABETES	YES	NO
THYROID PROBLEMS	YES	NO
OTHER:		
HEART DISORDERS		
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:		
BLEEDING DISORDERS		
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:		
NEUROLOGIC DISORDERS		
EPILEPSY/SEIZURES	YES	NO
NEURALGIA	YES	NO
STROKE	YES	NO
NUMBNESS	YES	NO
FAINTING	YES	NO
ASPERGER OR AUTISM	YES	NO
OTHER:		
MUSCULOSKELETAL DISORDERS		
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