Dear Valued New Patient:

We would like to welcome you to Park West Dentistry. We truly care about your well-being as an individual and as a patient. With this in mind, we have built and developed an Elite Team that is passionate about listening, educating, diagnosing and treating your dental needs and desires.

We have designed this practice to transform the average visit to the dentist into a positive and complete dental experience set in a relaxing and comfortable environment. We deliver a higher standard of technologically enhanced and clinically advanced patient care encompassed by exceptional customer service on all levels.

It is our unique environment, refreshing perspective and genuine concern that enables us to partner with patients who are committed to a path of wellness and value a lifetime of healthy and beautiful smiles.

Your initial appointment will consist of a consultation with me as well as a comprehensive oral examination including all necessary radiographs so that I may properly diagnose your hygiene needs and any dental treatment.

So that you may be prepared financially for your first visit, your investment will be no more than $325. Please be prepared to pay in full on the day of your visit. We accept all forms of payment. If you have dental insurance, we will promptly file your claim for you and have dental reimbursement sent to you. We find that our patients are typically reimbursed by their dental insurance company within 10-20 business days.

Enclosed, you will find a Smile and Medical Questionnaire. Please have the information completed <u>prior to your visit</u> so we may begin your appointment on time. This will allow us to respect your busy schedule as well as our other patients in the practice on the day of your visit.

If at any time you have any questions regarding treatment, scheduling or our practice in general, please do not hesitate to call.

I look forward to meeting you soon and thank you for entrusting me with your dental care.

Respectfully,

Amanda Seay, DDS

If you have any current radiographs or records from a previous dental office, please bring them to your appointment. You may also have your former dentist mail or email them directly to us by faxing them the enclosed Medical Records Release. *Please make sure we have received them before your scheduled appointment*.
Please contact Jennifer with any questions at (843)375-0395. Thank you.

3404 Salterbeck Street, Suite 202 Mount Pleasant, South Carolina 29465
Phone (843) 375-0395 Fax (843) 375-0398 Email: frontdesk@amandaseay.net
www.amandaseay.net

PARK
WEST
DENTISTRY
Amanda Seay, DDS, LLC

Smile Questionnaire

1. Do you have any sensitive or tender areas in your mouth? **Yes or No**
If yes, please explain______________________________

2. Are there foods that you avoid eating (i.e. very cold/hot foods or chewy/crunchy foods)? **Yes or No**
If yes, please explain.______________________________

3. Do you notice your gums bleeding on occasion? **Yes or No**
If yes, please explain. (When? What area?) ______________________________

4. Have you ever noticed problems with bad breath or a bad taste in your mouth? **Yes or No**
If yes, please explain. ______________________________

5. Do you smoke or chew tobacco? **Yes or No**
If yes, which and how often? ______________________________

6. Do you have any problems/concerns with any dental work? **Yes or No**
If yes, please explain. ______________________________

7. Do you have old (silver) fillings or previous dental treatment that is no longer satisfactory to you? **Yes or No**
If yes, please explain. ______________________________

8. Do you have any questions, concerns, or is there anything you don't like about your smile? **Yes or No**
If yes, please explain. ______________________________

9. Do you wish you had whiter teeth? **Yes or No**

10. Would you like to discuss any options to enhance your smile? **Yes or No**
If yes, please explain. ______________________________

11. To your knowledge do you clench or grind your teeth? **Yes or No**

12. Do you wear a night guard? **Yes or No**

13. Do you have a problem with dry mouth? **Yes or No**

14. How often do you consume citrus fruit, fruit juices, sports drinks, or sodas? ______________________________

15. Are you aware of having acid reflux or heartburn? **Yes or No**

16. Rate your brushing habits: **Poor 1 2 3 4 5 6 7 8 9 10 Excellent**

17. Rate your flossing habits: **Poor 1 2 3 4 5 6 7 8 9 10 Excellent**

18. Are there any concerns regarding your overall treatment you would like to share?
____
____
____
____

19. What can we do to make your experience at Park West Dentistry better?
____
____

Park West Dentistry
Amanda Seay, DDS

Referral Information – Please fill in this information – Thank you!

Whom may we thank for referring you to our practice? ☐ Yellow Pages ☐ Newspaper/Magazine____________
☐ Other__________________

Name of person or office referring you to our practice:____

Patient Information

Patient Name: ____ Date:_______________
Last First MI
☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____________

Social Security #: ________________________________ Birth Date:________________________________

Phone (Home): ________________ (Work): ________________ Phone # to confirm future appts:_____________

Driver's License #:______________ Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time

Address: ____
Street Apartment #

____
City State Zip Code

Email Address:_________________________________ **May we confirm your appointment via email? YES or NO**

Health Information

Date of Last Dental Visit: __________________ Reason for ***this*** visit:__________________________________

Have you ever had any of the following? Please check those that apply:

☐ AIDS
☐ Allergies __________
____
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ Currently Pregnant
Due date:_________
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Latex Allergy
☐ Codeine Allergy
☐ Penicillin Allergy
☐ Sulfa Allergy
OTHER:
☐ Pre Medication Needed
☐ Tobacco Use
☐ Taking Coumadin
List any medications you are taking___________
____
____
____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain:____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain:____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain:____
- Name of Physician: ____ Phone:__________________
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain:____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

____ Date:_____________________
Signature of patient, parent or guardian

Spouse or Emergency Contact Information

The following is for: ☐ the patient's spouse ☐ emergency contact

Name: ______________________________

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other ____________

Social Security #: ____________________ Birth Date: ____________________

Phone (Home): ____________ (Work): ____________ Ext:______ Best time to call: __________

Address: ______________________________
Street Apartment #

____
City State Zip Code

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. Your initial appointment must be paid for on the day services are rendered. Any insurance benefits will be filed for you and reimbursable insurance checks will be sent directly to you. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed. If your account becomes past due, we will take necessary steps to collect the balance owed. If we have to refer your account to a collection agency or small claims court, you agree to pay all of the cost/fees which are incurred. The finance charge will be computed at the rate of one and one half percent (1 ½%) per month or an annual percentage ratio of eighteen percent (18%). I understand that the fee estimate listed for this dental care can only be extended for a period of ninety (30) days from the date of the patient examination. I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form

I have read the above conditions of treatment and payment and agree to their content.

______________________________ Date: __________ Relationship to Patient: ______________
Signature of patient, parent or guardian

______________________________ Date: __________ Relationship to Patient: ______________
Signature of guarantor of payment/responsible party

Insurance Information (Reimbursement will be sent directly to you)

Primary

Name of Insured: ______________________________ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: ____________ ID #: ____________ Group #: ____________

Insurance Company Phone Number: ______________________________

Insured's Employer Name: ______________________________

Address: ______________________________
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other______________

Insurance Plan Name and Address: ______________________________

____

Secondary

Name of Insured: ______________________________ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: ____________ ID #: ____________ Group #: ____________

Insured's Address: ______________________________
Street City State Zip Code

Insured's Employer Name: ______________________________

Address: ______________________________
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other______________

Insurance Plan Name and Address: ______________________________

Employment Information

The following is for: ☐ the patient ☐ the insured named

Employer Name: ______________________ Occupation: ______________________

Address: ______________________________
Street City State Zip Code

Privacy Practices Acknowledgement - HIPPA

I understand that Park West Dentistry and Amanda Seay DDS LLC strictly adhere to the ***Health Insurance Portability & Accountability Act of 1996*** (“HIPPA”) in order to protect my privacy as a patient. As a patient, I understand that my information can be used to conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly or indirectly. It may also be used to obtain payment from the third party payers or conduct normal healthcare operations such as quality assessments and physician certifications. I understand that if I would like to read a detailed Notice of Privacy Practices, I may request to see one at anytime and one will be furnished. I may also view a copy online at www.amandaseay.net.

______________________________ Date: __________ Relationship to Patient: ______________
Signature of patient, parent or guardian

MEDICAL RECORDS RELEASE

Please fill out the following information if you would like our assistance in obtaining any dental records and/or radiographs from another dental/medical provider or fax this directly to your former doctor.

Doctor's Name: ____

Address: ____

____

Phone: ____

You are authorized to release my complete medical records to:

Park West Dentistry
Dr. Amanda Seay
3404 Salterbeck Street, Suite 202
Mt. Pleasant, South Carolina 29465
Phone: (843) 375-0395
Fax: (843) 375-0398
frontdesk@amandaseay.net

Print Full Name: ____

Date of Birth: ______________________

____

Authorized Signature (Patient or Parent/Legal Guardian)

Date:________________________