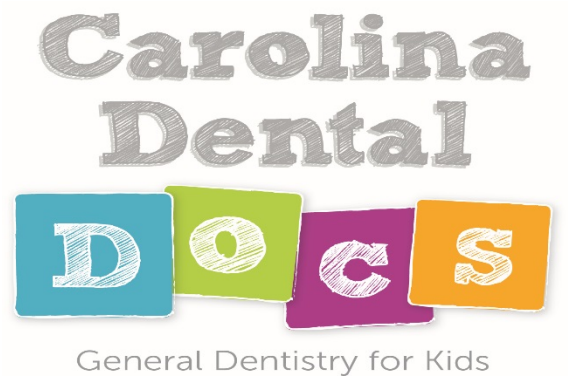



First Name: _____ Last Name: _____

Date of Birth: _____ Medicaid Number: _____

Mailing Address: _____

City: _____State:_____Zip:_____

Home Phone: _____ Cell Phone:_____

Email:_____

**Responsible Party (Only Complete if someone other than patient)**

First Name: _____ Last Name: _____

Mailing Address: _____

City: _____State:_____Zip:_____

Home Phone: _____ Cell Phone:_____

**Insurance Information (If patient has private insurance other than Medicaid)**

Name of Insured: _____

Relationship to Insured: _____ Policy Number: _____

Insured SSN: _____ Insured Date of Birth: _____

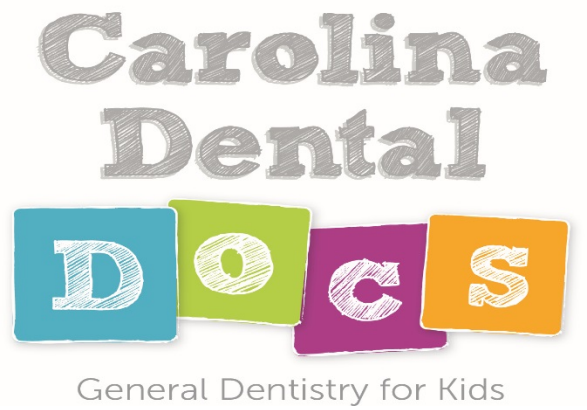
Insured Employer: _____

Insurance Name: _____

**PLEASE LET OUR PATIENT COORDINATOR KNOW IF YOU HAVE SECONDARY COVERAGE**

**Emergency Contact Name and Phone Number:**

_____




***Consent for Treatment***

I _____, give this practice my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for healthcare operations like quality reviews.

I have been informed that I may review the practice's Notice of Privacy Practices before signing this consent.

I understand that this practice has the right to change their privacy practices and I may obtain any revised notice at the practice.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice is not required to agree to the request. If the practice agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time by making a request in writing, except for information already used or disclosed.

Signature: _____ Date:_____
(Patient, parent, or legal guardian)

If signed by patient representative, state relationship to patient _____

# Carolina Dental Docs

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You may refuse to sign This Acknowledgement****

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

_____
(Please Print Name)

_____
(Signature)

_____
(Date)

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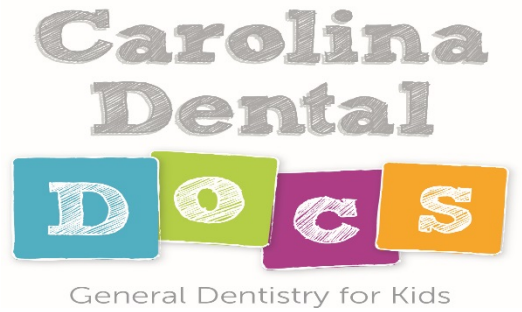
## For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An Emergency situation prevented us from obtaining the acknowledgement
- ☐ Other (Please Specify)




Columbia
2302 Bush River Rd.
Columbia, SC 29210
Ph: 803-798-875

Greenwood
355 W. Cambridge Ave.
Greenwood, SC 29646
Ph: 864-227-1953

Spartanburg
111 Powell Mill Rd.
Spartanburg, SC 29301
Ph: 864-641-0495

Blacksburg
305 W. Pine Street
Blacksburg, SC 29646
Ph: 864-839-0034

www.carolinadentaldocs.com

# Dental Permission Slip

Carolina Dental Docs is a dental office/mobile unit specializing in youth dental health. We have a full staff of extremely qualified dental professionals that are trained to handle each child with exceptional care. We currently have four locations to suit your child's dental needs. We see children in our office/mobile unit from ages of 0 to 20 and accept Medicaid as well as most major insurances.

Your facility has allowed us to come perform dental exams, cleanings, x-rays and fluoride treatments. We want your child to be as comfortable as possible in the dental office/ mobile unit and to prevent or calm any fear they may have. We want to assure them that the dentist is their friend and is there to help them.

The dental exam will be performed by a Licensed Dentist, the cleaning and fluoride will be performed by a licensed Dental Hygienist and Assistant. Once the dental exam is performed on your child, we will send home a form explaining what we found and if any other services are needed. Please complete the permission slip at the bottom of this page and return it to your child's facility, our conveniently located offices are available for follow-up on your child if additional treatment is required, or we can refer to your normal family dentist. We look forward to seeing your child soon!

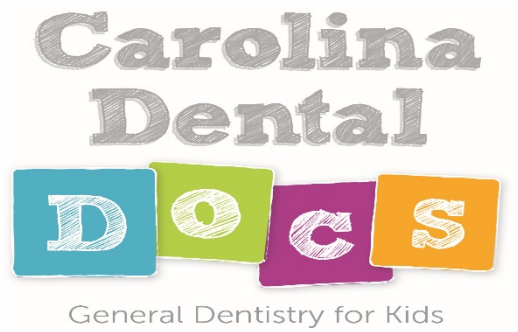
---

( )I DO / ( ) I DO NOT give permission for Carolina Dental Docs to perform a dental exam and cleaning along with any other necessary 6 month treatment such as x-rays, fluoride treatment, etc. on my child.

Child's Name (Print): _____Child's DOB: _____

Parent Name or Legal Guardian (Print): _____

Parent or Legal Guardian's Signature:_____Date:_____




# ***Photo Release Form***

Permission to use Photograph

Event: Routine Dental Appointment

Location: Carolina Dental Docs

I grant Carolina Dental Docs, the right to take photographs of me and my family in connection with the above-identified event. I authorize Carolina Dental Docs, its assigns and transferees to copyright, use and publish the same in print and or electronically.

I agree that Carolina Dental Docs may use such photographs of me with or without my name and for any lawful purpose, including for examples such purposes as publicity, illustration, advertising, and web content.

I have read and understand the above:

Signature: _____

Print name: _____

Address: _____

_____

Date: _____

Signature, parent or Legal guardian: _____
(If under age 18)

☐ **By checking here I do not give Carolina Dental Docs permission to have my child's picture taken and posted anywhere.**