Dear Valued New Patient:

We would like to welcome you to We Care Family Dentistry. We truly care about your well-being as an individual and as a patient.

We have designed this practice to transform the average visit to the dentist into a positive and complete dental experience set in a relaxing environment. We deliver a high standard of technologically advanced patient care, including same day crowns, where we design and mill your crown in our on-site lab and you leave with your permanent crown in place. It is our unique environment, updated technology 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 comprehensive oral examination. The examination includes an oral cancer screening, an exam for early signs of gum disease, an evaluation of your bite and jaw joints and all necessary radiographs to properly diagnose your dental needs.

The examination is followed by a consultation with one of us about your goals and dental needs. All questions and concerns are completely covered. Then the time and investment for the treatment you choose is outlined. Financial arrangements, including answers to questions regarding insurance coverage, are made with one of our Patient Coordinators before any treatment is begun.

Enclosed please find the New Patient Information form, along with a Medical History form, our Financial Agreement and a HIPAA Privacy Practices form. Please have the information completed and returned to our office before your visit, or you may bring the paperwork with you as long as you arrive ten minutes early, so we may begin your appointment on time. This will allow us to respect your busy schedule, as well as other patients in the practice, on the day of your visit.

We look forward to meeting you soon and thank you for entrusting us with your dental care.

Respectfully,

Walter Fingar, DMD

Danielle Schwartz Wooster, DMD

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 (treatment.wecare@hargray.com). *Please make sure we have received them before your scheduled appointment*.

We Care Family Dentistry
247 Mead Road, Hardeeville, SC 29927 • Office (843) 208-2270 • Fax (843) 208-2271 • wecarefamilydentistry.com

Welcome

Thank you for selecting our dental healthcare team!
We will strive to provide you with the best possible dental care. To help us meet all your dental needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Patient Information (Confidential)

Patient #_____ SS#/SIN#_____ Date_____ Male___ Female___

Name_____ Birthdate_____ Home Phone_____

Address_____ City_____ State_____ Zip_____

Email_____ Cell Phone_____

Do you prefer to receive calls at your: Home____ Work____ Cell Phone____

Are you a Minor___ Single___ Married___ Divorced___ Widowed___ Separated___

Full___ Part___time Student:

Name of School/College_____ City_____ State_____

Patient or Parent/Guardian's Employer_____ Work Phone_____

Business Address_____City_____ State____ Zip_____

Spouse or Parent/Guardian's Name_____

Employer_____ Work Phone_____

Whom may we thank for referring you?_____

Person to contact in case of emergency_____ Phone_____

Responsible Party

Person Responsible for this Account_____ Relationship to Patient_____

Address_____ Home Phone_____

Email_____ Cell Phone_____

Driver's License #_____ Birthdate_____ Financial Institution_____

Employer_____ Work Phone_____ SS#/SIN_____

Is this person currently a patient in our office? ___Yes ___No

Insurance Information

Name of Insured_____ Relationship to Patient_____

Birthdate_____ SS#/SIN_____

Name of Employer_____ Date Hired _____

Address of Employer_____ City_____ State_____ Zip_____

Insurance Company _____ Address _____

_____ City_____ State_____ Zip_____

Group #_____ Member ID #_____

Have you used your dental insurance, outside our office, within the last 12 months? _____

We Care Family Dentistry
Medical History

PATIENT NAME _____ BIRTHDATE _____

- Are you under Physician's care now? __YES __NO If yes_____
- Have you ever been hospitalized or had a major operation? __YES __NO If yes_____
- Have you ever had a serious neck Injury? __YES __NO If yes_____
- Are you taking any medications, Pills or drugs? __YES __NO If yes_____
- Do you take, or have you taken, Phen-Fen Or Redux? __YES __NO If yes_____
- Have you ever taken Fosamax, Boniva, Actonel or any other Medications containing Bisphosphonates? __YES __NO If yes_____
- Are you on a special diet? __YES __NO
- Do you use tobacco __YES __NO
- Do you use controlled substances? __YES __NO

Women: Are you…
__Pregnant/trying to get pregnant?
__Nursing?
__Taking Oral contraceptives?

Are you allergic to any of the following?

__Aspirin
__Penicillin
__Codeine
__Local Anesthetics
__Acrylic
__Metal
__Latex
__Sulfa Drugs
__ **NONE OF THE ABOVE**
__**Other If yes, Please explain**: _____

List of medications:

_____
_____
_____
_____
_____

Do you have, or have you had any of the following?

Aids/HIV Positive	__YES __NO	Frequent Cough	__YES __NO	Radiation Treatment	__YES __NO
Alzheimer's Disease	__YES __NO	Frequent Diarrhea	__YES __NO	Recent Weight loss	__YES __NO
Anaphylaxis	__ YES __NO	Frequent Headaches	__YES __NO	Renal Dialysis	__YES __NO
Anemia	__ YES __NO	Genital Herpes	__YES __NO	Rheumatic Fever	__YES __NO
Angina	__ YES __NO	Glaucoma	__YES __NO	Rheumatism	__YES __NO
Arthritis/Gout	__ YES __NO	Hay Fever	__YES __NO	Scarlet Fever	__YES __NO
Artificial Heart Valve	__ YES __NO	Heart Attack/Failure	__YES __NO	Shingles	__YES __NO
Artificial Joint	__ YES __NO	Heart Murmur	__YES __NO	Sickle Cell Disease	__YES __NO
Asthma	__ YES __NO	Heart Pacemaker	__YES __NO	Sinus Trouble	__YES __NO
Blood Disease	__ YES __NO	Heart Trouble/Disease	__YES __NO	Spina Bifida	__YES __NO
Blood Transfusion	__YES __NO	Hemophilia	__YES __NO	Stomach Disease	__YES __NO
Breathing Problems	__YES __NO	Hepatitis A	__YES __NO	Stroke	__YES __NO
Bruise Easily	__YES __NO	Hepatitis B or C	__YES __NO	Swelling of Limbs	__YES __NO
Cancer	__YES __NO	Herpes	__YES __NO	Thyroid Disease	__YES __NO
Chemotherapy	__YES __NO	High Blood Pressure	__YES __NO	Tonsillitis	__YES __NO
Chest Pains	__YES __NO	High Cholesterol	__YES __NO	Tuberculosis	__YES __NO
Cold Sores	__YES__ NO	Hives or Rash	__YES __NO	Tumors or Growth	__YES __NO
Congenital Heart Disease	__YES __NO	Hypoglycemia	__YES __NO	Ulcers	__YES__NO
Convulsions	__YES __NO	Irregular Heartbeat	__YES __NO	Venereal Disease	__YES__NO
Yellow Jaundice	__YES __NO	Kidney Problems	__YES __NO		
Cortisone Medicine	__YES __NO	Leukemia	__YES __NO		
Diabetes	__YES __NO	Liver Disease	__YES __NO		
Drug Addiction	__YES __NO	Low Blood Pressure	__YES __NO		
Easily Winded	__YES __NO	Lung Disease	__YES __NO		
Emphysema	__YES __NO	Mitral Valve Prolapse	__YES __NO		
Epilepsy/Seizures	__YES __NO	Osteoporosis	__YES __NO		
Excessive Bleeding	__YES __NO	Pain in Jaw Joints	__YES __NO		
Excessive Thirst	__YES __NO	Parathyroid Disease	__YES __NO		
Fainting/Dizzy Spells	__YES __NO	Psychiatric Care	__YES __NO		

Comments:

_____

_____

_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN_____DATE _____

We Care Family Dentistry Financial Agreement

Terms of Payment

We are committed to working with you to match a payment plan to meet your needs. We therefore offer different options to our patients which allows for payment to be convenient and flexible. Regardless of your method of payment, the decision must be made prior to your first day of service and your agreed upon portion paid at the first day of your service.

Dental Insurance

To help us assist you in determining your maximum benefit, please bring your insurance card to your first visit. Most plans cover only a portion of the dental fee, therefore, as a courtesy to our patients, we will file your primary insurance for you but we ask that you pay the non-covered balance at the time of service. Your insurance policy is a contract between you and your insurance company. If your insurance company has not paid within 60 days you will be billed for the unpaid balance and payment in full will be expected at this time. We recommend you become directly involved in communication with your insurance company in order to expedite payment.

Payment Options

- We accept Visa, MasterCard, Discover, money order, cash or personal check
- A convenient interest free payment plan through Care Credit
- For patients without dental insurance, we offer a membership club that covers preventative care as well as provides a discount for extended services

Appointments

In order to allow the best possible care for our patients, we reserve a specific time just for you and make every effort to see you as scheduled. We appreciate your promptness and your consideration in not changing your scheduled time. However if you need to change your appointment due to an emergency, a 24-hour notice is expected.

Patient Agreement

- I understand that my insurance policy is an agreement between myself and the insurance company, therefore, I am ultimately responsible for all fees incurred for my dental treatment regardless of payment or denial of my insurance claims by my insurance company.
- I authorize insurance payment directly to Dr. Walter Fingar.
- I authorize the release of necessary information to my insurance company to determine liability for payment and to obtain reimbursement for any claims.
- If this account is assigned to an attorney or collection agency, I agree to be responsible for any attorney fees, collection fees, and court cost incurred.

_____ _____

Signature of Responsible Party Date

HIPAA PRIVACY PRACTICES

I acknowledge that I have been given an opportunity to read (and take home) a copy of Dr. Fingar's Notice of Privacy Practices.

Patient Name_____

Below please let us know how you prefer we communicate with you:

You may speak with _____to leave a message about my appointment.

Or may we leave a message on your answering machine?_____

May we contact you at work, if applicable? _____

Signature_____ Date_____

WE CARE FAMILY DENTISTRY

We Care Family Dentistry Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED BY **WE CARE FAMILY DENTISTRY** AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

YOUR RIGHTS: When it comes to your health information you have certain rights. This section explains your rights.

Upon written request:

- Ask to see or get an electronic or a paper copy of your health record or other information we have about you. We will also provide a summary of your health information if requested. We will charge a reasonable, cost based fee. We will provide this information as soon as possible but no later than 30 working days of the request.
- Ask us to correct your health information you think is incorrect or incomplete. We may say "no" but will tell you why in writing within 60 days.
- You can ask us to communicate with you in a certain way (for example, home or office phone) or to send mail to a different address. We will accommodate all reasonable requests.
- Ask us not to use or share certain health information for treatment, payment or our operations. We are not required to agree with your request and may say "no" if it would affect your care.
- If you pay for a service or health care item out of pocket in full and you ask us not to share that information for payment or our operations with your health insurer we will agree unless we are required by law to share that information.
- Ask us for a list or an accounting of the times we have shared your health information for reasons other than treatment, payment, healthcare operations, and when you have asked us to share information. We will provide a list for the past six years for the request. One request per year will be provided free of charge. For additional requests we will charge a reasonable, cost based fee.
- Revoke an authorization to use or disclose PHI at any time except where action has already been taken.

You may also:

- Choose someone to act on your behalf. If you have given someone medical power of attorney or they are your legal guardian, that person can exercise your rights and make choices about your health information. We will ask for proof of this relationship before we take any action.
- Ask for a paper copy of this document even if you have agreed to receive the notice electronically. We will provide that copy promptly.
- File a complaint. If you feel your rights have been violated you may contact the designated Privacy Officer, Heidi Fingar, 247 Mead Road, Hardeeville, SC 29927, 843-208-2270, Heidi.wecare@hargray.com.
- File a complaint with the US Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Ave, S.W., Washington, D.C. 20201, calling 1.877.696.6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints.
- We will not retaliate for filing a complaint.

OUR RESPONSIBILITIES: The law requires us to:

- Maintain the privacy and security of your protected health information.
- Notify you promptly if a breach occurs that may compromise the privacy or security of your information.
- Follow the duties and privacy practices described in this notice and give you a copy of it.
- Not to use or share you information other what is described in this notice unless you tell us we can in writing. If you tell us we can and then change your mind, just let us know in writing you have changed your mind.

(OVER)

YOUR CHOICES - For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in situations described below, talk to us.

- In these cases you have both the right and the choice to tell us to: share information with your family, close friends, or others involved in your care and share information in a disaster relief situation.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

- In these cases we never share your information unless you give us written permission:
- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes
- In the case of fundraising, we may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURE – We typically use or share your health information in the following ways:

Treatment: We can use your health information and share it with other professionals who are treating you. Example: we may share your health information to an outside doctor for referral. We will also provide your health care providers with copies of various reports to assist them in your treatment.

Payment: We can use or share your health information to bill and get payment from health plans or other entities. Example: we give information about you to your health insurance plan so it will pay for your healthcare.

Health Care Operations: We can use and share your health information to run our practice, improve your care, and contact you when necessary. Example: we use health information about you to manage your treatment and services.

Other ways we can use or share your health information – We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

- **Help with public health and safety issues:** We can share health information about you for certain situations such as: preventing disease, helping with product recalls, reporting adverse reactions to medication, reporting suspected abuse, neglect, or domestic violence, and preventing or reducing a serious threat to anyone's health and safety.
- **Comply with the law**: We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see if we are complying with federal privacy law.
- **Respond to organ and tissue donation requests:** We will share health information about you with organ procurement organizations.
- **Work with a medical examiner or funeral director:** We can share health information with a coroner, medical examiner, or funeral director when you die.
- **Address workers' compensation, law enforcement, and other government requests:**
  - For workers' compensation claims
  - For law enforcement purposes or with a law enforcement official
  - With health oversight agencies for activities authorized by law
  - For special government functions such as military, national security, and presidential protective services
- **Respond to lawsuits and legal actions:** We can share your health information to respond to a court or administrative order, or in response to a subpoena.
- **Research:** We can use or share your information for health research.

CHANGES TO THIS NOTICE - We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office and on our website.

Privacy Officer: Heidi Fingar
Email Address: Heidi.wecare@hargray.com
Phone Number: 843-208-2270

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