Date of Completion:_____

WHITECAP DENTAL
912.925.9190

Patient Information

Full Name: _____Preferred Name: _____

Date of Birth: _____ Age:_____ SSN:_____

Mailing Address:_____

City/State/ZIP_____

Phone: Cell:_____Home:_____

Male _____ Female _____ Married _____ Single _____ Child_____

Email Address:_____

Employer:_____ Occupation:_____

How did you hear about our office?_____

Dental Insurance: _____

Policyholder's Name: _____

Policyholder's Employer:_____

Policyholder's SSN:_____DOB:_____

Family Physician: Name:_____ Phone #:_____

Emergency Contact:_____

Relationship:_____ Phone number:_____

11139 Abercorn Street, Suite 8
Savannah, GA 31419
Whitecapdental@medofficemail.com

Welcome to Whitecap Dental

We are committed to providing patients with the best possible treatment. Please understand that payment of your bill is considered part of your treatment and that you (the patient or guardian) are ultimately responsible for all incurred charges. The following is a statement of our OFFICE and FINANCIAL POLICIES, which we require you to read and sign prior to any treatment

FULL PAYMENT IS DUE AT THE TIME OF SERVICE UNLESS ARRANGEMENTS ARE MADE PRIOR TO TREATMENT. WE ACCEPT CASH, CHECKS, AND CREDIT CARDS.
We also offer Cherry financing.

DENTAL INSURANCE

Your dental insurance coverage is a contract between you and your dental insurance company. Responsibility for payment of fees is the obligation of every patient. We will file your insurance claim as a courtesy for you; however, any unmet deductible or estimated portion is due at the time of service. If your insurance company has a direct reimbursement policy, you will be required to pay for your series in full at the time they are rendered.

I understand that I am responsible for reading and understanding my dental insurance benefits. I am also responsible for notifying this office of any insurance plan or policy changes.

MISSED APPOINTMENTS

We require at least 24 hours advance notice if you are unable to keep your appointment. This courtesy allows someone else to be treated, a courtesy you would want if the circumstances were reversed. A fee of **$25.00** will be applied for appointments missed or arriving more than 15 minutes late without notice.

If two scheduled appointments are missed without 48 hours advance notice of cancellation, you may be required to pay for your next appointment in full before treatment is scheduled. If for any reason you do not keep your appointment or cancel with less than 48 hours' notice, your payment could be forfeited.

AUTHORIZATION FOR SERVICES AND RELEASE OF INFORMATION

The signature on this form serves as authorization for treatment by Whitecap Dental. I authorize the release of any dental/medical, or other information about me/patient including photos, to my insurance company in order to process this or future claims, or for utilization review or quality assurance. I also authorize Whitecap Dental to release or receive dental information, including photography for the purpose of patient treatment or referral. I hereby assign benefits and authorize payment under my insurance program to be paid directly to Whitecap Dental on any bill for services furnished to me when Whitecap Dental files my claim. I understand I am financially responsible to the office for any balance not covered by my insurance carrier. Regarding dental care to those under age 18, parents or legal guardians are financially responsible for payment.

This signature below serves as authorization for treatment and release of information as detailed above. This signature also acknowledges understanding and compliance with all the above stated polices. I assume financial responsibility for services rendered as detailed on this sheet.

Signature: _____ Date: _____

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HEALTH HISTORY

Please Check YES or NO
If YES, check those that apply where indicated.

1) Are you in good health? Yes ____No____
2) Are you currently under the care of a physician? Yes ____No____
3) Has there been a change in your health within the past year or have you been hospitalized or had a serious illness within the past 5 years? Yes ____No____
4) Do you have heart trouble or any form of cardiovascular disease? Yes ____No____

____ Angina (chest pains) frequency _____
____ Heart attack (date) _____
____ Heart surgery (date) _____
Type _____
____ Stroke (date) _____
____ Rheumatic fever (date) _____
____ Heart murmur
____ High or low blood pressure
____ Atherosclerosis
____ Other _____

5) Do you have or ever had any of the following? Yes ____No____

____ Diabetes or Hypoglycemia
____ Kidney disease
____ Liver disease or jaundice
____ Hepatitis: Type:_____
____ Excessive bleeding
____ Psychiatric problems
____ Hip or other joint replacement
____ Allergies (other than medications)
____ Hives or skin rash
____ Thyroid Disease
____ Anemia
____ AIDS or positive test
____ Other: _____
____ Arthritis
____ Glaucoma
____ Tuberculosis
____ Emphysema or breathing problems
____ Stomach or intestinal disorders
____ Fainting spells, epilepsy, seizures
____ Sinus trouble
____ Asthmas or hay fever
____ Cancer: Type:_____
Date: _____ Remission: _____
____ Leukemia
____ for HIV antibodies

6) Have you ever suffered trauma to your head or neck, such as in a car accident? Yes ____No____
7) Have you had surgery, radiation or other treatment for a tumor or growth in the head or neck area? Yes ____No____
8) Are you pregnant? Expected delivery date _____ or nursing? Yes ____No____
9) Are you allergic to or have you had any unusual reactions to any medications? Yes ____No____
If *Yes*, please list: _____

10) Have you ever been advised not to take a particular medication? Yes ____No____
If *Yes*, please list: _____

11) Have you ever been advised to take prophylactic antibiotics before dental treatment? Yes ____No____

12) Please list all of the medication you are currently taking:

Name	Purpose	Frequency	Since

Do you use tobacco products? YES____ NO____ Type: _____ Frequency:_____

Do you use controlled substances (Drugs)? YES____ NO____ Type: _____ Frequency:_____

Do you drink alcohol beverages? YES____ NO____ Frequency:_____

To the best of my knowledge, all the preceding answers are true and correct. If I have any change in my health or medications, I will inform the doctor at my next appointment. If deemed advisable, I grant permission for my physician to be contacted for details and advice. I further authorize the taking of radiographs, photographs, or other diagnostic measures appropriate for a thorough evaluation.

Signature: _____ Date:_____

Print Name:_____ BP_____ Pulse_____

MH Update: _____ Date: _____ BP_____ Pulse_____

MH Update: _____ Date: _____ BP_____ Pulse_____

MH Update: _____ Date: _____ BP_____ Pulse_____

No Medical Changes	Date/Time	No Medical Changes	Date/Time

DENTAL HISTORY

Your answers to this dental history questionnaire will help us to understand your specific dental problems, so that we may more effectively treat you with consideration for your individual needs:

Previous Dentist: _____ Specialty: _____

Period of Treatment: _____ Date of Last Dental Visit: _____

What is your immediate concern? _____

Please check Yes or No

1) Are you presently in pain? Yes ____No____

Teeth ____ Jaw ____ Face ____

Gums ____ Other _____

2) Is any part of your mouth sensitive to the following: Yes ____No____

Hot ____ Cold ____ Pressure ____

Sweets ____ Sour ____ Other _____

3) Do you have a burning sensation in your mouth? Yes ____No____

4) Are you troubled with dryness in your mouth? Yes ____No____

5) Have you ever had or do you presently have chronic head, neck or back pain problems? Yes ____No____

6) Have you ever had injury, pain or soreness from your jaw joint? TMJ Dysfunction. Yes ____No____

7) Have you ever had periodontal treatment or gum surgery? Yes ____No____

8) Have you ever been informed that you have or had gum problems? Yes ____No____

9) Please indicate which items you use daily:

____ Hard – bristle toothbrush ____ Proxi – brush ____ Water Spray

____ Soft – bristle toothbrush ____ Rubber tip ____ Stimudents or toothpicks

____ Electric toothbrush ____ Dental floss ____ Other _____

10) Are you aware of your jaw clicking, popping or making grating like noises? Yes ____ No____

11) Do your jaw muscles fee tired, stiff or painful? Yes____ No____

12) Are you aware of clenching your teeth during the day? Yes____ No____

13) Have you ever been told you grind your teeth during your sleep? Yes____ No____

14) Are you dissatisfied with the appearance of your teeth? Yes____ No____

15) Do you wear a removable denture or appliance? Yes____ No____

NOTICE OF PRIVACY PRACTICES

Effective Date: January 1, 2026

PURPOSE OF CONSENT

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

NOTICE OF PRIVACY PRACTICES

You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A full copy of our notice is available at the front desk. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

OUR LEGAL DUTY

We are required by law to maintain the privacy of your Protected Health Information (PHI), provide you with this Notice of our legal duties and privacy practices, and follow the terms of the Notice currently in effect.

USES AND DISCLOSURES OF YOUR HEALTH INFORMATION

We may use and disclose your PHI without your written authorization for the following purposes:

1. Treatment

We may use your PHI to provide, coordinate, or manage your dental care and related services. This includes consultations with other healthcare providers.

2. Payment

We may use and disclose your PHI to obtain payment for services provided to you, including billing and insurance claims.

3. Healthcare Operations

We may use your PHI for practice operations such as quality assessment, staff training, licensing, and accreditation.

ADDITIONAL PERMITTED OR REQUIRED DISCLOSURES

We may disclose your PHI when required by federal or state law, for public health activities, to report abuse or neglect, for health oversight activities, judicial proceedings, law enforcement purposes, and to avert a serious threat to health or safety.

2026 HIPAA UPDATES

In accordance with recent HIPAA updates (including the 2024 Final Rule and subsequent 2026 guidance):

• Enhanced Privacy Protections for Reproductive Health Information: We are prohibited from disclosing reproductive health information for investigations or proceedings related to lawful reproductive healthcare.

• Alignment with 42 CFR Part 2: Substance use disorder records receive heightened protections, and patient consent requirements have been strengthened.

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• Strengthened Breach Notification Requirements: In the event of a breach of unsecured PHI, affected individuals will be notified without unreasonable delay and no later than 60 days following discovery.

• Tracking Technology & Website Privacy: We comply with federal guidance regarding online tracking technologies and ensure that any digital tools used by our office protect patient PHI.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the following rights:

- Right to inspect and copy your health records.
- Right to request amendments to your records.
- Right to request restrictions on certain uses or disclosures.
- Right to request confidential communications.
- Right to receive an accounting of disclosures.
- Right to obtain a paper or electronic copy of this Notice.

QUESTIONS

Please contact Whitecap Dental at 912-925-9190 or whitecapdental@medofficemail.com with any questions or concerns.
If you believe your privacy rights have been violated, you may file a complaint with our office or with the U.S. Department of Health and Human Services. You will not be retaliated against for filing a complaint.

We reserve the right to change the terms of this Notice and to make the new Notice provisions effective for all PHI we maintain.

May we phone, email, or send a text to you to confirm your appointments? YES NO

May we leave a message on your answering machine at home or cell phone? YES NO

May we discuss your dental treatment, appointments, and insurance/financial

arrangements with anyone? YES NO

If YES, please provide the names of the allowed:

_____

_____

This consent was signed by:

Patient Name (Print) _____ Signature of Guardian _____

Patient Signature _____ Date of Guardian _____

Date _____ Description of Authority _____

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