MAGNOLIA RIDGE
DENTAL ASSOCIATES

3331 Hamilton Mill Rd Bldg 200 Suite 2200, Buford, GA 30519

Patient Information

First Name: _____ Last Name: _____ Middle Initial: ___

Preferred Name: _____ Date of Birth: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Preferred Contact Method: ○ TEXT ○ EMAIL ○ CELL PHONE

Social Security #:_____ Drivers License #:_____

Employer: _____ Job Title: _____

Sex: □ Female □ Male Marital Status: □ Married □ Single □ Divorced □Widow

How did you hear about us: _____

Emergency Contact: _____ Emergency Phone#:_____

Responsible Party (if someone other than the patient)

First Name:_____Last Name: _____ Birth Date: _____

Address: _____

City, State, Zip: _____

Cell Phone: _____ Work Phone: _____

Preferred Billing Method: ☐ MAIL ☐ EMAIL _____

Primary Insurance Information

Name of Subscriber: _____ Subscriber Date of Birth_____

Insurance Company: _____ Insurance phone #_____

Member ID:_____Subscriber Social Security#_____

Employer: _____Group#_____

Signature of Responsible Party:_____Date:_____

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PATIENT MEDICAL HISTORY **Patient Name:**_____ **DOB:**_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication that you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions:

Are you under a physician's care now? O Yes O No If yes _____
Have your ever been hospitalized or had a major operation? O Yes O No If yes _____
Have you been advised to premedicate before dental tx? O Yes O No If yes _____
Do you use controlled substances? O Yes O No If yes _____
Do you use tobacco? O Yes O No

Medications:

Do you have or have you ever taken any of the following medications?

Blood Thinner _____ Cortisone Medicine _____ High/Low Blood Pressure _____ Phen-fen or Redux _____

Other:_____

Are you allergic to any of the following?

Aspirin _____ Penicillin _____ Codeine _____ Latex _____ Sulfa Drugs _____ Local Anesthetics _____

Other: _____

Women: Are you Pregnant/Trying to get pregnant O Yes Taking oral Contraceptives O Yes

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

Aids/HIV Positive O Yes O No	Hemophilia O Yes O No	Alzheimer's O Yes O No	Diabetes O Yes O No
Anaphylaxis O Yes O No	Hepatitis A, B, or C O Yes O No	Renal Dialysis O Yes O No	Anemia O Yes O No
Herpes O Yes O No	Rheumatic Fever O Yes O No	Angina O Yes O No	Emphysema O Yes O No
High Blood Pressure O Yes O No	Rheumatism O Yes O No	Arthritis/Gout O Yes O No	Epilepsy/Seizures O Yes O No
High Cholesterol O Yes O No	Scarlett Fever O Yes O No	Artifical Valve O Yes O No	Hives/Rash O Yes O No
Shingles O Yes O No	Artificial Joint O Yes O No	Hypoglycemia O Yes O No	Sickle Cell Disease O Yes O No
Asthma O Yes O No	Fainting/Dizziness O Yes O No	Blood Disease O Yes O No	Kidney Problems O Yes O No
Spina Bifida O Yes O No	Blood Transfusion O Yes O No	Leukemia O Yes O No	Stomach/Intestinal Disease O Yes O No
Frequent Headaches O Yes O No	Liver Disease O Yes O No	Stroke O Yes O No	Bruise Easily O Yes O No
Low Blood Pressure O Yes O No	Swelling of Limbs O Yes O No	Cancer O Yes O No	Lung Disease O Yes O No
Thyroid Disease O Yes O No	Allergies/Hay Fever O Yes O No	Osteoporosis O Yes O No	Tuberculosis O Yes O No
Cold Sore/Fever Blisters O Yes O No	Pain in Jaw Joints O Yes O No	Tumors/Growth: O Yes O No	Congenital Heart Disorder O Yes O No
Pacemaker O Yes O No	Ulcers O Yes O No	Heart Trouble O Yes O No	Psychiatric Care O Yes O No
Venereal Disease O Yes O No	ADD/ADHD O Yes O No	Autism O Yes O No	

Do you have any medical condition not listed above? O Yes O No If yes, please list below in comments.

Comments:

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

Signature of Patient, Parent or Guardian:

X_____ Date: _____

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Welcome to our practice!
We appreciate the trust you have placed in us.

OFFICE POLICIES

Payment is due at the time service is rendered. We accept cash, check and all major credit cards. If you present a check for insufficient funds or stop payment on an issued check, you will be charged a $30.00 processing fee.

In the event that your account is turned over to our collection agency, a 40% charge will be added on to the entire family balance. If an account is turned over to collections, all family members will be automatically dismissed.

If you break an appointment with our office, we ask for a 24-hour notice of cancellation. If we do not receive a 24-hour notice, you will be charged a $30.00 fee for the scheduled appointment. If you repeatedly miss scheduled appointments, you may be asked to pursue treatment elsewhere.

INSURANCE

Professional services are rendered and charged to you, not your insurance company. Please understand that the contract is between you and the insurance company and payment for services is your responsibility. We will accept assignment of claims for primary insurance. **All deductibles and coinsurances are due at the time of treatment.**

Our office will not enter into a dispute with your insurance company over your claim. This is your responsibility and obligation. If at the end of 60 days your insurance company has not paid, you are responsible for the entire balance. Upon request, we will supply you with a copy of the claim so that you can resubmit if necessary.

In order to honor any insurance benefits, you must provide insurance identification (i.e., insurance cards, phone numbers, & picture I.D.) and we must be able to verify the current benefits available. It is your responsibility to provide new policy information to our office if your insurance changes.

Be advised that you may be billed for services that your insurance company will not cover due to exclusions or plan limitations. In most cases, a pre-treatment estimate can be sent to your insurance company, therefore giving us an estimated portion due by you at time of service.

Please be advised that we do not do amalgams (silver fillings) in our office. At times, insurance may pay the composite (white) restorations at a reduced rate, making you responsible for the balance owed.

I have read and understand the statements outlined above.

Patient/ Responsible Party: _____

Signature: _____ Date: _____