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#:________________________

Preferred Billing Method: ○ MAIL ○ EMAIL ____

Responsible Party (if someone other than the patient)

First Name:____________________Last Name: _______________________ Birth Date: _____________

Address: ____

City, State, Zip: ____

Cell Phone: _____________________________ Work Phone: __________________________________

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:_________________

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	Please list: ____________________
Have your ever been hospitalized or had a major operation?	O Yes O No	Please list: ____________________
Have you been advised to premedicate before dental tx?	O Yes O No	Please list reason and medication: ____________
Do you use controlled substances?	O Yes O No	Please list: ____________________
Do you use tobacco?	O Yes O No	

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 ______

CURRENT MEDICATIONS, REASON and DOSAGE: ____

Are you allergic to any of the following?

Aspirin _______ Penicillin _______ Codeine ______ Latex _______ Sulfa Drugs ______ Local Anesthetics ______

OTHER ALLERGIES: ____

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/Growths	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: ________________________

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: _________________________