Buckhead Dental
Office Phone: 404-603-8350

WELCOME

Date: ______________________

Patient Information

Name: ____
Last First MI

Email address: ____

Mailing Address: ____

____

Phone # (H)______________________ (W) ____________________ (Other) ______________

Can we call you at work? ❑ Yes ❑ No

Date of Birth: ______________ Sex: ❑ Male ❑ Female SS#: ______________________

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Minor

Occupation: ____________________________ Employer: ______________________________

Employer Address: ____ Phone: ____________________

How did you hear about our practice? ____

Emergency contact: Name: ________________ Relation: ____________ Phone #: ________________

Phone #: (H) ____________________ (W) ____________________

Primary Care Physician: Name: ____________________ Fax Number: __________________

Address: ____

____

Financial Information

Name of person responsible for this account: ____

Relationship to patient (if other than self): ______________________ Phone # ______________________

License Number: ________________________

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Dental Insurance Information

Do you have Dental Coverage: ❑ Yes ❑No

Insurance Company: ______________________________

Insurance Company address and phone # : ______________________________

Policy Holders Name: ______________________________

Policy Holders SSN: ______________________________

Policy Holders Date of Birth: ______________________________

Policy Holders Employer: ______________________________

Group Number: ____________________ ID number: ____________________

Dental History

Previous Dentist: ______________________________

Date of Last Visit: ______________________________

How Many times do you brush daily: ____________ Floss____________

Do you use electric toothbrush: ______________________________

Do you wake up with soreness in your jaw? ❑ Yes ❑ No

Have you ever had gum disease therapy or deep cleaning? ❑Yes ❑ No

Do your gums bleed when brushing? ❑Yes ❑ No

What type of toothpaste do you use? ______________________________

Do you suffer from bad breath? ❑ Yes ❑ No

Are any of your teeth sensitive? ❑ Yes ❑ No

Do you grind or clench your teeth? ❑ Yes ❑ No

Would you be interested in cosmetically replacing older dark fillings with new tooth colored restorations? ❑ Yes ❑ No

Would you be interested in teeth whitening? ❑ Yes ❑No

Are you deeply concerned about the finances required to return your mouth to excellent dental health? ❑ Yes ❑ No

If you could change anything about your smile what would it be? ______________________________

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Medical History

Are you currently under a physician's care? ❑ Yes ❑No

Have you ever been hospitalized or had a major operation ❑ Yes ❑ No
If yes, please explain ____

Have you ever had a serious head or neck injury? ❑ Yes ❑ No

Has a doctor told you that you need antibiotics to premedicate for dental work? ❑ Yes ❑ No

Are you on a special diet? ❑ Yes ❑No

Do you use tobacco? ❑ Yes ❑No

Do you use controlled substances? ❑ Yes ❑ No

Do you take, or have you taken, Phen-Fen or Redux? ❑ Yes ❑ No

Are you taking any medications, pills, and/or drugs? ❑ Yes ❑ No
If so, please list ____

WOMEN ONLY

Are you pregnant? ❑ Yes ❑No

Are you taking oral contraceptives? ❑ Yes ❑No

Are you nursing or trying to get pregnant? ❑ Yes ❑ No

Please check to indicate if you are allergic to any of the following:

❑ Aspirin ❑ Codeine ❑ Metal ❑ Local Anesthetics
❑ Penicillin ❑ Acrylic ❑ Latex ❑ Other (please list) _____________

Please check to indicate if you have ever had any of the following:

❑ Aids/HIV positive
❑ Alzheimer's Disease
❑ Anaphylaxis
❑ Anemia
❑ Angina
❑ Appendicitis
❑ Arthritis/ Gout
❑Artificial Heart Valve
❑Artificial Joint
❑ Asthma
❑ Bleeding Disorders
❑ Breast Lump
❑ Bronchitis
❑Blood Disease
❑Blood Transfusion
❑Bruise Easily
❑ Cancer
❑Chest Pains
❑ Cold Sores/Fever blisters
❑ Congenital Heart Disease
❑ Convulsions
❑ Cortisone Medicine
❑ Diabetes
❑ Drug Addiction
❑ Easily Winded
❑ Emphysema
❑ Epilepsy or Seizures
❑ Excessive Bleeding
❑ Excessive Thirst
❑ Fainting spells/dizziness
❑ Frequent Cough
❑ Frequent Diarrhea
❑ Frequent Headaches
❑Genital Herpes
❑ Glaucoma
❑ Hay Fever
❑ Heart Attack/Failure
❑ Heart Murmur
❑ Heart Pace Maker
❑ Heart Trouble/Disease
❑ Hemophilia
❑ Hepatitis A
❑ Hepatitis B or C
❑ Herpes
❑ High Blood Pressure
❑ Hives or Rash
❑ Hypoglycemia
❑ Irregular Heartbeat
❑Kidney Problems
❑Leukemia
❑Liver Disease
❑Low Blood Pressure
❑Lung Disease
❑Mitral Valve prolapse
❑Pain in Jaw Joints
❑ Parathyroid Disease
❑Psychiatric Care
❑Radiation Treatment
❑ Recent Weight Loss
❑Renal Dialysis
❑Rheumatic Fever
❑ Rheumatism
❑ Scarlet Fever
❑Shingles
❑Sickle Cell Disease
❑Sinus Trouble
❑Spina Bifida
❑Stomach Disease
❑Stroke
❑Swelling of Limb
❑Thyroid Disease
❑Tonsillitis
❑Tuberculosis
❑Tumor or Growth
❑ Ulcers
❑ Venereal Disease
❑ Yellow Jaundice
❑Other___________
____
____

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PATIENT MISSED APPOINTMENT POLICY

DEFINITIONS

POLICY- a way of managing affairs so as to achieve some purpose.

APPOINTMENT- a meeting with someone at a certain time and place.

MISSED- fail to keep, do, or be present at.

It is our wish that each and every one of our patients receive the very best care and service possible. **Your Treatment Program** consists of a specific series of treatment given over a pre-planned time span. If you do not follow this plan, then you will not receive the desired results.

If we did not insist that you meet all your appointments, we would be doing you a disservice and it would be indicative that we did not care. We do not want to do you a disservice and we do care about you and the success of your program here. Therefore, we have a few simple rules that we insist you follow:

1. Meet all your appointments. Arrange the activities in your life so that this can occur.
2. If you are unable to make it in due to an emergency, please call us and let us know so we can reschedule your appointment.
3. With the exceptions of unexpected emergencies, we request that you notify us at least 48 hours in advance as to any appointment changes.
4. **All cancelled or missed appointments must be rescheduled and made up within one week.**
5. **All Patient Appointments without a 24 hour notification will be charged a $50.00 service charge.**

I have read, understand, and agree to follow the above policy.

Patient's Name: ___________________________________

Signature: ____

Staff Witness: _____________________________________

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PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: ________________________________ DOB: ____________________

I acknowledge that I have reviewed the Notice of Privacy Practices of Buckhead Dental Inc.

(Please initial one of the following options and sign below.)

__________ I wish to receive a paper copy of Privacy Notice.

__________ I wish to receive an electronic copy of Privacy Notice.

My email address is: ____@_______________

__________ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office.

Please initial below:

__________ I acknowledge that it is the policy of Buckhead Dental Inc. to leave reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

__________ I acknowledge that if I should have a problem or question in regard to my rights, I may speak with the office manager about my concerns.

____ ________________________
Signature of Patient/Guardian Date

____ ________________________
Witness (Office Staff) Date

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Dental Insurance Coverage

Patient Name______________________________________

As a courtesy to our patients, we will file your insurance claims on your behalf. All insurance information must be COMPLETE and up to date if insurance is to be billed for you. Our office does verify coverage and benefits with your insurance company, but that does not mean it is a guarantee of payment. The patient will be responsible for any balance not covered by their insurance. It is the patient's responsibility to call their insurance company to check on their coverage prior to the appointment, as well as getting an explanation of benefits (EOB) or claims status/payments after the appointment.

I understand that I am responsible for payment for whatever my insurance does not cover or pay in full.

_______________________________ _____________________________

Signature Date