

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: _____

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? _____

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:

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

PATIENT MISSED APPOINTMENT POLICY

Missed Appointment Policy

It is our wish that each and every one of our patients receive the very best care and service possible. We pride ourselves in offering you personalized care and reserve appointment times to accommodate your needs. Late arrivals, missed appointments, or canceled appointments without sufficient notice create a gap in our providers' schedule. These are appointments that could have been offered to another patient in need.

Late Arrivals:

If a patient arrives 10 or more minutes late for an appointment they will be asked to reschedule because the remaining time is not sufficient to complete the scheduled services. Late arrivals disrupt the daily schedule and result in delays for other patients who are on time. If an appointment must be rescheduled it may result in a Broken Appointment.

Broken Appointments:

We require 48 hour notice for any appointment changes, whether rescheduling or canceling. As a courtesy to our patients we make multiple attempts to confirm all appointments. We do recognize that situations arise that are out of your control; however, it is imperative that you contact our office as soon as possible.

Appointments canceled or rescheduled with less than a 48 hour notice or appointments missed entirely, will be considered broken and will be subject to a **\$50.00 fee**. This fee may be waived as a courtesy if it is the first broken appointment.

Any appointment not confirmed within 24 hours may be forfeited in order to accommodate emergency appointments.

We appreciate your cooperation in scheduling and maintaining appointments in order to provide you with the best level of care.

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

Patient's Name: _____

Signature: _____

Staff Witness: _____

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

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