Patient Registration Form

Date of Appointment:

Patient Information

Patient's First Name		Middle Name	Last Name (as it appears on insurance card or ID)
Sex	Marital Status	Date of Birth(Age)	Social Security Number

Patient's Address	City	State	Zip

Home Phone	Mobile Phone	Email Address
Referred by		

Patient Employer/School Information

Employer/School	Occupation	Employer/School Phone

Employer/School Address	City	State	Zip

Emergency Contact Information

Emergency Contact Name	Emergency Contact Phone	Relation to Patient

Billing and Insurance

Primary Dental Insurance

Insurance Company		Plan
Plan Number	Group Number	Insured's Employer/School

Insured's Name(as it appears on insurance card or ID)	Relation to Patient	Insured's Phone Number

Insured's Address	City	State	Zip

Insured's Social Security Number	Insured's Birthdate	

Secondary Dental Insurance

Insurance Company		Plan	
Plan Number	Group Number	Insured's Employer/School	Insured's Social Security Number

Insured's Name(as it appears on insurance card or ID)	Relation to Patient	Insured's Phone Number

Responsible Party

Billing Name (if other than patient)	Phone	Relation to Patient

Address	City	State	Zip

Signature of Patient or Authorized Guardian

Date

Date of Appointment: _____

Name _____ Gender _____ Age _____

Reason for Visit

What brings you to the office?

_____

_____

_____

_____

_____

Current Medications

Are you currently taking any blood thinners?

☐ Yes ☐ No

What medications are you currently taking?

Name	Dosage	Frequency

Allergies

Are you allergic to any of the following?

☐ Adhesive Tape ☐ Antibiotics ☐ Latex
☐ Barbiturates (Sleeping Pills) ☐ Aspirin ☐ Iodine
☐ Codeine ☐ Sulfa ☐ Local Anesthetics

Do you have any other allergies?

Name	Reaction

Hospitalizations &Surgeries

Reason	Date

Dental History

When was your last dental exam?

Date_____

When were your last dental x-rays taken?

Date_____

How often do you brush?

#times/day_____

How often do you floss?

#times/day_____

Do you grind your teeth?

☐ Yes ☐ No

Have you ever had orthodontic (braces) treatment?

☐ Yes ☐ No

Have you ever had periodontal (gum) treatments?

☐ Yes ☐ No

Do you have any of the following?

☐ Bad Breath ☐ Dry Mouth ☐ Partials
☐ Bleeding Gums ☐ Difficulty Chewing ☐ Sensitivity to Cold
☐ Blisters on Mouth ☐ Ear Pain ☐ Sensitivity to Heat
☐ Broken Fillings ☐ Jaw Pain ☐ Sensitivity to Sweets
☐ Clicking Jaw ☐ Loose Teeth ☐ Sensitivity to Pressure
☐ Dentures ☐ Mouth Pain ☐ Swollen Gums
☐ Difficulty Opening or Closing ☐ Mouth Sores

Past Medical History

Have you ever had any of the following?

☐ Alcoholism ☐ Bleeding Disorder ☐ Eating Disorder
☐ Allergies ☐ Blood Disease ☐ Epilepsy
☐ Anemia ☐ Blood Transfusion ☐ Hay Fever
☐ Anxiety Disorder ☐ Bowel Disorder ☐ Heart Disease
☐ Arthritis ☐ Cancer ☐ Heart Problems
☐ Asthma ☐ Diabetes ☐ Hepatitis-A,B,orC
☐ AIDS/HIV ☐ Depression ☐ High Blood Pressure
☐ High Cholesterol ☐ Migraines ☐ Stomach Ulcer
☐ Joint Disorder ☐ Osteoporosis ☐ Substance Abuse
☐ Kidney Disorder ☐ Pacemaker ☐ Thyroid Disorder
☐ Liver Disorder ☐ Rheumatic Fever ☐ Tuberculosis
☐ Lung Disease ☐ Sinus Problems ☐ Venereal Disease
☐ Lupus ☐ Skin Disorder
☐ Measles ☐ Stroke

Lifestyle Factors

Have you ever smoked?

☐ Yes ☐ No #of years_____ #packs/day_____

Do you smoke now?

☐ Yes ☐ No #packs/day_____

Do you use recreational drugs?

☐ Yes ☐ No types?_____ #times/week_____

How much alcohol do you drink per week?

#drinks/week_____

How much caffeine do you drink per day?

#drinks/day_____

Women Only

Are you pregnant?

☐ Yes ☐ No

Are you breastfeeding?

☐ Yes ☐ No

What is your method of birth control?

_____

A Statement of Financial Policies for our Patients

First, please allow us to welcome you to our office. We hope to make your visit as pleasant as possible. Unfortunately, aside from the emotional and physical impact of any dental treatment, there is all too often a degree of financial impact as well. We would like to erase your potential financial burden as much as possible. Your review of our financial policies at this time will help greatly to avoid future misunderstanding and make everyone's job that much easier.

1. Our relationship and our contract with you is that of Dentist-Patient. We do not provide dental services to insurance companies and have no responsibility to assure that the insurance company is pleased with your dental care.

2. Any contract that exists between you and your insurance company for dental care reimbursement does not obligate us to comply with the provision of your policy. We will assist you in the filing of your claims. Our ultimate responsibility is for the correct filing and processing of insurance paperwork. However, all other inquires remain with you and your insurance company. Please ask them; do not depend on us to be familiar with all the different types of insurance plans.

3. We do not file for medical coverage with your insurance under any circumstances.

4. We take a deposit for scheduling any major treatment. Deposits taken goes towards the treatment that is done on the appointment day. Payment is expected at time of service for all procedures not covered by your insurance.

5. Often the insurance companies will use the term "usual and customary" or similar language when denying charges for dental care. The implication is that the doctor charges too much for a given procedure or visit. Universal "usual and customary" fee schedules do not exist. The amount an insurance company reimburses for a procedure will vary with the company, the type, and the quality of a policy. Our fee schedule is the same for everyone. The only time there is a variation in charges is when there exists a contract between an insurance company and us to provide care at a discount in exchange for qualifying as a "participating provider-dentist".

6. In the event of default, patient’s guarantor will be responsible for all collections cost, including attorney and court fees. Quality, personalized dental care is sometimes necessarily quite expensive. Despite the pressure to pass along increased cost to the patient, we work hard on your behalf to contain fees and other charges. We are here to serve you for your dental care needs. If we have done well, please tell your family and friends. If not, tell us!

I have read and understood the above. I have kindly been given a copy of this document for my records.

Signed: _____ Date: _____

HIPAA Patient Consent Form

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patient's consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal dental records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect that privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal dental records as provided by the Georgia Code. We may have indirect treatment relationships with you (such as laboratories that only interact with doctors and not patients), and may have to disclose personal health information for purposes of treatment, payment or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.
You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Patient/Parent/Guardian's Name

Signature

Missed Appointment Policy

We feel the doctor/patient relationship is built on mutual trust and respect. As such, we strive to be on time for your scheduled appointments, and ask that you give us the same courtesy. However, we understand that unforeseen circumstances occasionally occur and you will be unable to keep your scheduled appointment.

If you are unable to keep your scheduled appointment, we require a 24-hour notice (1-full business day) so that we may accommodate the dental needs of another patient. This guideline applies to both visits with our hygienist and our doctors. **If an appointment is cancelled or rescheduled within 24 hours of the reserved appointment time, Marietta Dental Professionals may charge the patient the following nominal fees:**

$45.00 for first missed appointment
$75.00 for second missed appointment

Hygiene Visits: All patients will receive the opportunity to miss one scheduled appointment. A $30 fee will be charged to the patient account for any additional late- cancel/failed appointments.

If 2 appointments are broken without proper advance notice, we may be unable to schedule additional appointments for you.

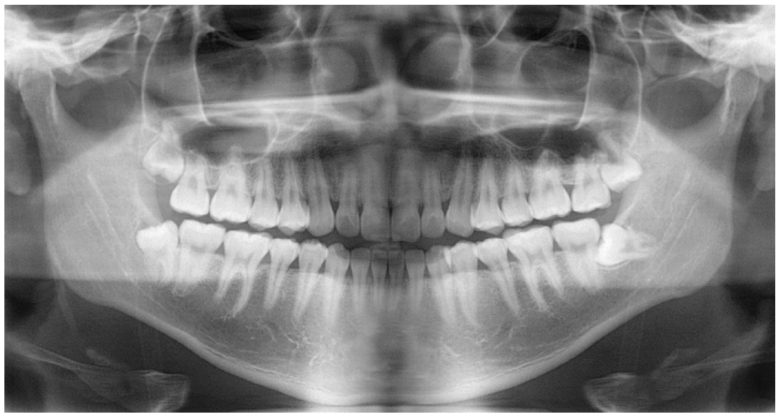
I have read the above notification, and I understand its implications to my account with Marietta Dental Professionals. I assume full responsibility for making and keeping my own appointments. Furthermore, I assume any charges that may be assessed to my account when I violate the above stated policy.

Name: _____

Date: _____

Signature: _____

Panoramic Imaging



Panoramic X-rays are wraparound photographs of the face and teeth. There is a picture of what this x-ray looks like above. They offer a view that would otherwise be invisible to the naked eye. Taking one is easy; a machine rotates around your head to capture the image.

Panoramic X-rays give us the big picture and allow us to see things the smaller x-rays cannot.

The most common uses for panoramic X-rays are below:

- Expose cysts, abnormalities, and to check for oral cancer
- Expose impacted wisdom teeth
- Expose jawbone fractures
- Assess patients with an extreme gag reflex
- Evaluate the progression of TMJ
- Plan treatment (full and partial dentures, braces and implants)
- Reveal gum disease and cavities

The fee for this is **$75** and it is <u>not</u> an insurance covered benefit. We will be able to send this x-ray via email to any provider you choose or to a specialist in the event anything abnormal is seen. Please circle 'Yes' or 'No' at the bottom of this page to indicate your selection. Thank you.

YES NO

Signature:_____