

WELCOME

Your smile is important to us.

*We want to welcome you to our office. Our dental team will make every effort to make your visit pleasant.
Our goal is to provide quality dental care to you and your family.*

PATIENT INFORMATION RECORD

Patient: _____ **SS#:** _____ **Date of Birth:** _____

Sex: Male Female **Marital Status:** Married Single Divorced Widowed

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone: _____ **Cell:** _____ **E-mail:** _____

Employer: _____ **Work Phone:** _____

In the event of an emergency, whom should we contact?

Name: _____ **Relationship:** _____ **Phone:** _____

Referred By: _____

RESPONSIBLE PARTY

MUST COMPLETE ALL SPACES

Person Responsible for Account (if other than Patient) _____

SS#: _____ **Date of Birth:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone: _____ **Cell:** _____

Email address: _____ **Relationship to Patient:** _____

Employer: _____ **Employer's Phone:** _____

PLEASE READ: I understand and agree that I will be responsible for any balances for patients listed on this account. Broken appointments will be assessed and returned checks will be assessed of which I will also be responsible.

I HAVE READ, UNDERSTAND AND AGREE TO THE OFFICE POLICIES STATED ABOVE. (MUST BE SIGNED BY PERSON RESPONSIBLE FOR THIS ACCOUNT)

Responsible Party Signature: _____ **Date:** _____

PATIENT SIGNATURE: _____ **Date:** _____

West Georgia Family Dentistry

8590 Bowden Street

Douglasville, GA 30134

Phone: (770) 949-1680 Fax: (770) 949-0707

Website: westgeorgiafamilydentistry.com

Email: wgd@bellsouth.net

MEDICAL HISTORY

Patient's name: _____ Date: _____

Physician's name: _____ Physician's Phone #: _____

Last Medical Exam: _____

Do you have any Drug Allergies or have you ever had an adverse reaction to any medication? _____

Has a physician directed you to take antibiotics prior to having dental treatment? _____ Yes _____ No

Have you had a joint replacement or heart valve replacement within the last year? _____ Yes _____ No

If yes, please take your Pre-Med antibiotic as prescribed by your physician prior to your appointment.

***Please check if you have any of the following:*

- | | | |
|--|---|---|
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Orthopedic Hardware |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pre-Med |
| <input type="checkbox"/> Angina Pectoris | <input type="checkbox"/> HIV+/AIDS | <input type="checkbox"/> Pace Maker |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Psychiatric Problems |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Radiation Therapy |
| <input type="checkbox"/> Artificial Valve | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> RX- Blood Thinner |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Cancer-Chemo/Radiation | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Hepatitis A or B | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Lung/Pulmonary Disease | <input type="checkbox"/> Yellow Jaundice |
| <input type="checkbox"/> Fever Blisters | <input type="checkbox"/> Mitral Valve Prolapse | Other _____ |

Are you under the care of a physician at this time? _____ Yes _____ No

If so, what conditions _____

Have you been a patient in a hospital during the past two years? _____ Yes _____ No

Have you been under a doctor's care during the past two years? _____ Yes _____ No

Have you ever responded adversely to medical or dental treatment? _____ Yes _____ No

Are you currently taking any medication? _____ If so, please list: _____

Do you have any other medical conditions not mentioned above? _____ Yes _____ No

If so, please explain. _____

Do you smoke or use tobacco? _____

For women:

Are you or do you suspect that you are pregnant? _____ # of weeks _____ Are you nursing? _____

To the best of my knowledge, the information given is accurate and complete. I understand that in order to provide the best dental care, it is my responsibility to inform this office of any changes in my patient information or medical information.

Patient (or Guardian) Signature: _____ **Date:** _____

INSURANCE INFORMATION

Appointment Date _____

Account # _____

Name of patient _____ DOB _____

Full Address _____

Best Phone Number _____ Home /wk/cell _____

Reason for new insurance: New patient _____ New job _____ Co. changed insurance _____ other _____

PRIMARY COVERAGE

SECONDARY COVERAGE

Subscriber Name _____

Subscriber Name _____

Date of Birth _____

Date of Birth _____

Social Security # _____

Social Security # _____

Insurance ID # _____

Insurance ID# _____

Employer _____

Employer _____

Insurance Co. _____

Insurance Co. _____

Insurance Co. Address _____

Insurance Co. Address _____

Insurance Phone # _____

Insurance Phone # _____

Group Number _____

Group Number _____

Coverage: Individual () Family ()

Coverage: Individual () Family ()

List Covered Family Members
insured

Date of Birth

Relationship to

<u>List Covered Family Members</u> <u>insured</u>	<u>Date of Birth</u>	<u>Relationship to</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PLEASE READ: Your signature serves as an assignment of benefits for your insurance coverage and as a release of information to your insurance company. Once verified we will submit your claims to your insurance for payment as a courtesy of this office. Payment is required on the date of service for the deductible and any estimated uncovered portion of your visit. If insurance will only pay you directly, payment will be due at the time of service unless arrangements are made ahead of time with our financial coordinator.

I understand and agree that I will be responsible for any balance not covered by insurance, to be paid in full within 30 days. In the event that my account is turned over to a collection agency, I understand and agree I will be responsible for collection fees, court cost, etc, any returned checks will be assessed at a \$35.00 fee.

I have read, understand and agree to the office policies stated above.

X _____ Date _____

Office Use Only

Primary Coverage: eff date _____

Coverage: Ind EE & _____ Fam
_____ Fam

Deductible: Ind _____ Fam _____
Fam _____

Maximum _____
Maximim _____

% Ded applies Wait
applies Wait

Prev _____

Basic _____

Major _____

Frequencies:

Prophy: _____

4910 _____

Exam: _____

150/180 _____ or all same
_____ or same

Bitewings: _____

FMX: _____

FL: age _____ Freq: _____
Freq: _____

Slts: age _____ Freq _____ Th _____
_____ Th _____

Replacements:

Secondary Coverage: eff date

Coverage: Ind EE &

Deductible: Ind _____

% Ded

Prev _____

Basic _____

Major _____

Prophy:

4910

Exam:

150/180

Bite wings:

FMX:

FL: age _____

Slts: age _____ Freq

Replacements:

Crns _____

Brdg/dent _____

SD PD

Missing tooth clause: yes no
yes no

Assgn of bene: pays provider pays pat
provider pays pat

Crns _____

Brdg/dent

SD PD

Missing tooth clause:

Assgn od bene: pays

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Privacy Practice and Discloser Instructions

In general, the HIPPA privacy rule gives individual's the right to request a restriction on the use and disclosures of their protected health information. (PHI) The individual is also provided the right to request confidential communications and the form in which they receive such communications.

I wish to be contacted in the following manner. (check all that apply)

_____ Home Phone	_____
_____ Work Phone	_____
_____ Cell Phone	_____
_____ Fax	_____
_____ Email	_____
_____ Other	_____

I allow you to discuss my clinical or account information with the following people:

Name _____	Relationship _____
Name _____	Relationship _____
Name _____	Relationship _____

A copy of the HIPPA privacy notice is posted in our lobby and one is available to each individual upon request.

I, _____, have viewed and had an opportunity to receive a copy of the Notice of Privacy Practice (HIPPA) for this office.

Emergency Contact _____ Phone _____

Relationship _____ Date _____

Name _____

Sign (patient or guardian) _____

Photograph / Video Release

West Georgia Family Dentistry
8590 Bowden Street, Douglasville, GA 30157
770-949-1680

In our office we use photographs of our patients to help determine problem areas and as an aid to treatment options. With these photographs, we can relate any necessary information to the patient's insurance company to aid in receiving benefits toward dental care. We may also use photographs with referring doctors and dental labs. Photographs of your face, teeth and jaws will be used as a record of your care.

Our doctors also use the photographs to educate our team and other patients who might have similar dental needs. The educational photographs **will not** include images of your face, in order to protect your rights to privacy. These photos may be used in marketing and advertising as well.

We are very thankful for our patients, and very proud of our team. We may occasionally take photographs with you and/or a team member, to be used for our marketing and advertising. We use some of our photo booth photographs on social media as well. Occasionally you may be asked to participate in a video, or you may accidentally be filmed in a video as a bystander. Many of the photograph/videos used in our office, on our web site, and in our ads, are our own patients and photography. I understand I will not receive compensation, financial or otherwise, for the use of these photographs/videos. I understand I can revoke my authorization at any time.

AUTHORIZATION AND RELEASE

Please initial one.

_____ I do not wish to have my face shown for advertisements.

_____ I do not mind if my face and teeth are used in any of the above stated situations.

_____ I only agree to have photographs/videos taken for dental treatment and diagnosis. I do not wish to have these photographs/videos shared with anyone outside this office unless it directly relates to my treatment.

Print Name: _____

Signature: _____ Date: _____

For minors, signature parent/guardian: _____

Minor's Name: _____