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: _________________________

<u>PLEASE READ</u>: 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: wgfd@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:*

___Abnormal Bleeding
___Anemia
___Angina Pectoris
___Arthritis
___Artificial Joints
___Artificial Valve
___Asthma
___Blood Transfusion
___Cancer-Chemo/Radiation
___Congenital Heart Defect
___ Diabetes
___ Difficulty Breathing
___ Drug Abuse
___ Emphysema
___ Epilepsy
___ Fainting Spells
___ Fever Blisters
___Frequent Headaches
___ Glaucoma
___ HIV+/AIDS
___ Hay Fever
___ Heart Attack
___ Heart Disease
___ Heart Murmur
___ Heart Surgery
___ Hemophilia
___ Hepatitis A or B
___ Hepatitis C
___ High Blood Pressure
___ Kidney Problems
___ Liver Disease
___ Low Blood Pressure
___Lung/Pulmonary Disease
___Mitral Valve Prolapse
___Orthopedic Hardware
___ Pre-Med
___ Pace Maker
___Psychiatric Problems
___Radiation Therapy
___Rheumatic Fever
___RX- Blood Thinner
___Seizures
___Shingles
___Sickle Cell Disease
___Sinus Problems
___Stroke
___Thyroid Problems
___Tuberculosis
___Ulcers
___Yellow Jaundice
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

Subscriber Name _________________________

Date of Birth _____________________________

Social Security # __________________________

Insurance ID # ____________________________

Employer ________________________________

Insurance Co. _____________________________

Insurance Co. Address ______________________

____

Insurance Phone # _________________________

Group Number ____________________________

Coverage: Individual ( ) Family ( )

SECONDARY COVERAGE

Subscriber Name _____________________

Date of Birth _______________________

Social Security # _____________________

Insurance ID# _______________________

Employer ___________________________

Insurance Co. _______________________

Insurance Co. Address _________________

____

Insurance Phone # ____________________

Group Number _______________________

Coverage: Individual ( ) Family ( )

List Covered Family Members **Date of Birth** **Relationship to insured**

____

____

____

____

____

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 __________________

West Georgia Family Dentistry

8590 Bowden St. Douglasville Ga, 30134

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

wgfd@bellsouth.net

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: ___________________________