DentalHome

Patient Information

Today's Date_____

Patient Name: _____
Last First MI (Preferred Name)

Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Child

Birth Date: _____/_____/_____ Social Security #: _____

Address:_____
Street Apt # City State Zip Code

Email: _____

Phone (Home): _____ (Work):_____Ext:_____ (Cell): _____

Health Information

Date of Last Dental Visit: _____ Reason for coming today: _____

Have you EVER had any of the following? Please check all those that apply:

- ☐ ADD/ADHD-circle one
- ☐ AIDS / HIV(circle one)
- ☐ Allergies _____ _____
- ☐ Anemia
- ☐ Arthritis
- ☐ **Artificial Joints**
- ☐ Aspirin Allergy
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Codeine Allergy
- ☐ Cold Sore or Fever Blister
- ☐ **Diabetes**
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Erythro Allergy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ **Heart Disease**
- ☐ Heart Murmur
- ☐ Hepatitis A__ B__C__
- ☐ **High Blood Pressure**
- ☐ Jaundice
- ☐ **Joint Replacement**
- ☐ Kidney Disease
- ☐ Latex Allergy
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ **Pacemaker**
- ☐ **Penicillin Allergy**
- ☐ **Currently Pregnant Due date:_____**
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Smoker
- ☐ Stomach Problems
- ☐ **Stroke**
- ☐ Sulfa Allergy
- ☐ **Tuberculosis**
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Other_____

- Have you ever had a history of drug or alcohol abuse? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you ever taken any Bisphosphonates such as Fosamex, Actonel, Boniva, etc? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you ever been told you need to pre-med? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____
- List any medications you are currently taking including any over the counter or supplements:

_____

_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Internet ☐ School ☐ Insurance ☐ Other _____

Name of person or office referring you to our practice: _____

Dental Information

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No

  If yes, please explain: _____

- When was your last dental cleaning? _____
- Are you experiencing any dental pain? ☐ Yes ☐ No

  If yes, please explain: _____

- Are you happy with your smile? ☐ Yes ☐ No

  If no, please explain? _____

- What would you like to change about your smile? _____

  _____

- Are you interested in whitening your smile? ☐ Yes ☐ No
- Are you interested in orthodontics (braces/Invisalign)? ☐ Yes ☐ No
- Are you interested in replacing missing teeth? ☐ Yes ☐ No
- Are you aware of clenching or grinding your teeth? ☐ Yes ☐ No

Responsible Party or Parent/Guardian Information

The following is for: ☐ the patient ☐ the patient's spouse ☐ parent/guardian

Name: _____ Relationship to patient_____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ (Cell):_____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the parent/ guardian

Employer Name: _____ Phone #_____

Address: _____
Street City, State Zip Code

Insurance Information

Primary

Name of Policy Holder: _____ Policy Holder's Birth Date: ____/____/____
Last First MI

Social Security # _____ Member Id # _____ Group Id # _____

Name of Insurance _____

Insurance Company's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

DentalHome

Our Financial Policy

ABOUT FINANCIAL ARRANGEMENTS AND DENTAL INSURANCE

We are committed to providing you with the best possible care. If you have dental or medical insurance, we are anxious to help you receive your maximum allowable benefits, in order to achieve these goals, we need your assistance and your understanding of our payment policy.

Payment for services is due at the time services are rendered. We will accept cash, checks, and all major credit cards. We also accept Care Credit payment plans. We will be happy to help you process your insurance claim. Any such request must be accompanied by a completed insurance form and any updates at each visit.

Returned checks and balances older than 30 days will be subject to a $25 charge and additional collections fees. **Charges may also be made for broken appointments and appointments cancelled without 48 hour advance notice.**

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a PARTY to that contract.
2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies that pay a percentage (such as 50% or 80%) of "U.C.R. is defined as usual, customary, and reasonable."
3. This statement does not apply to companies that reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and no cost of care in this area.
4. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
5. You will be fully responsible for any balance not paid by insurance sixty days after your claim has been submitted. You will receive a bill from us showing the outstanding balance. We will be happy to provide any documentation to help assist you in collecting reimbursement from your insurance company directly.

We must emphasize that, as dental care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding your insurance coverage, please don't hesitate to ask us.

I have read and understand the financial policy:

Signature of patient, parent, or guardian:_____**Date:**_____/_____/_____

DentalHome

Consent for Services

I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs.

Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents, regardless of insurance coverage. I understand and agree that I am responsible for any portion of my bill that my insurance company does not pay within sixty days of claim submission. I understand payment is due at the time of service. In the event payments are not received by agreed upon dates, I understand that a 1.5% late charge (18% APR) may be added to my account.

If this account must be turned over to collections, then I would be responsible for all collection fees charged by the agency.

_____ _____/_____/_____ _____

Signature of patient, parent, or guardian **Date** **Relationship to patient**

Acknowledgement of Receipt of Privacy Practices and HIPAA Statement

I have received a copy of the Notice of Privacy Practices and a copy of the HIPAA statement for the above named practice.
I also give permission for Dentalhome @ Gwinnett Place to release my information to :
(If there is no one we can talk to please put NONE and sign)

Name: _____Relationship to patient:_____

Name: _____Relationship to patient:_____

Name: _____Relationship to patient:_____

Name: _____Relationship to patient:_____

_____ _____/_____/_____ _____

Signature of patient, parent, or guardian **Date** **Relationship to patient**

Insurance Authorization

I authorize release of information to all my insurance carriers. I understand that I am responsible for any part of my bill not covered by my insurance. I understand that I will be billed for treatment not paid by my insurance sixty days after claim submission
I authorize payment directly to my doctor. I authorize my doctor to act as my agent in helping me obtain payment from my insurance

_____ _____/_____/_____ _____

Signature of patient, parent, or guardian **Date** **Relationship to patient**

DentalHome

ELECTRONIC COMMUNICATIONS CONSENT FORM

I acknowledge that I have read and fully understand the risks, limitations, conditions of use, and instructions for use of the selected electronic communication Services more fully described in the Appendix to this consent form. I understand and accept the risks outlined in the Appendix to this consent form, associated with the use of the Services in communications with Dentalhome @ Gwinnett Place. I consent to the conditions and will follow the instructions outlined in the Appendix, as well as any other conditions that the doctor may impose on communications with parents/patients using the Services.

I acknowledge and understand that despite recommendations that encryption software be used as a security mechanism for electronic communications, it is possible that communications with the doctor or the doctor's staff using the Services may or may not be encrypted. Despite this, I agree to communicate with Dentalhome @ Gwinnett Place using these Services with a full understanding of the risk.

I acknowledge that either I or Dentalhome @ Gwinnett Place may, at any time, withdraw the option of Communicating electronically through the Services upon providing written notice which will take effect upon receipt, excluding prior communications. Any questions I had have been answered.

Dentalhome @ Gwinnett Place has offered to communicate using these means of HIPPA-Compliant electronic communication ("the Services"). My preferences are indicated below by Checking "yes" or "no":

YES☐ NO☐ EMAIL: _____ @ _____ .com

YES☐ NO☐ SOCIAL MEDIA : Facebook, Office Website, **(Dentalhome @ Gwinnett Place will not use social media for health, account, finance, insurance information)**

YES☐ NO☐ VOICEMAIL: (_____) _____ - _____

YES☐ NO☐ TEXT: (_____) _____ - _____

Description of patient information to be used or disclosed via Voicemail or Text:

YES☐ NO☐ APPOINTMENT/ RECALL REMINDERS
YES☐ NO☐ MEDICAL/DENTAL INFORMATION
YES☐ NO☐ ACCOUNT/INSURANCE/BILLING

Patient Name: _____ **Date:** ___ /___ /___

Patient Signature: _____ **Date:** ___ /___ /___

Witness: _____ **Date:** ___ /___ /___

Appendix: Risks of Using Electronic Communications

Dentalhome @ Gwinnett Place (hereafter "DH@GP") will use reasonable means to protect the security and confidentiality of information sent and received using the Services ("Services" is defined in the attached Consent to Use Electronic Communications). However, because of the risks outlined below, DH@GP cannot guarantee the security and confidentiality of electronic communications:

- Use of electronic communications to discuss sensitive information can increase the risk of such information being disclosed to third parties.
- Despite reasonable efforts to protect the privacy and security of electronic communication, it is not possible to completely secure the information.
- Employers and online services may have a legal right to inspect and keep electronic communications that pass through their system.
- Electronic communications can introduce malware into a computer system, and potentially damage or disrupt the computer, networks, and security settings.
- Electronic communications can be forwarded, intercepted, circulated, stored, or even changed without the knowledge or permission of CPD or the parent/legal guardian.
- Even after the sender and recipient have deleted copies of electronic communications, back-up copies may exist on a computer system.
- Electronic communications may be disclosed in accordance with a duty to report or a court order.
- Videoconferencing using services such as Skype or FaceTime may be more open to interception than other forms of videoconferencing.

If the email or text is used as an e-communication tool, the following are additional risks:

- Email, text messages, and instant messages can more easily be misdirected, resulting in increased risk of being received by unintended and unknown recipients.
- Email, text messages, and instant messages can be easier to falsify than handwritten or signed hard copies. It is not feasible to verify the true identity of the sender, or to ensure that only the recipient can read the message once it has been sent.

Conditions of using the Services

- While DH@GP will attempt to review and respond in a timely fashion to your electronic communication, DH@GP cannot guarantee that all electronic communications will be reviewed and responded to within any specific period of time. The Services will not be used for medical emergencies or other time-sensitive matters.
- If your electronic communication requires or invites a response from DH@GP and you have not received a response within a reasonable time period, it is your responsibility to follow up to determine whether the intended recipient received the electronic communication and when the recipient will respond.
- Electronic communication is not an appropriate substitute for in-person or over-the-telephone communication or clinical examinations, where appropriate, or for attending the Emergency Department when needed. You are responsible for following up on DH@GP's electronic communication and for scheduling appointments where warranted.
- Electronic communications concerning diagnosis or treatment may be printed or transcribed in full and made part of your medical record. Other individuals authorized to access the medical record, such as staff and billing personnel, may have access to those communications.

Appendix, cont'd

- DH@GP may forward electronic communications to staff and those involved in the delivery and administration of your care. DH@GP might use one or more of the Services to communicate with those involved in your care. The Physician will not forward electronic communications to third parties, including family members, without your prior written consent, except as authorized or required by law.
- You agree to inform DH@GP of any types of information you do not want sent via the Services, in addition to those set out above. You can add to or modify the above list at any time by notifying DH@GP in writing. • Some Services might not be used for therapeutic purposes or to communicate clinical information. Where applicable, the use of these Services will be limited to education, information, and administrative purposes.
- DH@GP is not responsible for information loss due to technical failures associated with your software or internet service provider.

Instructions for communication using the Services

To communicate using the Services, you must:

- Reasonably limit or avoid using an employer's or other third party's computer.
- Timely inform DH@GP of any changes in the parent/legal guardian's email address, mobile phone number, or other account information necessary to communicate via the Services.

If the Services include email, instant messaging and/or text messaging, the following applies:

- Include in the message's subject line an appropriate description of the nature of the communication (e.g. "prescription renewal"), and your full name in the body of the message.
- Review all electronic communications to ensure they are clear and that all relevant information is provided before sending to DH@GP
- Ensure that DH@GP is aware when you receive an electronic communication from DH@GP, such as by a reply message or allowing "read receipts" to be sent.
- Take precautions to preserve the confidentiality of electronic communications, such as using screen savers and safeguarding computer passwords.
- Withdraw consent only by email or written communication to DH@GP
- If you or your child require immediate assistance, or if your child's condition appears serious or rapidly worsens, you should not rely on the Services. Rather, you should call DH@GP's office or take other measures as appropriate, such as going to the nearest Emergency Department or urgent care clinic.
- Other conditions of use in addition to those set out above: (parent/legal guardian to initial)

I have reviewed, understand and accept the risks, conditions and instructions described in this Appendix:

Patient Name: _____ Date: ____ /____ /____

Patient Signature: _____ Date: ____ /____ /____

Witness: _____ Date: ____ /____ /____