PATIENT REGISTRATION

ID: Chart ID: (Required Information)

First Name:_____ Last Name:_____ Middle Initial:_____

Preferred Name:_____

Patient is : □ Responsible Party □ Policy Holder

Responsible Party: (if someone other than the patient)

First Name:_____ Last Name:_____ Middle Initial:_____

Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____-_____-_____ Work Phone:_____-_____-_____ Cell Phone:_____-_____-_____

Birth date:_____/_____/_____ Social Security #:_____ Drivers Lic#& State:_____

○ Responsible Party is also Policy Holder for Patient ○ Primary Policy Holder ○ Secondary Policy Holder

Patient Information:

Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____-_____-_____ Work Phone:_____-_____-_____ Cell Phone:_____-_____-_____

Sex: ○ Female ○ Male Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth date:_____/_____/_____ Social Security #:_____ Drivers Lic#& State:_____

E-mail:_____ □ I would like to receive email correspondences

Patient Information (section 2):

Employment Status: ○ Full Time ○ Part Time ○ Self Employed ○ Retired ○ Unemployed

Student Status: ○Full Time ○ Part Time

Preferred Pharmacy:_____ Pharmacy Phone #:_____

Emergency Contact:_____ Emergency #:_____

Primary Insurance Information:

Name of Insured:_____ Relationship to Insured: ○Self ○Spouse ○Child ○ Other

Member ID:_____ Group ID #:_____

Insured Social Security #:_____ Insured Birth date:_____

Employer:_____ Insurance Company:_____

Secondary Insurance Information: (If Applicable)

Name of Insured:_____ Relationship to Insured: ○Self ○Spouse ○Child ○ Other

Member ID:_____ Group ID #:_____

Insured Social Security #:_____ Insured Birth date:_____

Employer:_____ Insurance Company:_____

Gentle Dental Care

Patient Name: _____ Date: _____

1. Do you have a primary care physician (PCP)? If yes please include name and phone number. ◌ Yes ◌ No If yes _____
2. Have you ever been hospitalized or had a surgical operation? ◌ Yes ◌ No If yes _____
3. Have you ever had a head or neck injury? ◌ Yes ◌ No If yes _____
4. Do you use recreational drugs? ◌ Yes ◌ No If yes _____
5. Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◌ Yes ◌ No If yes _____
6. Do you use any nicotine products?

☐ No ☐ Cigarettes ☐ Vape ☐ Dip

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Metal
☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics ☐ Ibuprofen

Other Allergies (Including Food Allergies) ◌ Yes ◌ No If yes _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	◌ Yes ◌ No	Hemophilia	◌ Yes ◌ No	Radiation Treatments	◌ Yes ◌ No	Alzheimer's Disease	◌ Yes ◌ No
Diabetes	◌ Yes ◌ No	Anaphylaxis	◌ Yes ◌ No	Drug Addiction	◌ Yes ◌ No	Hepatitis B or C	◌ Yes ◌ No
Renal Dialysis	◌ Yes ◌ No	Anemia	◌ Yes ◌ No	Rheumatic Fever	◌ Yes ◌ No	Angina	◌ Yes ◌ No
High Blood Pressure	◌ Yes ◌ No	Arthritis/Gout	◌ Yes ◌ No	Epilepsy or Seizures	◌ Yes ◌ No	High Cholesterol	◌ Yes ◌ No
Artificial Heart Valve	◌ Yes ◌ No	Excessive Bleeding	◌ Yes ◌ No	Shingles	◌ Yes ◌ No	Artificial Joint	◌ Yes ◌ No
Excessive Thirst	◌ Yes ◌ No	Hypoglycemia	◌ Yes ◌ No	Sickle Cell Disease	◌ Yes ◌ No	Asthma	◌ Yes ◌ No
Fainting Spells/Dizziness	◌ Yes ◌ No	Sinus Trouble	◌ Yes ◌ No	Frequent Cough	◌ Yes ◌ No	Kidney Problems	◌ Yes ◌ No
Stomach/Intestinal Disease	◌ Yes ◌ No	Breathing Problems	◌ Yes ◌ No	Frequent Headaches	◌ Yes ◌ No	Stroke	◌ Yes ◌ No
Low Blood Pressure	◌ Yes ◌ No	Cancer	◌ Yes ◌ No	Glaucoma	◌ Yes ◌ No	Lung Disease	◌ Yes ◌ No
Thyroid Disease	◌ Yes ◌ No	Chemotherapy	◌ Yes ◌ No	Seasonal Allergies	◌ Yes ◌ No	Mitral Valve Prolapse	◌ Yes ◌ No
Chest Pains	◌ Yes ◌ No	Heart Attack/Failure	◌ Yes ◌ No	Osteoporosis	◌ Yes ◌ No	Tuberculosis	◌ Yes ◌ No
Cold Sores/Fever Blisters	◌ Yes ◌ No	Heart Murmur	◌ Yes ◌ No	Pain in Jaw Joints	◌ Yes ◌ No	Congential Heart Disorder	◌ Yes ◌ No
Heart Pacemaker	◌ Yes ◌ No	Mouth Ulcers	◌ Yes ◌ No	Heart Trouble/Disease	◌ Yes ◌ No	Anxiety Disorder	◌ Yes ◌ No

Have you ever had any illness, disease or medical condition not listed above? ◌ Yes ◌ No If yes _____

Please list all medications you are currently taking. This includes prescription, over-the-counter, supplments, recreational or controlled drugs.

Any additional comments?

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian

X _____ Date: _____

Welcome to Gentle Dental Care – Georgia Dental Implant Center. Please fill out the following survey to give us a better idea of your initial needs and goals.

Name: _____ Date: _____

What is the reason for your visit today? _____

How did you hear about us? _____

When was your last visit to a dentist? _____

When was your last dental cleaning? _____

Have you ever had difficulties with previous dental treatments? ☐ Yes ☐ No

If so explain: _____

How many times a *day* do you brush your teeth? _____

How many times a *week* do you floss? _____

Have you ever had a deep cleaning (also called scaling and root planning)? ☐ Yes ☐ No

If so when was this done? _____

Please check below if you have any of the following:

- ☐ Currently in pain
- ☐ Bleeding or swollen gums
- ☐ Pain, clicking or popping in jaws
- ☐ Clenching or grinding your teeth
- ☐ Wear a night guard
- ☐ Partials or dentures
- ☐ Dry mouth
- ☐ Gag easily or difficulty swallowing
- ☐ Frequent oral ulcers
- ☐ Sensitive teeth
- ☐ History of braces
- ☐ Bad breath

Are you interested in Invisalign® or teeth whitening? ☐ Yes ☐ No

Are there any other concerns you have that you would like to discuss today? _____

_____

_____

_____

Gentle Dental Care

HIPAA Notice of Privacy Practices

This notice describes how your personal, dental and medical information may be used, disclosed and how you can get access to this information. Please review it carefully.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatments, payment for services and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information (PHI). PHI is information about you, including demographic information, that may identify you and that relates to your past, present or future oral and physical condition and related health care services.

USES AND DISCLOSURES of PROTECTED HEALTH INFORMATION

Your PHI may be used and disclosed by your dentist, the office & clinical staff and others outside our offices that are involved in your care and treatment for the purpose of providing dental services to you, to pay your dental care bills, to support the operation of the dentist's practice and any other use required by law.

TREATMENT: We will use and disclose your PHI to provide, coordinate or manage your dental care and any related service. This includes the coordination or management of your dental care to a third party. For example we would disclose your PHI, as necessary, third party payer, a dental lab, or specialty office that you have been referred to, that provides services to you. Only information that will be disclosed is that which is required to diagnose or treat you.

PAYMENT: Your PHI will be used, as needed to obtain payment for your dental services. Your PHI will be shared with your insurance carrier or any outside service necessary to collect payment for your dental services.

HEALTH CARE OPERATIONS: We may use or disclose, as needed, your PHI in order to support the business activities of your dentist practice. These activities include, but are not limited to, quality assessment activities, employee review activities, staff training, licensing and conducting or arranging for other business activities. We may use a sign in sheet at registration where you may be asked to sign your name and indicate your doctor; we may also call your name out in the reception room when your doctor or hygienist is ready to see you. We may also use your PHI, as necessary, to contact you to remind you of your upcoming appointment(s).

We may disclose your PHI in the following situations without your authorization. The situations include: as required by law, Public Health Issues; Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration Requirements: Legal Proceedings; Law Enforcements; Military Activity and National Security; Workers' Compensation; Under the law, we must disclose to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164-500.

Patient's authorization to release information to: I, _____, authorize the release of my PHI to the following: _____

_____

I understand that unless listed above NO PHI can or will be released, under any circumstance unless listed above as an exception. Before any information may be release to a spouse, sibling, or friend they must be listed above or the patient listed above must notify the office IN WRITING of authorization to release your PHI.

I have read and understand the above statements.

_____ _____

Patient/or Guardian Date

Insurance Disclaimer

As a service to our patients, our practice accepts most dental insurance programs, including non-managed care and indemnity (traditional). We are not part of any managed care network, DMO or DHMO plans. Our accounting staff will prepare all the necessary forms for your dental benefits. However, we remind you that your specific policy is an agreement between you and your insurance company. **Please keep in mind that you are responsible for your total obligation should your insurance benefits result in less coverage than anticipated.** Our staff will gladly submit a pre-treatment estimate to your insurance company so that you will know what your benefits will be.

The fees charged for services rendered to those who are insured are the usual and customary fees charged to all our patients for similar services. Your policy may base its allowances on a fixed fee schedule, which may or may not coincide with our usual fees. You should be aware that different insurance companies vary greatly in the types of coverage available. Also, some companies take care of claims promptly while others delay payment for several months. All co-payments must be made at time of service. Patient financing is available with approved credit with third party vendors.

I understand this statement.

Signature_____ Date_____

Gentle Dental Care and Georgia Dental Implant Center
Financial Policy

1. Payment is due at time of service for all services.
2. Failure to notify us at least 24 hours in advance of canceling or rescheduling an appointment may result in a **BROKEN APPOINTMENT FEE** of $35.00.
3. Any dishonored check will result in a $35.00 return check charge.
4. If your balance becomes 60 days delinquent, your account is subject to collections and you will be responsible for all costs associated with collecting the balance.
5. **Payment options**: Full payment is due at time of service unless other arrangements are made by our staff. We do not offer monthly payments for treatment.
    a. Cash or Check
    b. All Major Credit Cards – Visa, Mastercard, Discover, Amex
    c. Wells Fargo Health Advantage, Care Credit, and Health Credit Services: these 3rd party financing options give you convenient low monthly payment options so you can get the procedure you want now. This involves a simple one page application and immediate approval online. There are no up-front costs, no pre-payment penalties and no annual fees.
6. **Insurance Cases**
    a. For cases covered by insurance, all co-payments are due at time of service.
    b. It is your responsibility to confirm that our doctors participate in your insurance plan. If you see one of our doctors that is not on your plan, you are responsible for all charges in full.
    c. Insurance coverages are **estimates only**. You will be responsible for all charges not covered by your insurance plan.
7. **Dental Records**
    All dental records requests must be in writing and received 72 hours prior to the date needed. Records over 10 pages will be mailed (NOT FAXED) and an administrative fee will be assessed to cover the time and expense of reproducing the documents.
8. **Surgery Cancellation Policy**
    We understand that a situation may arise that could force you to reschedule, postpone, or cancel your surgery. Please understand that such changes affect not only your surgeon and staff, but other patients as well. We require a **$100 appointment deposit** for procedures valuing over $2000 or more than 2 hours in duration. Failure to provide us with at least 72 hours of notice when canceling or rescheduling such an appointment may result in the forfeit of your deposit. We appreciate the courtesy of notification as early as possible in order to make time available to other patients.

Signed: _____ Date: _____