WELCOME!

We recognize you had a choice and thank you for choosing our dental healthcare team! Your information is confidential. To help us better assist you, please print and complete all spaces. Periodically you will be asked to update your information. This replaces all previous provided.

PATIENT INFORMATION (CONFIDENTIAL)

Date________________ Birth Date_______/_______/________ SS# ________/_______/___________

Name__________________/______/____/_____________

First MI Last Suffix Male / Female

Address______________________________City________________, GA Zip Code_______________

Home Phone ( )__________________ Cell ( )________________Work ( )_______________

Emergency Contact _______________________________Phone ( ) ___________________________

Is anyone authorized to discuss your account other than you, the patient? Yes________ No_________

If yes, whom?_____________________________ Relationship to patient_________________________

How did you hear about us?____

Your email address?____

RESPONSIBLE PARTY – LEAVE BLANK IF SAME AS PATIENT

Name of person responsible for Account____

Is the responsible party a patient in our office? Yes _____________________ No__________________

Date________________ Birth Date_______/_______/________ SS# ________/_______/___________

Name__________________/______/____/_____________

First MI Last Suffix Male / Female

Home Phone ( )__________________ Cell ( )________________Work ( )_______________

PATIENT MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, the mouth is part of the entire body. Health problems that you may have or medicine that you may be taking could have an important inter-relationship with the dentistry you will receive. **Providing incorrect and/or withholding important health information can be dangerous to your health.**

Are you under a physician's care now?	Y	N
Have you ever been hospitalized or had a major operation?	Y	N
Have you ever had a serious neck injury?	Y	N
Do you take or have you taken Phen-Fen or Redux?	Y	N
Are you on a special diet?	Y	N
Do you use any type of tobacco?	Y	N
Do you use any controlled substance?	Y	N
WOMEN: Are you pregnant /trying to get pregnant?	Y	N

Are you nursing ? Y N Are you taking oral contraceptives? Y N

<u>Are you allergic to any medicine</u>? If so, please list all allergies:
Please list all medications, herbal supplements, vitamins you are taking:

Please circle any of the following you have, or have had:

AIDS/HIV Positive Chest Pains	Genital Herpes	Low Blood Sugar	
Alzheimer's	Cold Sores/Fever Blisters	Glaucoma	Lung Disease
Anaphylaxis	Convulsions	Hay Fever/Allergies	*Mitral Value Prolapse
Anemia	Cortisone Meds	Heart Problems	Psychiatric Care
Arthritis/Gout	Diabetes	*Heart Pace Maker	Renal Dialysis
*Artificial Heart Value	Drug Addiction	Hemophilia	*Rheumatic Fever
*Artificial Joint/Limb	Emphysema /COPD	Hepatitis A/B/C	Rheumatism
Asthma	Epilepsy/Seizures	Herpes	Scarlet Fever
Blood Disease	Excessive Bleeding	High Blood Pressure	Shingles
Breathing Problems	Fainting/Dizziness	Irregular Heartbeat	Sickle Cell Disease
Bruise Easily	Frequent Cough	*Joint Replacement	Stomach/Intestinal
Cancer	Frequent Headaches	Kidney Problems	STD
Chemo/Radiation	Frequent Diarrhea	Liver / Jaundice	Stroke

*Please advise us of any illness not listed above. Some conditions require pre-medication. Please consult your personal physician prior to treatment to see if this applies to you.

PATIENT DENTAL HISTORY

Name of previous Dentist?__________________________________ City____________________State___________

Date of last cleaning? ___________ Date of last exam? _________________Date of last X-rays _____________

Purpose of your visit today? ____

How often do you brush your teeth?_________________ How often do you floss your teeth?__________________

Please circle the appropriate answers to the following questions with YES (Y) NO (N) DON'T KNOW (DN)

1.	Have you made regular dental visits?	Y	N	DN
2.	Have you lost any teeth or had any removed	Y	N	DN
3.	If so, have they been replaced?	Y	N	DN
4.	Have you ever had past unpleasant dental care?	Y	N	DN
5.	Do you experience dry mouth?	Y	N	DN
6.	Do your gums bleed?	Y	N	DN
7.	Are your teeth sensitive to hot/cold/sweet/sour?	Y	N	DN
8.	Do you feel pain in your teeth?	Y	N	DN
9.	Do you have sores/lumps in/near your mouth?	Y	N	DN
10.	Do you bite your lips/gums frequently?	Y	N	DN
11.	Have you had prolonged bleeding following extractions?	Y	N	DN
12.	Have you ever had braces?	Y	N	DN
13.	Do you currently wear dentures/partials?	Y	N	Date replaced?_________
14.	Have you ever received oral hygiene instructions?	Y	N	DN
15.	Do you have difficulty chewing?	Y	N	DN
16.	Do you have difficulty opening/closing your mouth?	Y	N	DN
17.	Do you grind your teeth?	Y	N	DN
18.	Is there anything you would like to discuss today?	Y	N	DN

CONSENT FOR TREATMENT

You hereby authorize County Dental Providers, Inc., and his/her designated staff to take x-rays, photographs, models and any other diagnostic aids considered appropriate by the doctor to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives and other medications as necessary. You fully understand that using anesthetic agents embodies certain risks and that certain dental procedures can have inherent and potential risks, and that you can ask for a complete recital of any possible complications.

HIPPA PRIVACY PRACTICES

OUR LEGAL DUTY - We are required by applicable law to maintain the privacy of your protected health information. We are also required to provide you this notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice took effect April 14, 2003, and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this notice at any time provided such changes are permitted by applicable law, effective for all protected health information that we maintain, including medical information we created or received before we made the changes. We are happy to provide you with additional copies of this notice if requested.

Uses and Disclosures of Protected Health Information: We will use and disclose your protected health information about you for your treatment, payment, health care operations, to provide, coordinate or manage your healthcare and any related services, including a third party. These may include, but are not limited, and at the request of your physician, to a doctor, home health agency, specialist, laboratory, or to whom you have been referred to ensure the necessary information has been provided to diagnose or treat you.

AUTHORIZATION and RELEASE

You hereby authorize the release of any information, including diagnostic and records of treatment and examination rendered to my insurance company. If need be, you hereby authorize another party to bring your minor child in for treatment. This person must be a minimum of 18 years old and must remain in the office during treatment at all times.

DIRECT PAYMENT FROM YOUR INSURANCE COMPANY

If your insurance is the type that sends you, the patient, payment directly to you, it is imperative that monies due to Country Dental Providers be forwarded to us upon receipt of payment from your insurance company. Failure to do so can result in legal actions against you.

DENTAL TREATMENT CONSENT FORM

Please read and initial the items and sign at the bottom of form. Patient's Name:_______________________________________

1. **X-RAYS** - (Initials____________)
2. **DRUGS and PESCRIPTIONS** – I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction.) (Initials___________)
3. **CHANGES IN TREATMENT PLAN** - I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination; the most common being root canal therapy following restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary upon my approval (Initials____________)
4. **REMOVAL OF TEETH** – Alternatives to removal have been explained to me (root canal therapy, crowns, periodontal surgery, etc.) and I authorize the dentist to remove the following teeth and others necessary for reasons in paragraph #3. I understand removing teeth does not always remove the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (Paresthesia) that can last for an indefinite period of time (days or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility (Initials___________.)
5. **CROWNS, BRIDGES AND CAPS –** I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge or cap (including shape, fit size and color) will be before cementation. (Initials___________.)
6. **PARTIAL DENTURES** – I realize that partial dentures are artificial, constructed of plastic, metal and/or porcelain. The problems of wearing these appliances have been explained to me, including looseness, soreness and possible breakage. I realize the final opportunity to make changes in my new partial (including shape, size, fit, placement and color) will be the "teeth in wax" try-in visit. I understand that most partials require adjustments and/or relining approximately three to twelve months after initial placement. An adjustment is at no charge, however, the cost for a reline is not included in the initial denture fee and is an additional fee. (Initials _______________.)
7. **ENDODONTIC TREATMENT (ROOT CANAL**) – I realize there is no guarantee that root cancel treatment will save my tooth, and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extend through the root, which does not necessarily affect the success of the treatment. I understand that occasional surgical procedures may be necessary following root canal treatment (apicoectomy.) (Initials __________)
8. **FILLINGS –** I understand that care must be exercised in chewing on filling especially during the first 24 hours to avoid breakage. I understand that a more expensive filling that initially that was initially diagnosed may be required due to additional decay. M I understand that significant sensitivity is a common after effect of a newly placed filling. (Initials__________.)
9. **PERIODONTAL LOSS (TISSUE & BONE**) – I understand removal of microbial plaque and calculus is necessary to establish periodontal health. The first step in the treatment of periodontitis involves nonsurgical cleaning below the gum line with a procedure called scaling and debridement.). This procedure involves use of specialized curettes to mechanically remove plaque and calculus from below the gum line, and may require multiple visits and local anesthesia to adequately complete. In addition to initial scaling and root planning, it may also be necessary to adjust the occlusion (bite) to prevent excessive force on teeth that have reduced bone support. Also, it may be necessary to complete any other dental needs, such as replacement of rough, plaque-retentive restorations, closure of open contacts between teeth, and any other requirements diagnosed at the initial evaluation. Further, I understand that once successful periodontal treatment has been completed, with or without surgery, an ongoing regimen of "periodontal maintenance" is required. This involves regular checkups and detailed cleanings every three months to prevent repopulation of periodontitis-causing microorganism, and to closely monitor affected teeth so early treatment can be rendered if disease recurs. Usually, periodontal disease exists due to poor plaque control, therefore if the brushing techniques are not modified, a periodontal recurrence is probable.
10. **PARTIAL DENTURES** – I understand the wearing of partials is difficult. Sore spots, altered speech and difficulty in eating are common problems. Immediate partial (placement of dentures immediately after extractions) may be painful, may require considerable adjusting and several relines. (Reline cost is not included in the cost of a partial denture.) I understand it is my responsibility to return for delivery of my partial dentures and failure to keep my delivery appointment may result in poorly fixed partial dentures. If a remake is required due to my delay of more than 30 days, there will be additional charges. (Initials _________________.)

    I understand that dentistry is not an exact science and therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction and I consent to the proposed treatment.

    Signature of Patient ____Date ___________________________________

    Signature of Patient/Guardian if patient is minor_____________________________ Date ___________________________________
11. understand that significant sensitivity is a common after effect of a newly placed filling. (Initials__________.)

FINANCIAL and CANCELLATION POLICY

Payment of all deductibles, all co-pays, and any other *authorized* charged incurred are due at the time that service is rendered. This office accepts approved **PPO** insurances only. Insurance payments are estimates and additional costs may be due. In the event your insurance does not pay your claim within 60 days, the entire balance remains is your responsibility.

Our office makes every attempt to remind you of your scheduled appointment. If you need to cancel or reschedule, we require a 24 notice. Failure to notify us will result in a $50.00 fee to you which must be paid prior to rescheduling your next dental appointment. For your convenience, we accept cash, the below credit/debit cards and Flex Spending Cards. We do not accept checks.

By signing below, I acknowledge that I have read and understand your policies. I believe the information I have provided is true and correct to the best of my knowledge. I understand it is my responsibility to inform this office of any change in my name, address, insurance and/or medical status <u>prior</u> to my treatment.

Please list who is allowed access to your account____

Signature of Patient (or parent/guardian if minor)____

Print Name of Patient (or parent/guardian if minor)____

Relationship_____________________________________ **Today's Date:**___________________________

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