Druid Hills Dental

Thank you for selecting our dental healthcare team! We will strive to provide you with the best dental care. To help us meet all your dental healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask us—we will be happy to help.

Today's Date_____

Patient Information

Name_____ Nickname_____

Date of Birth_____ Sex_____ Identify as:_____

Address_____City, State, Zip_____

Home Phone_____ Work Phone_____

Cell Phone_____ Social Security #_____

Email_____

Check appropriate box Minor [ ] Single [ ] Married [ ]

Preferred Pharmacy _____

Referred to our office by_____

Responsible Party Guarantor

Name of Responsible Party (Guardian)_____ Social Security #_____

Address (if different than patient)_____ City, State, Zip_____

Occupation_____Employer_____

Employer's Address_____ Phone_____

How would you like to pay for your portion of the provided services? Cash [ ] Check [ ] Credit Card [ ] Other [ ]

Emergency Contact

Name of relative or person NOT LIVING with you_____

Relationship to you_____

Address_____

Phone_____

Children or Minors

Because (name of child)_____is a minor, it is necessary that signed permission be obtained from a parent or guardian before any dental services are rendered. Such authorization is hereby granted. Furthermore, I agree to be responsible for any bills incurred on behalf of this child during his/her dental treatment.

Signature_____ Date_____

Patient Medical History

Druid Hills Dental

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ☐ Yes ☐ No If yes _____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes _____

Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes _____

Are you taking any medications, pills, or drugs? ☐ Yes ☐ No If yes _____

Do you, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No If yes _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ Yes ☐ No

If yes _____

Are you on a special diet? ☐ Yes ☐ No Do you use controlled substances? ☐ Yes ☐ No

Do you or have you ever used tobacco? ☐ Yes ☐ No

Women: Are you

Pregnant/Trying to get pregnant? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Are you allergic to any of the following? ☐ Aspirin ☐ Acrylic ☐ Codeine ☐ Latex ☐ Local Anesthetics

☐ Metals (Gold, Stainless steel) ☐ Penicillin ☐ Sulfa Drugs ☐ Other Please explain:_____

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

AIDS/HIV Positive	☐ Yes ☐ No	Excessive thirst	☐ Yes ☐ No	Mitral valve prolapse	☐ Yes ☐ No
Alzheimer's Disease	☐ Yes ☐ No	Fainting Spells/Dizziness	☐ Yes ☐ No	Osteoporosis/osteopenia	☐ Yes ☐ No
Anaphylaxis	☐ Yes ☐ No	Frequent cough	☐ Yes ☐ No	Pain in Jaw Joints	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Frequent Diarrhea	☐ Yes ☐ No	Parathyroid Disease	☐ Yes ☐ No
Angina	☐ Yes ☐ No	Frequent headaches	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No
Arthritis/Gout	☐ Yes ☐ No	Genital Herpes	☐ Yes ☐ No	Radiation treatments	☐ Yes ☐ No
Artificial heart valve	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Recent Weight Loss	☐ Yes ☐ No
Artificial joint	☐ Yes ☐ No	Hay fever	☐ Yes ☐ No	Renal dialysis	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Heart Attack/failure	☐ Yes ☐ No	Rheumatic fever	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Rheumatism	☐ Yes ☐ No
Blood transfusion	☐ Yes ☐ No	Heart pacemaker	☐ Yes ☐ No	Scarlet fever	☐ Yes ☐ No
Breathing problems	☐ Yes ☐ No	Heart trouble/Disease	☐ Yes ☐ No	Shingles	☐ Yes ☐ No
Bruise Easily	☐ Yes ☐ No	Hemophilia	☐ Yes ☐ No	Sickle Cell Disease	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Hepatitis (Type_____)	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Sleep Apnea	☐ Yes ☐ No
Chest pains	☐ Yes ☐ No	High Blood pressure	☐ Yes ☐ No	Spina Bifida	☐ Yes ☐ No
Cold sores/Fever blisters	☐ Yes ☐ No	High cholesterol	☐ Yes ☐ No	Stomach/intestinal disease	☐ Yes ☐ No
Congenital heart disorder	☐ Yes ☐ No	Hives, rash, hay fever	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Convulsions	☐ Yes ☐ No	HPV(Human Papilioma Virus)	☐ Yes ☐ No	Swelling of Limbs	☐ Yes ☐ No
Cortisone medication	☐ Yes ☐ No	Hypoglycemia	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Irregular Heartbeat	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Drug Addiction	☐ Yes ☐ No	Kidney Problems	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Easily Winded	☐ Yes ☐ No	Leukemia	☐ Yes ☐ No	Tumor, abnormal growth	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Liver disease	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Epilepsy or seizures	☐ Yes ☐ No	Low blood pressure	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Excessive Bleeding	☐ Yes ☐ No	Lung disease	☐ Yes ☐ No	Yellow Jaundice	☐ Yes ☐ No

If joint replacement, please list your Doctor and year completed_____

If cancer, please list your type and year diagnosed_____

Do you use a CPAP for sleep apnea? ☐ Yes ☐ No

Have you had a sleep study test within 2 years? ☐ Yes ☐ No If yes, when _____

Have you ever had any serious illness not listed? ☐ Yes ☐ No If yes _____

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 or Parent/Guardian _____ Date _____

HIPAA Policy

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

Serving you with professionalism and accuracy is one of our most important goals. At Druid Hills Dental, we're also legally charged to protect your private health information (PHI).

Here are the things we may do with your information:

- Submit claims, x-rays, periodontal charts and notes to your insurer, in an attempt to receive payment for services rendered to you.
- Share your PHI with our laboratory sources, as they create/fabricate restorations that are custom-made for you.
- Share your PHI with specialists or others who may give a second opinion or agree to handle the next step in your treatment, if it's outside the scope of our expertise.
- Use your PHI to initiate a complaint to the State Insurance Commissioner, on your behalf.
- Transfer your records, with your permission, to other entities (another dentist or specialist, or a third party).

These actions are governed by the Department of Health and Human Services. If any other uses or disclosures not mentioned above are needed, **information will only be released with your written authorization.** This includes communication with:

Your spouse or significant other
Family members or friends listed as emergency contacts
Your parent(s) or guardian(s); *effective for any person over the age of 18*

You must sign below to allow us to discuss your PHI (including your account balance) with any of the above. Written authorization may be revoked at any time, as provided for by law.

Please list any person we may discuss your dental treatment or billing questions with:

Name _____ Relationship: _____ Phone Number:_____
Name _____ Relationship: _____ Phone Number:_____
Name _____ Relationship: _____ Phone Number:_____
Name _____ Relationship: _____ Phone Number:_____
Name _____ Relationship: _____ Phone Number:_____

If you have any questions or comments regarding your protected health information, feel free to call our office.

I have read and understand the above notice of privacy practice.

Signature: _____ Date: ____/____/____

Print Name: _____

Druid Hills Dental

Authorization for Signature on File

Release of Information—Financial Responsibility—Authorization for Payment

I (name of patient) _____ and/or (name of insured)_____ hereby authorize _____to affix my name to any and all claims or documents as related to any and all health benefits due me and my dependents through my employment with (name of employer) _____. I hereby authorize payment of dental benefits otherwise payable to me directly to the office above. I have reviewed the treatment plan and fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize the release of any information relating to the claim.

Signature of Patient (parent or guardian, if minor)_____

Signature of Insured_____ Today's date_____

This "Authorization" will be valid from this date and shall expire in one year. Expiration date_____

A photocopy of this document may act as an original.

Release of Information For Photography

I,_____, hereby assign and allow Druid Hills Dental the right and permission to use and publish photographs taken of me while at the office for marketing and promotional purposes. I hereby release Druid Hills Dental and staff from any and all liability from such use and publication.

I understand my name will only be listed with first name and last initial.

☐ I do not allow my permission for photographs to be used by Druid Hills Dental.

Signature of Patient (parent or guardian, if minor)_____

Signature of Insured_____ Today's date_____

Financial Policy

Please read and sign at the bottom, acknowledging that you were informed of these policies. Let us know if you have any questions about our Office Policies. Thank you.

Thank you for choosing Druid Hills Dental to serve your dental care needs. We provide high-quality dental care to our patients and are committed to your success in every treatment modality. Please understand that your financial obligation is considered a part of your treatment. We strive to maintain positive relationships, and financial communication and expectations are essential to them. Please be aware of the following policies:

- On your first visit we expect you to supply our office with your insurance information and photo ID card. If any changes should occur during the time you are patient, it is your responsibility to inform our office with any changes. Our office will not be responsible for claims submitted to insurance companies by which you are no longer covered.
- All patients are required to pay their portion for services rendered at each visit. If the patient is a member of a PPO plan, they are required to pay their co-payment at each visit, along with an annual deductible, if applicable.
- **Patients are responsible for the full payment of their portion of any lab-created restoration prior to its delivery. Please be prepared to pay prior to being seated.** If insurance pays less than expected, or the service is uncovered, the balance will revert to the patient. While we accept most insurance plans, and are happy to aid in submission of your claims, it is your responsibility to read your policy and be aware of services covered or not covered by your individual plan.
- As a courtesy, we will gladly bill your insurance when you provide us with the current information and any necessary forms. Often, we are able to confirm your insurance benefits and coverage prior to your appointment and estimate your portion of the bill. We ask that you either pay your portion of the bill at the time of service, or that you engage in a written financial agreement, with defined times and amounts of payments, at the time of service. Even though you may have an insurance claim pending, you are responsible for the outstanding balance of your account until it is paid in full. We are not responsible for collecting an insurance claim after 90 days; please note that in this case, the full balance reverts to the patient. We are also not responsible for negotiating denied or disputed claims.

  Insurance policies are a contract between you, your employer and the insurance carrier. Please be aware that some, and perhaps all, of the services rendered may not be covered under your individual insurance policy. You are ultimately responsible for payment of your account.
- If no payment is received on an account after two monthly statements, our office will make every effort to contact the responsible party. If the party responsible cannot be reached, a third bill will be sent indicating that “This will be the final notice for payment”. If the party fails to contact our office after receiving such notice, the account will be sent to a collection agency or taken to Justice Court for garnishment of wages.
- Financial options are available to all patients. Please feel free to ask one of our office staff.

Failed or Cancelled Appointments

If you have reserved an appointment, we kindly ask that you give us at least 24 hours’ notice for cancellations. Patients who have short notice cancelled or/or no-showed will be asked to reserve future appointments with a credit card. The charge is $30 per half hour of reserved time. This amount will either be refunded, credited to care upon your arrival, or forfeited if the appointment is abandoned. We will not offer appointments to patients who fail multiple appointments without having given us proper notice. Thank you for your understanding.

Estimates and Fees

After X-Rays and examination, you are entitled to and should ask for an estimate of fees to cover your treatment. Large treatment plans can be completed in phases. All estimates are based upon conditions viewed at the time of diagnosis and good for 90 days; unforeseen circumstances, such as pulpal therapy, further degeneration of a tooth, or cracked teeth could alter an estimated fee. It is customary to pay for dental services when they are rendered. There is a service charge on all unpaid accounts.

Delinquent Accounts

Delinquent accounts will be turned over to a Credit Reporting Collection Agency. This will obviously have a negative impact on your credit rating.

Signature of Patient (parent or guardian, if minor)_____