Welcome

Patient Information: (CONFIDENTIAL) Date:_____

First Name: _____ Middle Int: ___ Last Name: _____

Preferred Name: _____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cellular: _____

Sex: ___ Male ___ Female Marital Status: __ Married __ Single __ Divorced __ Widowed

Birth Date: _____ Social Security #: _____ Drivers License #: _____

Employment Status: __ Full Time __ Part Time __ Retired Student: __ Full Time __ Part Time

Employer: _____

Insurance Information:

Name of Insured: _____

Relationship to Patient: __ Self __ Spouse __ Child __ Other

Insured Birthdate: _____ Insured Social Security #: _____

Name of Employer: _____

Address of Employer: _____ City: _____ State: ___ Zip: _____

Insurance Company: _____ Group #: _____ Member ID#: _____

Ins Co. Address: _____ City: _____ State: ___ Zip: _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ___ YES ___ NO IF YES, COMPLETE THE FOLLOWING:

Name of Insured: _____

Relationship to Patient: __ Self __ Spouse __ Child __ Other

Insured Birthdate: _____ Insured Social Security #: _____

Name of Employer: _____

Address of Employer: _____ City: _____ State: ___ Zip: _____

Insurance Company: _____ Group #: _____ Member ID#: _____

Ins Co. Address: _____ City: _____ State: ___ Zip: _____

EMERGENCY CONTACT:

Name: _____ Relation: _____

Phone: _____

Medical History

Patient Name: _____ Birth Date: _____ Today's Date _____

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.

Primary Care Physician: _____
Please List All Previous Major Surgeries/Hospitalizations (IncludeYear): _____
Have you ever had a serious head or neck injury? _ Yes _ No If Yes: _____
Do you or have you ever taken Phen-Fen or Redux? _ Yes _ No If Yes, What dates: _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? _ Yes _ No
If Yes, What Dates: _____
Are you on a special Diet? _ Yes _ No
Do you use tobacco? _ Yes _ No

Women: Are you...
___ Pregnant/Trying to get pregnant? ___ Nursing? ___ Taking oral contraceptives?

ALLERGIES:

_Aspirin _Penicillin _Codeine _Acrylic _Metal _Latex _Sulfa Drugs
_Local Anesthetics _Other- If Yes: _____

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

- ☐ AIDS/HIV Positive
- ☐ Alzheimer's Disease
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Angina/Chest Pains
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Breathing Problems
- ☐ Bruise Easily
- ☐ Cancer:_____
- ☐ Chemotherapy
- ☐ Cold Sores/Fever Blisters
- ☐ Congenital Heart Disorder
- ☐ Convulsions
- ☐ Cortisone Medicine
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Easily Winded
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Excessive Thirst
- ☐ Fainting Spells or Dizziness
- ☐ Frequent Cough
- ☐ Frequent Diarrhea
- ☐ Frequent Headaches
- ☐ Genital Herpes
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack- _____ Year
- ☐ Heart Murmur
- ☐ Heart Pacemaker
- ☐ Heart Trouble/Disease
- ☐ Hemophilia
- ☐ Hepatitis A, B or C- _____ Type
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hives or Rash
- ☐ Hypoglycemia
- ☐ Irregular Heartbeat
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Pain in Jaw Joints
- ☐ Thyroid Disease
- ☐ Psychiatric Care
- ☐ Radiation Treatments
- ☐ Recent Weight Loss
- ☐ Renal Dialysis
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Spina Bifida
- ☐ Stomach/Intestinal Disease
- ☐ Stroke- Year _____
- ☐ Swelling of Limbs
- ☐ Tuberculosis
- ☐ Tonsillitis
- ☐ Tumors or Growths
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Jaundice

Have you ever had any serious illness not listed above? _ Yes _ No If Yes: _____

Medications

MEDICATIONS: _____

^^PLEASE LIST ALL MEDICATIONS HERE ^^ (If you have a list we can make a copy)

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing the 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 Guardian:

_____ Date _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that directly and indirectly.
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certification.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the users and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient _____

Signature _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature and acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _____ Initials: _____

Reason: _____

CONSENT FOR DENTAL TREATMENT

PATIENT NAME: _____

BIRTHDATE: _____

I give consent for myself/my child to receive dental treatment deemed necessary by the providers at Ideal Smile Dentistry. These procedures include, but are not limited to; examinations, oral prophylaxes (cleanings), fluoride treatments, sealants, restorations (composite fillings and crowns), periodontal (gum) treatments, endodontic (root canal) treatments, extractions, and the use of local anesthetics. I understand that the use of local anesthetics carries a small risk for swelling, bruising, allergic reaction, changes in pain perception or prolonged anesthesia. This consent shall be considered in effect until rescinded or revoked.

_____ _____ _____

Printed Name Relationship Date

_____ _____

Signature Witness

Ideal Smile Dentistry

CONSENT FOR PAYMENT

PAYMENT IS EXPECTED AT THE TIME SERVICE IS RENDERED. WE ACCEPT CASH, CHECK AND ALL MAJOR CREDIT CARDS.

INSURANCE:

Professional services are rendered and charged to you, not the insurance company. Please understand that the contract is between you and your insurance company therefore payment for services are your responsibility.

Our office will not enter into a dispute with your insurance company regarding your claim. The amount you are responsible to pay on the day of service is an ESTIMATE ONLY based on information provided by your insurance company. After insurance is rendered payment you will be billed for any remaining balance. If at the end of 60 days, your insurance company had not paid, you are responsible for the entire balance.

In order to honor any insurance benefits, you must provide insurance identification (insurance cards and photo ID) and we must be able to verify the current benefits available.

OFFICE FEES:.

If you present a check for insufficient funds or stop payment on an issued check, you will be charged a $60.00 processing fee.

If you must break an appointment with our office, we ask for a 24 hour notice of cancellation. If we do not receive 24 hour notice, we may charge a $50-75 fee for the scheduled appointment based on the total amount of time reserved. This fee can not be charged to your insurance company. If you repeatedly miss scheduled appointments, you may be asked to pursue treatment elsewhere. We also require all appointments be confirmed 24 hours in advance to avoid being removed from our schedule.

I HAVE READ AND UNDERSTAND THE STATEMENTS OUTLINED ABOVE.

Signed: _____ Date_____

Ideal Smile Dentistry

2979 Northlake Pkwy, Suite 100

Columbus, Ga 31909

706-257-7374

Seth Walden, DMD

Updated Policy Notice:

_____ We require a **24 hour** notice for all Cancellation/Rescheduled appointments. Failure to give notice for same day cancellations or reschedule could result in a fee and/or deposit that must be paid in advance in order to reschedule your next appointment. Our fees will range from **$50-75** depending on what kind of appointment was scheduled and previous cancellation history. Excessive same day cancellations, reschedules and no shows could result in dismissal from our practice.

_____ We require confirmation for all scheduled appointments **24 hours** prior to your appointment to avoid being removed from our schedule.

_____ We ask that you be on time for all appointments. Should you arrive more than **10 minutes** late, depending on what kind of appointment was scheduled, you may be rescheduled. If you are late more than **2 occurrences** there will be a **$50** late charge added to your account.

I acknowledge that I have read this Policy Update Notice.

_____

Signature

_____ _____

Printed Name Date