Patient Information

Patient Name: _____ **Date**:_____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ **Birth Date**:_____

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

Address: _____
Street Apartment #

_____
City State Zip Code

E-mail Address: _____

Health Information

Date of Last Dental Visit: _____ Reason for today's visit:_____

Have you ever had any of the following? Please check those that apply

☐ Allergies _____
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur/MVP
☐ Hepatitis (type:____)
☐ High Blood Pressure
☐ HIV/AIDS
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ Pregnancy (current)
Due date:_____
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Codeine Allergy
☐ Penicillin Allergy
OTHER:_____
_____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain:_____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ 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 all medications you are currently taking: _____
  _____
  _____
  _____
  _____

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 ☐ Online Reviews

☐ Dental Office ☐ Insurance List ☐ Google ☐ Work ☐ Other_____

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

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

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

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

Consent for Use and Disclosure of Health Information and Notice of Privacy Practices

Health Insurance Portability Accountability Act (HIPAA), 1996 http://www.hhs.gov/ocr/hipaa/finalreg.html

YOU ARE ENTITLED TO A COPY O F THIS CONSENT AFTER YOU SIGN IT. Please advise us if you want a copy.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and the healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected heath information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions by contacting: North Park Family Dentistry 2418 Capstone Court Columbus, GA 31909 (706)507-0606.

Right to Revoke: You will have the right to revoke this Consent at any time by providing written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I, _____ have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

North Park Family Dentistry

Financial Policy

Financial Policy:

Payment is expected at the time of service unless prior arrangements have been made. We accept cash, checks and all major credit cards. If you have questions about the fees for services you are to receive, just ask and we will be glad to help you.

Insurance Policy:

For our patients who have insurance to help with the cost of their dentistry, we offer the convenience of filing your claims for you. Please present us with your current dental insurance card at the beginning of your appointment. We are a participating, in-network provider with many dental insurance plans. We are glad to offer this service to you and help you in any way possible. In this regard we would like to offer the following tips:

1. Know your plan. If you have questions regarding what your insurance will cover, call the number on your card and ask that your benefits be explained to you. **The more you know the less likely it is that you will receive any unexpected bills.**

2. Call your insurance company or ask at the front desk, prior to your appointment, what your estimated co-payment will be. We reach this amount based on the information your insurance company gives us. **It is only an estimate**.

3. **Your co-payment is expected at the time of service**. You are responsible for any amount not covered by your plan.

I have read and agree to comply with the above financial policy as it applies to my dental treatment:

Print: _____

Sign: _____ **Date:** _____

We respect your time and ask that you respect ours as well:

We reserve the right to charge a $75 missed appointment fee for appointments canceled with less than 24 hours notice or if you are too late to your appointment for us to see you.

Sign: _____ **Date:** _____