Thank you for selecting our dental health care team! Our goal is to provide you with the best possible dental care and experience. To help us meet all of your dental needs, please fill out this form completely.

If you have questions or need assistance, please ask us - we are happy to help!

Patient Last Name: _____ Date of Birth: _____

Patient First Name: _____ Gender: _____

If child, Parent's Name: _____

Single Married Separated Divorced Minor

Address: _____ Home Phone: _____

City: _____ Work Phone: _____

State: _____ Cell Phone: _____

Zip Code: _____ Fax#: _____

EMAIL: _____

Patient SSN: _____ Parent SSN: _____

Employed By: _____ Present Position: _____

Spouse Employed By: _____ Present Position: _____

Who is responsible for payment?: _____

Emergency Contact Name: _____ Number: _____

Were you referred by someone?: _____

Other Family Members in our practice: _____

Patient Name: _____DOB: _____

Method of Payment: Visa___ MC___ Discover____ Cash____ Check___ Ins.____

Dental Insurance 1st Coverage:
Employee Name: _____ DOB: _____ SSN: _____

Employer: _____ # of Yrs with: _____

Employer Address: _____ City: _____ State: _____

Zip Code: _____ Phone Number: _____

Name of Insurance Company: _____

Member Number:_____ Group Number: _____

Dental Insurance 2nd Coverage:
Employee Name: _____ DOB: _____ SSN: _____

Employer: _____ # of Yrs with: _____

Employer Address: _____ City: _____ State: _____

Zip Code: _____ Phone Number: _____

Name of Insurance Company: _____

Member Number:_____ Group Number: _____

CONSENT:
I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care. I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.

I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services and that I am financially responsible for payment in full on all accounts with this practice. I certify that I have read and understand this information to the best of my knowledge:

Patient or Guardian Signature: _____ Date: _____

Patient Name: _____DOB: _____

Purpose of Initial Visit: _____
Are you having any dental or related problems? _____
How long since your last dental visit?_____
Last Dental X-Rays?_____ Last Teeth Cleaning? _____
Previous Dentist:_____ Phone Number: _____
How often do you brush?
Do you use Dental Floss regularly? Yes_____ No_____
Do your gums hurt or bleed? Yes_____ No_____
Have you ever had gum treatment or surgery? Yes_____ No_____
Do you worry about bad breath? Yes_____ No_____
Are any of your teeth sensitive? Yes_____ No_____
Are they sensitive to Hot_____ Cold _____ Pressure_____ Sweets_____
How do you feel about your teeth in general?_____
If you could fix one thing with your teeth, what would it be? _____
Does food get stuck in your teeth?Yes_____ No_____
Have any teeth been lost or removed? Yes_____ No_____
If Yes, When and Why? _____
Are any teeth loose, chipped or shifted? Yes_____ No_____
Do you clinch or grind your teeth? Yes_____ No_____
Does your jaw make a popping noise? Yes_____ No_____
Have you experienced soreness or pain in the muscles in your cheeks or near ear? Yes_____ No_____
Do you have frequent headaches, neck aches or shoulder aches? Yes_____ No_____
Have you had any orthodontic work? Yes_____ No_____
Do you have questions or concerns? _____

I certify that the information above is accurate and complete:

Patient or Guardian Signature: _____ Date: _____

Patient Name: _____ DOB: _____

Are you under a Physician's Care: Yes_____ No_____
Name of Physician: _____
When was last Physical Examination: _____
Do you take Vitamins or Supplements: Yes_____ No_____
Are you taking any medications or substances? Yes_____ No_____
Which ones: _____
Are you allergic to any medications or substances? Yes_____ No_____
Which ones? _____
Do you have any allergies or hives? Yes_____ No_____
Are you sensitive to latex or metal? Yes_____ No_____
Have you been treated for, or told you have, heart disease? Yes_____ No_____
Do you have a pacemaker or artificial heart valve?Yes_____ No_____
Are you aware of a heart murmur? Yes_____ No_____
Have you ever had Rheumatic Fever? Yes_____ No_____
Do you have High or Low Blood Pressure (Circle if so)
Have you ever had Chemo or Radiation for a Tumor? Yes_____ No_____
Do you have any artificial joints, screw or pins? Yes_____ No_____
Do you have an inflammatory disease such as Arthritis or Rheumatism? Yes_____ No_____
Do you have any blood disorders such as Leukemia or Anemia? Yes_____ No_____
Do you bleed excessively when cut or injured? Yes_____ No_____
Do you have any stomach issues? Yes_____ No_____
Kidney Issues? Yes_____ No_____
LIver Issues? Yes_____ No_____
Are you Diabetic? Yes_____ No_____
Do you have fainting or dizzy spells? Yes_____ No_____
Do you have seasonal allergies? Yes_____ No_____
Do you have asthma? Yes_____ No_____
Do you have epilepsy or seizures? Yes_____ No_____
Have you tested positive for HIV or AIDS? Yes_____ No_____
Have you tested positive for Hepatitis? Yes_____ No_____
Have you taken any weight loss products? Yes_____ No_____
Do you use any form of tobacco? Yes_____ No_____
Do you consume alcoholic beverages? Yes_____ No_____
If so, how many per week on average? _____
Do you use or have ever used controlled substances on a regular basis? Yes_____ No_____
Have you had psychiatric treatment? Yes_____ No_____
Are you pregnant or suspect that you might be? Yes_____ No_____
Are you using any form of Birth Control? Yes_____ No_____ Which?_____
Have you ever had a serious illness or major surgery? Yes_____ No_____
Details: _____
Do you have any medical conditions or problems not listed above? Yes_____ No_____
Details: _____

I certify that the information above is accurate and complete

Patient or Guardian Signature: _____ Date: _____

PATIENT CONSENT FORM

I understand that under the Health Insurance Portability and Accountability Act of 1996, that 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 my treatment directly or indirectly.
- Obtain payment from Third-Party providers
- Conduct normal health care operations such as quality assessments and physicians certifications.

I have been informed by you of your Notice of Privacy Practice containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such privacy practices prior to signing this consent. 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 at the address above 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 healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree, you are bound to abide by such restrictions.

I understand that I may revoke this consent at any time in writing, except to the extent that you have taken action relying on this consent.

Patient Name: _____Signature: _____

Guardian Signature: _____ Date: _____

Financial Agreement for Coweta Family Dental

Your dental health is our Number 1 concern. We do not recommend treatment based on any insurance coverage. In order to avoid any future misunderstanding, please read and sign the following:

Payment is due at the time services are rendered. For your convenience we accept Cash, Checks, MC, Visa, Discover and Insurance. Insurance benefits are determined by your employer, not the dentist. Insurance is not a guarantee of payment; insurance companies will not pay for all of the costs incurred. Your insurance policy is a contract between you and your employer. Your insurance and payment are still your responsibility. As a courtesy we will be glad to file your claim for you if you bring all required employer information. You will be expected to pay for services rendered at the time of service.

We reserve the right to charge and collect fees for broken appointments or appointments cancelled without 24 hours advance notice. The fee will be $50. Appointments are reserved exclusively for you. As a benefit to you, we may offer to move your appointment to an earlier slot if availability arises.

If a check rendered does not clear the bank and is returned to us, a fee of $35 will be added to your account balance. Payment plans and financial agreements can be entered into for comprehensive dental treatment, prior to commencing treatment. We also offer outside financing available through CareCredit.

We request that you be responsible for understanding your insurance benefits, coverage and limitations. You are responsible for any amount unpaid by your insurance provider. We allow 30 days for your insurance company to make payment. After 30 days, all inquiries and follow-up become your responsibility. Balances over 90 days unpaid may accrue a monthly finance charge and be subject to being retrieved by an outside collection agency.

Patient Name: _____Signature: _____

Guardian Signature: _____ Date: _____