PATIENT REGISTRATION AND MEDICAL HISTORY

Date_____ (PLEASE PRINT)

Patient _____
Last Name First Name Initial Preferred Name

Street Address_____ City_____ State_____ Zip_____

Home Phone (____)_____ Alt. Phone (____)_____ Email address:_____

Sex: ☐ M ☐ F Age_____ Birthdate_____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Employed by _____ Occupation_____

Employer Address _____ Work Phone (____)_____

Spouse/Parent Name _____ Spouse/Parent Birthdate _____

Employed by _____ Occupation_____

Employer Address _____ Work Phone (____)_____

Who is responsible for this account?_____ Relationship to Patient_____

Social Security # _____ Spouse/Parent Social Security #_____

Name of Dental Insurance Company _____ Group Number_____

In case of emergency, who should be notified?_____ Phone (____)_____

Whom may we thank for referring you?_____

MEDICAL HISTORY

Physician's Name _____ Date of Last Physical_____

ARE YOU ALLERGIC TO LATEX? YES or NO

Have you ever had any of the following? (check boxes that apply):

- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Circulatory Problems
- ☐ Nervous Problems
- ☐ Radiation Treatment
- ☐ Artificial Heart Valves or Joints
- ☐ Recent Weight Loss
- ☐ Back Problems
- ☐ Diabetes
- ☐ Respiratory Disease
- ☐ Epilepsy
- ☐ Headaches
- ☐ Hepatitis, Jaundice or Liver Disease
- ☐ Cancer
- ☐ Psychiatric Care
- ☐ Chronic Diarrhea
- ☐ Allergies to Anesthetics
- ☐ Allergies to Medicine or Drugs
- ☐ General Allergies
- ☐ Blood Disease
- ☐ Arthritis
- ☐ Special Diet
- ☐ Swollen Neck Glands
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ HIV / AIDS or Other Immunosuppressive Disorders
- ☐ Thyroid Disease
- ☐ Stroke
- ☐ Ulcer
- ☐ Venereal Disease
- ☐ Chemical Dependency
- ☐ Hemophilia

Do you have any drug allergies or have you ever had an adverse reaction to any medication?_____ If so, please describe _____

_____

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. ☐ Yes ☐ No

Have you ever responded adversely to medical or dental treatment?_____

Are you taking any medication at this time?_____ If so, what_____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Are you under the care of a physician? ☐ Yes ☐ No For what conditions? _____

If patient is a child, what is his/her weight? _____

(Women) Do you suspect that you are pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

Is there anything else we should know about your medical history?_____

_____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date_____ Signature_____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance with _____
Name of Insurance Company(ies)

and assign directly to Dr. _____ all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

_____ _____
Date *Signature*

MINOR/CHILD CONSENT

I, being the parent or guardian of _____ do hereby request
Name of Minor/Child
and authorize the dental staff to perform necessary dental services for my child, including but not limited to X-rays, and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

_____ _____
Date *Signature of Insured/Guardian*

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges not covered by insurance.

_____ _____
Date *Signature of Insured/Guardian*

MEDICAL HISTORY UPDATE

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications? _____ If so, what _____

_____ _____
Date *Patient Signature*

_____ _____
Date *Dentist Signature*

MEDICAL HISTORY UPDATE

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications? _____ If so, what _____

_____ _____
Date *Patient Signature*

_____ _____
Date *Dentist Signature*

Addevale Family Dentistry
210 Addevale Street, Griffin, GA 30224
770-229-1490

Financial Policy and Agreement

All payments, including insurance co-pays and deductibles, if applicable, are due and payable at the time of treatment.

PAYMENT OPTIONS:

We accept Cash, Checks, and all major Credit Cards.

We offer financing through Care Credit. They have several convenient payment options, including up to 24 months with no interest. Applications are available at the front desk, or you may visit their website at www.carecredit.com

When lab cases are involved, and there are several appointments required to complete treatment, you may split your payments between appointments. Your portion must be paid in full by the last appointment at which we insert your crown, bridge, denture or appliance.

INSURANCE:

We are happy to file insurance claims as a courtesy to our patients. **However, your policy is ultimately a contract between you and your insurance company.** As a courtesy, we will do everything we can to help you maximize your benefits, but our office holds no responsibility for payment or non-payment of your claims. **You are responsible for payment of any unpaid amounts on your account.**

We estimate your co-pays and deductibles and those must be paid at the time of treatment. **The amount you are asked to pay at the time is just an estimate and not a guarantee.** If your insurance pays a different amount than what was estimated, you will be billed for the difference. Any over payments will be refunded.

Due to the large volume of Insurance claims, We will refile an unpaid claim once. After that it is your responsibility to follow up on any unresolved insurance claims.

We will file secondary insurance claims, however there is no guarantee that your Insurance companies will coordinate benefits, and any estimates of payment are not guaranteed. **Therefore, your co-payment will be estimated based on primary coverage only.**

It is your responsibility to provide us with accurate Insurance coverage information, and to inform us of any changes to your coverage in a timely manner.

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Financial Policy and Agreement
Page 2

ADDITIONAL FEES:

We charge a fee of **$35.00** on all returned checks.

Finance Charges of 1.5% per month are charged on accounts with an over 90 day balance.

Accounts that are over 90 days are considered past due, and may be turned over to a collection agency. Accounts that are turned over for collections may be reported by the collection agency as delinquent on your credit report.

I , _____, understand and agree to all the financial policies set forth above. I accept full financial responsibility for any treatment received by myself and any family members on this account.

Patient Name:_____

Patient Signature:_____

Responsible Party Name:_____
(if patient under age 18)
Responsible Party Signature:_____

Date:_____

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Acknowledgment of Receipt of Notice of Private Practices

You may refuse to sign this acknowledgment

I have been given the opportunity to review this office's Notice of Privacy Practices and will be provided with a copy at my request.

_____
Print Name

_____ _____
Signature Relationship to patient

Account Agreement

I understand that if I default on payment of my account that I may be subject to credit check and/or verification of employment and any information collected will be used as means of collecting a debt.

_____ _____
Signature Date

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

____Individual refused to sign
____Communication barriers prohibited obtaining the acknowledgment
____An emergency situation prevented us from obtaining acknowledgment
____Other (Please specify) _____