Athens Dental Design

175 Hawthorne Park

Athens GA 30606

706-353-7860

Welcome to our practice! We are excited to be your dental health team and we look forward to taking you great care of you! Please take a few moments to share your dental and medical history with us. We are always happy to answer any questions you may have.

Your Time – we reserve your appointment time especially for you. It is our goal to see you promptly. Please give us at least 24 hours' notice if you are unable to keep a scheduled appointment.

Payment - due when services are rendered - cash, check, Visa, Mastercard, Discover, American Express

Other affordable options – financing via *CareCredit* – please ask our team if you are interested. We also offer *Plan for Health*, our in-house membership plan

Dental Insurance - As a courtesy, our team will file your insurance claim for you and collect your estimated portion of treatment based on your plan's coverage – this is an estimate of your portion to be determined by your plan. You will be responsible for the total fee for services provided less any amount your plan pays. We are not a Medicare or Medicaid provider. We will give you the information necessary to file your claim with Medicare. Medicaid will not cover any services provided in our office.

Female patients – please inform us *before* your visit if you are or may possibly be pregnant

I have read and understand these office policies. I acknowledge that any questions I have about the above have been answered to my satisfaction. I, undersigned patient or legally responsible party, authorize treatment to be rendered and assume full financial responsibility. I understand any balance remaining on my account will be paid in full promptly upon receipt of billing statement. I acknowledge that all accounts over 60 days old will be charged a service fee of 1.5% per month (18% annually) on the unpaid balance. Any collection or attorney fees incurred to collect this account will be my responsibility.

Patient/Guarantor Name (please print): _____

Patient/Guarantor Signature: _____ Date: _____

WELCOME TO Athens Dental Design!

WE'RE HAPPY YOU ARE HERE!

To assist us in providing the most comprehensive care, please provide the following information.

PERSONAL INFORMATION

Name: _____
First Middle Last

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

Email: _____ Home Phone #: (_____) _____ Cell #: (_____) _____

Date of Birth: _____/_____/ _____ Age: _____ Sex: _____ Social Security #: _____

May we contact you via text? Y N May we contact you via email? Y N

Emergency Contact: _____ Phone #_____

How did you hear about our office? _____

Person Financially Responsible for Account:
Name: _____

Date of Birth: _____ SS#: _____

Address: _____

Telephone #: _____

INSURANCE INFORMATION

Primary Insurance:

Policy Holder: _____

Date of Birth: _____ Social Security #: _____

Member ID: _____ Group #: _____

Employer Name and Address: _____

Relationship to Patient: _____

Name of Insurance Company: _____ Telephone # of Insurance Company: (_____) _____

Address to Send Dental Claims: _____

Secondary Insurance:

Policy Holder: _____

Date of Birth: _____ Social Security #: _____

Member ID: _____ Group #: _____

Employer Name and Address: _____

Relationship to Patient: _____

Name of Insurance Company: _____ Telephone # of Insurance Company: _____

Address to Send Dental Claims: _____

AUTHORIZATION

The information I provided is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence and it is my responsibility to inform this office of changes in medical status.

Adult Consent:
I am the patient, _____, and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services.

Insurance Assignment and Release:
I certify that I am covered by insurance with _____. I assign directly to ATHENS DENTAL DESIGN all insurance benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

ATHENS DENTAL DESIGN may use my health care information and may disclose such information to the above-named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

_____ _____
Signature of Patient, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Guardian or Personal Representative Date

PATIENT MEDICAL HISTORY

Patient's Physician: _____ Phone #: _____
Date of last physical examination: _____

Are you currently under the care of a physician? Yes No
If *yes*, explain: _____

Any serious illness, hospitalizations or surgeries in past 5 years? Yes No
If yes, explain: _____

For Women: Are you taking birth control pills? Yes No / Are you pregnant? Yes No
Due Date: _____ Are you nursing? Yes No

Please list current prescription medications and over the counter medications:

_____

_____

Y N Do you take any type of ***blood thinners***? If yes, explain: _____

Y N Have you taken (currently or previously or plan to) ***bone loss prevention medication*** such as Fosamax, Actonel, Boniva, or any other antiresorptive agent for osteoporosis or another medical condition?
_____

Y N Do you have ***artificial joints (hip/knee/etc***)? If yes, which joint and date placed?
_____

Y N Do you have…

**** artificial heart valve***	**** previous infective endocarditis***
****damaged heart valve***	**** congenital heart disease or defect***
****rheumatic heart disease***	****rheumatic/scarlet fever with heart or valve defect***
****heart disease/angina***	****heart murmur***

If yes, explain: _____

Y N Has a physician recommended you take ***antibiotic premed prior to dental treatment?***
Physician Name: _____ Phone: _____
For what condition: _____
Antibiotic name and dosage prescribed: _____

Y N Do you smoke or use tobacco? How often? _____

<u>Are you allergic to any of the following:</u>

Y N Aspirin	Y N Amoxicillin
Y N Augmentin	Y N Biaxin
Y N Codeine	Y N Dental Anesthetics
Y N Erythromycin	Y N Ibuprofen
Y N Keflex	Y N Latex
Y N Metals	Y N Omnicef
Y N Penicillin	Y N Sulfa
Y N Tetracycline	Y N Zithromax
Y N Clindamycin	Y N Sedatives
Y N Topical Anesthetics	
Y N Dental Injection reaction	

Other allergies, if not listed:
_____

<u>Do you currently have or have you had the following:</u>

Y N ADD/ADHD	Y N Heart Surgery
Y N Alcohol/Drug Dependency	Y N Heart Valve Defect
Y N Anemia	Y N Hemophilia/Blood Transfusion
Y N Anorexia/Bulimia	Y N Hepatitis (A, B, C) / Liver Disease
Y N Arteriosclerosis	Y N High Blood Pressure
Y N Asthma	Y N HIV+ / AIDS
Y N Autism/Asbergers	Y N Kidney Disease
Y N Autoimmune Disease	Y N Low Blood Pressure
Y N Bleeding Abnormally with Extraction or otherwise	Y N Lupus
	Y N Mitral Valve Prolapse
	Y N Osteoporosis
Y N Blood Disease	Y N Psychiatric Care
Y N Cardiac Pacemaker	Y N Anxiety/Depression/Panic Attacks
Y N Cancer / Chemotherapy	Y N Respiratory Disease
Y N Radiation Treatment	Y N Rheumatoid Arthritis
Y N Congestive Heart Failure	Y N Arthritis
Y N Cough (Chronic)	Y N Chicken Pox/Shingles

Y N Cold Sores/Fever Blisters
Y N Diabetes
Y N Emphysema
Y N Environmental Allergies
Y N Epilepsy or Seizures
Y N Fainting
Y N Glaucoma
Y N Headaches (Frequent and/or severe)
Y N Neurologic Disorders
Y N Hearing Concerns
Y N Heart Attack History
Y N Sexually Transmitted Disease
Y N Shortness of Breath
Y N Sickle Cell Disease
Y N Sinusitis
Y N Stomach Problems
Y N Stroke
Y N Thyroid Disease
Y N Tuberculosis

Please explain any YES answers: _____
_____
_____
_____

PATIENT DENTAL HISTORY

Do you currently have or have you had the following?

Y N Tooth sensitivity to hot, cold &/or sweet
Y N Frequent fever blisters, mouth ulcers
Y N Burning of tongue &/or cracking of the corners of mouth
Y N Permanent teeth removed (wisdom teeth)
Y N Any head, neck or jaw injuries
Y N Any popping, clicking or soreness of the jaws
Y N Teeth clenching &/or grinding
Y N Dry mouth
Y N Orthodontic treatment
Orthodontist: _____
Y N Any problems with previous dental treatment
Y N Earaches
Y N Do you wear night guards
Y N Do you wear dentures &/or partials
Y N Concerns with teeth/fillings breaking
Y N Concerns with teeth, gums, or mouth
Y N Do you brush 2 times per day
Y N Do you floss daily
Y N Does food catch between teeth
Y N Do you have periodontal disease
Y N Previous scaling and root planing
Y N Gum bleeding while brushing &/or flossing
Y N Serious Head or Mouth Injuries
Y N Unpleasant taste &/or odor in your mouth
Y N Do you chew on one side of your mouth
Y N Do you bite your lips &/or cheeks
Y N Are you a mouth breather
Y N Sleep apnea
Y N Wear or have been told to wear a C-PAP
Y N Are you happy with your smile
Y N Are you interested in braces (orthodontics)?

Please explain any YES responses: _____
_____
_____

Recent Dental Checkup/Cleaning:
Date: _____ By Whom:
_____
Date of Last: Panoramic Radiograph
_____
Bitewing Radiographs _____
Frequency of brushing: _____
Frequency of flossing: _____

DR. HAS REVIEWED THE PATIENT MEDICAL & DENTAL HISTORY:
DR'S INITIALS _____

	DATE: _____

HIPAA Authorization to Release Protected Information
Athens Dental Design

I, _____ authorize the following person(s) to have access to my personal information covered under the HIPAA Privacy Act.

Name Relationship

_____

_____

_____

I understand that I may revoke this authorization at any time, and that my revocation is not effective unless it is in writing and received by the dental practice's Privacy Officer at

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If I revoke this authorization, my revocation will not affect any actions taken by the dental practice before receiving my written revocation.

Patient Signature: _____ Date: _____

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Acknowledgement of Receipt of HIPAA Policies and Procedures

ATHENS DENTAL DESIGN

I have received and reviewed a copy of the dental practice's privacy, security and breach notification policies and procedures.

I understand that I should ask the dental practice's Privacy Official if I have any questions about these policies and procedures.

Print Name:_____

Signature:_____
Date:_____