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

ADA American Dental Association®
America's leading advocate for oral health

Today's Date: ___________________________________

Child's Dental & Medical Health History Information

To the parents/guardians of the patient: Please know that we may ask follow-up questions to make sure we have all of the information we need in order to treat the patient.

PATIENT INFORMATION

Last Name: | First Name: | Middle Name: | Nickname:

Date of Birth: / / | Gender:

Parent's/Guardian's Name: | Relationship to Patient:

Email Address:

Home Phone: | Cell Phone: | Work Phone:

Mailing Address: | City: | State: | Zip:

Please use an "X" to mark your answers to the following question.

Have you (the adult) or the patient (the child) had? n A cough that's lasted longer than three weeks n A cough that produces blood n Active Tuberculosis

Please bring this form to the receptionist right away if you marked "Yes" to any of these items.

PATIENT'S DENTAL HEALTH HISTORY

What is the reason for your visit today?

How would you describe the patient's oral health? n Excellent n Good n Fair n Poor

Does the patient currently have any dental pain or discomfort? n Yes n No If yes, where? ____

Is this the patient's first visit to a dentist? n Yes n No
If no, when was the patient's last dental exam? ________________ What was done at that appointment? __________________________________

When was the last time the patient had dental x-rays taken?

Please use an "X" to mark your answers to the following questions.	Yes	No	?
Has the patient had any problem with dental treatment in the past? If yes, please describe what happened: ____	n	n	n
Has the patient had any problems with teeth coming in or losing teeth?	n	n	n
Does the patient use fluoride toothpaste when brushing teeth? How often are the patient's teeth brushed? ______ time(s) per _______ At what time(s) of day are the teeth brushed? __________	n	n	n
Has the patient ever worn braces or other orthodontic appliances?	n	n	n
Has the patient ever had a serious injury to the head, mouth or teeth? If yes, please describe what happened and when it happened: __________________________________	n	n	n
Does the patient play any contact sports or participate in active recreational activities? If yes, please describe those activities here: ____	n	n	n
Is your home water supply fluoridated?	n	n	n
What is the patient's primary source of drinking water? n Tap n Bottled n Filtered n Well			
Does the patient take fluoride supplements?	n	n	n

Does/did the patient use a pacifier or suck his/her thumb or fingers? n n n
At what age did the patient stop breastfeeding? __________ At what age did the patient stop bottle feeding? __________

Has the patient ever experienced any sleep-related breathing disorders? n Mouth breathing n Snoring n Trouble breathing during sleep

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PATIENT'S MEDICAL HEALTH HISTORY & VACCINATION STATUS

Please list the name and phone number of the patient's physician:

Doctor's Name: ______________________________ Phone: ______________________________ Does the patient see any medical specialists? n Yes n No If yes, please explain. ______________________________

Please use an "X" to mark your answers to the following questions. **Yes No ?**

Is the patient currently being treated for any condition(s) or illness(es)? n n n If yes, what is the illness and when did it start?

Has the patient ever had a serious illness? n n n If yes, what was the illness and when did it happen?

Has the patient ever been hospitalized? n n n When and why?

Has the patient ever been given a general anesthetic? n n n

Has the patient ever had a blood transfusion? n n n

Does the patient experience excessive bleeding when cut? n n n

Has a physician or dentist ever suggested that the patient take If so, please explain why and provide the name of the doctor making that recommendation. antibiotics before seeing the dentist? n n n Doctor's Name: ______________________________ Phone: ___________________

Has the patient been diagnosed with any physical, developmental, mental or emotional conditions?
n n n If yes, please explain.

Does the patient have any genetic (inherited) conditions? n n n If yes, please explain.

Does the patient have any speech difficulties? n n n If yes, please explain.

How would you describe the patient's eating habits?

Is the patient up-to-date with immunizations related to patienthood diseases (tetanus, measles, mumps, etc.)? n Yes n No

If of the appropriate age, what is the patient's Human papillomavirus/HPV immunization status? n Immunized n Not immunized

Please check the box in front of any health conditions or issues the patient has now or has had in the past:

n ADD/ADHD n Chicken Pox n Hepatitis n Seizures
n Alcohol/Drugs n Chronic sinusitis n HIV/AIDS n Sexually transmitted infection (STI)
n Anemia n Diabetes n Immunizations n Sickle Cell Anemia n Arthritis n Ear aches n Kidney problems n Thyroid issues n Asthma n Epilepsy n Liver problems n Tobacco/Vaping
n Bladder problems n Fainting n Measles n Tuberculosis
n Bleeding disorders n Growth problems n Mononucleosis n Other: ______________________ n Bone/Joint issues n Hearing problems n Mumps ______________________________ n Cancer n Heart Issue n Pregnancy (teens) n Cerebral Palsy n Heart Murmur
n Rheumatic Fever

MEDICATIONS & ALLERGIES

Please use an "X" to mark your answers to the following questions. **Yes No ?**

Is the patient currently taking any prescription medications, vitamins, supplements and/or over-the-counter medications? n n n If yes, please list them here:
____

Is the patient allergic to any antibiotics (penicillin), pain medications (acetaminophen, ibuprofen, opioids) or any other medications? n n n If yes, please list those medications and what happened when the patient took them: ____

Does the patient have other allergies, such as to latex, metals, certain foods, animals, plants, etc.? n n n
If yes, please describe the allergy and the reaction: ____

NOTE: I understand that it's important for both the dentist and the patient or his/her parent/guardian to talk honestly about the patient's health before dental treatment starts. I have answered all of the questions above completely and accurately. I understand that the dentist and his/her staff need this information so the patient receives the right kind of dental care. I represent and warrant that I have full legal right and authority to consent to the performance of any procedure(s) on this patient. If for any reason I no longer have such legal right and authority, I will immediately notify the practice in writing.

The dentist and I have talked about any questions I had about this form.

I will not hold the dentist, or any other member of his/her staff, responsible for anything they did, or didn't do, because of any mistakes I might have made in filling out this form.

Signature of Parent/Legal Guardian: ____ Date: ____

FOR COMPLETION BY DENTIST

Comments: ____

Office Use Only:

n Medical Alert n Premedication n Allergies n Anesthesia

Reviewed by: ____ Date: ____

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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

Athens Dental Design

175 Hawthorne Park

Athens GA 30606

706-353-7860

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:____