Inspiring Smiles

pagebarden@gmail.com Inspiringsmiles.net

1024 Market Place Blvd. • Cumming, GA 30041 (770)844-6771

Patient Information

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.

Chart#: ____________ FOR OFFICE USE ONLY

Patient Name: ____________ Last ____________ First ____ MI

____________ Preferred Name

Title: ____________ Mr/Ms/Mrs/etc

Gender: ◯ Male ◯ Female

Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: ____________

Prev. Visit: ____________

Email Address: ____________

Phone: ____________ Home ____________ Mobile ____________ Work ______ Ext

Best time to call: ____________

Address: ____________ Address 1

____________ Address 2

____________ City ______ State ______ Zip Code

Social Security Number * ____________

Preferred appointment times:

☐ Mon ☐ Tue ☐ Wed ☐ Thur ☐ Fri ☐ Sat ☐ Morning ☐ Afternoon ☐ Evening

☐ Any time

Whom may we thank for referring you to our practice?

☐ Dental Office ☐ Yellow Pages ☐ Internet ☐ Newspaper ☐ School

☐ Work ☐ Other (name below):

Name of person, office, or other source referring you to our practice:

____

Spouse or Responsible Party Information

The following is for: ○ the patient's spouse ○ the person responsible for payment ○ both ○ neither-not applicable

Name: ______ Last ______ First ___ MI

______ Preferred Name

Title: ______ Mr/Ms/Mrs/etc

Gender: ○ Male ○ Female

Family Status: ○ Married ○ Single ○ Child ○ Other

Birth Date: ______

Email Address: ______

Phone: ______ Home ______ Mobile ______ Work ______ Ext

Best time to call: ______

Address: ______ Address 1

______ Address 2

______ City ______ State ______ Zip Code

Employment Information

The following is for: ○ the patient ○ the person responsible for payment ○ both ○ not applicable

Employer Name: ______

Phone: ______

Employer Address: ______ Address 1

______ Address 2

______ City

______ State ______ Zip Code

Primary Insurance Information

Primary Dental Insurance:

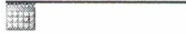
Name of Insured:

Last

First

MI

Insured's Birth Date:



ID #:

Group #:

Insured's Address:

Address 1

Address 2

City

State

Zip Code

Insured's Employer Name:

Employer Address:

Address 1

Address 2

City

State

Zip Code

Patient's relationship to insured: ○ Self ○ Spouse ○ Child ○ Other

Insurance Plan Name:

Insurance Address:

Address 1

Address 2

City

State

Zip Code

Primary Medical Insurance:

Name of Insured:

Last

First

MI

Patient's relationship to insured: ○ Self ○ Spouse ○ Child ○ Other

Insurance Plan Name:

Consent for Services

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. 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 unless other arrangements are made.

Patients with dental insurance understand that all dental services 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 patient's insurance forms or assist in making collections from insurance companies and will credit any 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 any fee estimate 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 by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. 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 to discuss this statement or my treatment.

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

Signature of patient, parent, or guardian (responsible party):

Signature ______________________ ________

Date

Relationship to Patient:

Inspiring Smiles

pagebarden@gmail.com Inspiringsmiles.net

1024 Market Place Blvd. • Cumming, GA 30041 (770)844-6771

Medical & Dental History Form

Patient Name:

Last First MI

Preferred Name

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well-being.

Would you consider yourself to be in fairly good health? ○ Yes ○ No

Within the past year, have there been any changes in your general health? ○ Yes ○ No

What is the date (or approximate date) of your last medical exam?

Your Primary Care Physician's name, address, & phone number:

Please mark any of the following to indicate Yes in response to the question:

- ☐ Have you ever had complications following dental treatment?
- ☐ Are you currently under the care of a physician due to a specific condition?
- ☐ Have you been hospitalized within the last 5 years due to a surgery or illness?
- ☐ Are you currently taking any prescription or non-prescription medications?
- ☐ Do you use tobacco (smoking or chewing)?
- ☐ Do you require the use of corrective lenses (contacts or glasses)?
- ☐ Do you have any other conditions, diseases, etc., not listed above that we should be aware of?

If any of the previous questions are marked, please explain:

WOMEN ONLY: Are you pregnant? ○ Yes ○ No

If Yes, when is the due date? ____________________

Please indicate if you have experienced any of the following:

- ☐ *Pre-Med - Amox
- ☐ *Pre-Med - Clind
- ☐ *Pre-Med - Joint Rep
- ☐ *Pre-Med - Other
- ☐ ADHD
- ☐ AIDS
- ☐ Allergies
- ☐ Allergy - Aspirin
- ☐ Allergy - Codeine
- ☐ Allergy - Erythro
- ☐ Allergy - Hay Fever
- ☐ Allergy - Latex
- ☐ Allergy - Other
- ☐ Allergy - Penicillin
- ☐ Allergy - Sulfa
- ☐ Allergy- Amoxicillin
- ☐ Allergy- Clindamycin
- ☐ Allergy- Nitrile
- ☐ Allergy-Niacin
- ☐ Allergy-Tetracycline
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Artificial Heart Val
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Cholesterol
- ☐ Codeine
- ☐ Conginital Heart Dis
- ☐ Contact Lenses
- ☐ COPD
- ☐ Coumadin
- ☐ Dental Gloves
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Erythromycin
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Head Injury
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ Hepatitis B
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Hives
- ☐ Hormone Therapy
- ☐ Hospitilaization
- ☐ Kidney Disease
- ☐ Latex
- ☐ Liver Disease
- ☐ Llidocaine Spray
- ☐ Low Blood Pressure
- ☐ Mental Disorders
- ☐ Mitral Valve Prolaps
- ☐ Nervous Disorders
- ☐ Neuropathy
- ☐ Nuts
- ☐ Other
- ☐ Other Medication
- ☐ Other Substances
- ☐ Pacemaker
- ☐ Penicillin
- ☐ Phenergan
- ☐ Pregnancy
- ☐ Psychological Care
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Sleep Apnea
- ☐ Stomach Problems
- ☐ Stress
- ☐ Stroke/Heart Attack
- ☐ Sulfa Drugs
- ☐ Surgery
- ☐ Tetracycyline
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease

List all medications, supplements, and /or vitamins taken within the last two years:

Do you take any antibiotic premedication for your dental visits? If yes, please explain.

Do you have any other health issues or allergies?

What is the reason for your dental visit today?

When was your last visit to the dentist (if to a different office)?

What was done on your last dental visit (if to a different office)?

Prior Dentist's name, address, & phone number:

How frequently do you brush your teeth?

- 3 (+) a day
- Twice a day
- Once a day
- Weekly
- Seldom

How frequently do you floss your teeth?

- 1 (+) a day
- 2 - 6 weekly
- 1 - 6 monthly
- Seldom
- Never

Please mark any of the following to indicate Yes in response to the question:

- [ ] Do your gums bleed when you brush or floss?
- [ ] Do your teeth experience sensitivity to cold or hot temperatures?
- [ ] Are any of your teeth currently causing you pain?
- [ ] Do you grind your teeth (either consciously or during sleep)?
- [ ] Are any of your teeth loose, or are you concerned about any teeth loosening?
- [ ] Do you currently have any dental implants, dentures, or partials?

If any of the previous questions are marked, please explain:

If you could change anything about your mouth, teeth, or smile, what would it be?

☐ **To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next detal appointment without fail.**

Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Signature of patient, parent, or guardian:

Signature
Date
Relationship to Patient:

Inspiring Smiles

pagebarden@gmail.com
Inspiringsmiles.net
1024 Market Place Blvd. • Cumming, GA 30041
(770)844-6771

HIPAA Acknowledgement
Notice of Privacy Practices

Patient Name:

Last First MI

Preferred Name

I have been provided with a copy of the Inspiring Smiles Notice of Information and Privacy Practices, which describes how my health information is used. I understand that the practice has the right to change this Notice at any time. I may obtain a current copy by contacting the Privacy Officer via (770) 844-6771, or by visiting the practice's web page via https://www.dentistincumming.co/.

Patient privacy is important to us. Our policy to keep health information confidential and not disclose such information without your consent or written authorization unless otherwise required by federal or state privacy laws.

Please provide us with information with whom we can communicate with your care. We would also like to obtain information regarding alternative communication preferences so that we know the best way to contact you with appointment reminders or other information related to your care.

Please note: If you have someone accompany you in the treatment area, we will assume this person is entitled to receive information regarding your care and we can freely discuss your information.

You are free to make changes to your preferences at any time. Updates must be made in person and a new form completed.

Please provide the names and relationship to the patient for those individuals you will need or want your health information to be provided. This includes members of the patient's family, caregivers, and legal representatives.

Name:

Please select relationship to patient

☐ Mother ☐ Father ☐ Child ☐ Spouse ☐ Power Of Attorney
☐ Guardian

Name:

Please select relationship to patient

☐ Mother ☐ Father ☐ Child ☐ Spouse ☐ Power Of Attorney
☐ Guardian

Patient Communication: As a service to our patients, we will communicate appointment reminders and other information via text message, email, or phone. Limited information regarding the patients upcoming appointment will be left via voicemail should the option be available at the time of the call. Please inform the office staff if you would prefer a different communication preference for appointment reminders.

My signature below acknowledges that I have been offered and /or provided with a copy of the Notice of Information and Privacy Practices:

Signature
Date

Print Name and/or Personal Representative with title (i.e. Health Care Power of Attorney)