PATIENT REGISTRATION INFORMATION

DATE: ____/____/____

CONFIDENTIAL

Welcome to our Practice!
Thank you for selecting our dental healthcare team. Please fill out this form completely in ink. If you have any questions or concerns, please do not hesitate to ask for assistance—we will be happy to help!

NAME: _____ PREFERS TO BE CALLED: _____
FIRST MI LAST

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: ( ) _____ -_____ WORK PHONE: ( ) _____ -_____ CELL PHONE: ( ) _____ -_____

Soc Sec #: _____ - _____ - _____ BIRTHDATE: _____/_____/_____ GENDER: ☐FEMALE ☐MALE

WHOM MAY WE THANK FOR REFERRING YOU? _____

PERSON TO CONTACT IN AN EMERGENCY _____ PHONE: ( ) _____ -_____

DO YOU PREFER TO RECEIVE CALLS AT: ☐ WORK ☐ HOME ☐CELL E-MAIL _____

CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

PERSON FINANCIALLY RESPONSIBLE

NAME: _____ RELATIONSHIP TO PATIENT _____

OCCUPATION _____ EMPLOYER'S NAME _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

WORK PHONE: ( ) _____ -_____ CELL PHONE: ( ) _____ -_____ E-MAIL_____

SPOUSE NAME: _____

OCCUPATION _____ EMPLOYER'S NAME _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

WORK PHONE: ( ) _____ -_____ CELL PHONE: ( ) _____ -_____ E-MAIL_____

AUTHORIZATION, RELEASE, AND AGREEMENT TO PAY FOR SERVICES RENDERED

I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids appropriate to make a thorough diagnosis of the patient's dental needs.

Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks, I understand that I can ask for a complete recital of any possible complications.

I agree to be responsible for payment of all services rendered on my behalf or my dependants, including any insurance benefits, submitted as a courtesy and at the discretion of this practice on my behalf, which are disputed, denied, or unpaid by my insurance company in 45 days from the date of service. I understand that payment is due at time of service unless other arrangements have been made. In the event payments are not received by an agreed dates, I understand that a $10.00 per month late fee may be added to my account.

I further understand this office reserves the right to charge me a broken or missed appointment if notice is not given 24 hours in advance. Furthermore, I understand by signing this form I have read and understood this agreement in its entirety.

_____ _____
SIGNATURE OF PATIENT/ RESPONSIBLE PARTY DATE

DENTAL HISTORY

What is the reason for your visit?_____

Please tell us about your past dental care: Former Dentist_____ City/State_____

Date of Last Visit _____/_____/_____ Last Dental Cleaning _____/_____/_____ Last Full Mouth X-Rays _____/_____/_____

How often do you brush your teeth?_____ How often do you floss?_____

What dental aides to you use? (electric toothbrush, toothpick, mouthwash, fluoride rinse) _____

Circle **Yes** or **No** to indicate if you have had any of the following:

Sensitivity to Hot or Cold?	Yes	No	Orthodontic treatment?	Yes	No
Sensitivity to sweets?	Yes	No	Oral surgery?	Yes	No
Sensitivity when biting or chewing?	Yes	No	Periodontal treatment?	Yes	No
Have you noticed any mouth odors or bad tastes?	Yes	No	Your teeth ground or the bite adjusted?	Yes	No
cold sores, blisters or any other oral lesions?	Yes	No	A bite plate or mouth guard?	Yes	No
			A serious injury to the mouth or head?	Yes	No
Do your gums bleed or hurt?	Yes	No	Do you have a removable appliance in your mouth?	Yes	No
Have parents experienced gum disease or tooth loss?	Yes	No			
Noticed any loose teeth or change in your bite?	Yes	No	Clicking or popping of the jaw?	Yes	No
Food collection in between your teeth?	Yes	No	Pain? (joint, ear, side of face)	Yes	No
			Difficulty in opening or closing the mouth?	Yes	No
Clench or grind your teeth while awake or asleep?	Yes	No	Difficulty in chewing on either side of the mouth?	Yes	No
Bite your lips or cheeks regularly?	Yes	No	Headaches, neck aches or shoulder aches?	Yes	No
Hold foreign objects with your teeth?			Sore muscles (neck, shoulders)?	Yes	No
(pencils, pipe pins, nails, fingernails)	Yes	No			
Mouth breathe while awake or asleep?	Yes	No	Are you satisfied with your teeth's appearance?	Yes	No
Have tired jaws, especially in the morning?	Yes	No	Would you like to keep all of your teeth all of your life?	Yes	No
Smoke/chew tobacco?	Yes	No	Do you feel nervous about having dental treatment?	Yes	No

MEDICAL HISTORY

1. Are you under a physicians care now? If yes, for what_____ Yes No

   Physician's Name: _____ Phone: ( ) _____ -_____

2. Have you taken any medication or drugs during the past two years?..... Yes No

3. Are you taking any medications, pills, or drug? If yes, name and dosage_____ Yes No

4. Have you ever taken Phen-Fen, Redux, or Pondimen for weight loss (diet pills)?..... Yes No

(Women) Are you: pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

5. Are you allergic to any of the following? (please circle all that apply) Yes No

   Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Other_____

6. Do you have, or have you had, any of the following? (please circle all that apply) *Conditions may require medication

AIDS/HIV Positive	Chemotherapy	Glaucoma	Hives/Rash	Rheumatic Fever*
Allergies	Chest Pains	Hay Fever	Kidney Problems	Sickle Cell Disease
Arthritis/Rheumatism	Cold Sores/Fever Blisters	Heart Attack	Leukemia	Sinus Trouble
Artificial Heart Valve*	Congenital Heart Disorder	Heart Murmur*	Liver Disease	Stroke
Artificial Joint*	Cortisone Medicine	Heart Pace Maker*	Mitral Valve Prolapse*	Swelling of Limbs
Asthma	Diabetes	Heart Surgery/Disease	Nervous/Anxious	Thyroid Problems
Blood Disease	Diet (Special/Restricted)	Hemophilia	Neurological Disorders	Tuberculosis
Blood Transfusion	Emphysema	Hepatitis A (infectious)	Psychiatric/Psychological Care	Tumors
Breathing Problems	Epilepsy or Seizures	Hepatitis B (serum) or C	Radiation Therapy	Ulcers
Bruise Easily	Fainting Spells/Dizziness	Herpes	Recent Weight Loss/Gain	Venereal Disease
Cancer	Frequent Cough	High Blood Pressure		Yellow Jaundice

7. Do you have any disease, condition, or problem not listed?..... Yes No

   If yes, please list_____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health or medication.

_____ _____

SIGNATURE OF PATIENT/ GUARDIAN DATE

Snellville Family Dental Office Policies

Welcome to our practice! We are pleased to have you as a patient and to be given the opportunity to be your partner in informed dental health care.

Referrals: The greatest compliment our patients can give us is the referral of their friend, loved ones and co-workers. We do not take the confidence you place in us lightly. We welcome new patients and promise to give them the same special attention and care you receive.

Telephone Calls: All patients are encouraged to call with any questions they have concerning dental procedures. Our staff is well-qualified to answer most questions. If a call requires the doctor to speak with you,the doctor will return your call at the earliest opportunity.

Emergencies: The office is closed on Friday - Sunday and Major Holidays. We reserve a limited amount of time each day to accommodate emergency patients so as not to infringe on the care of our scheduled patients. If you have a dental emergency please call our office as early in the day as possible. If you have an after-hours emergency, simply call the office at (770) 800-7545 and leave a message and someone will return your call.

Appointments: We try to see all patients on an appointment basis and ask that you please call in advance so we can reserve the appropriate treatment time for you. Because we respect the value of your time, we make every effort to be on time for our patients and ask that you please extend us the same courtesy.

Appointment Confirmations: Our office will make confirmation phone calls or send a text message to each scheduled patient two (2) days prior to their appointment. If we are unable to speak to you directly to confirm your appointment, please pay us the courtesy of returning our call to confirm your appointment.

Rescheduling Appointments: Even the most organized person will occasionally need to reschedule an appointment. When rescheduling is necessary, please provide our office a minimum of 48 hours notice. This courtesy makes it possible for us to offer your appointment time to patients in need of emergency or more timely care. Failure to extend this courtesy may result in a cancellation fee of $35.00 for the hygienist and $75 for an appointment with the doctor.

Diagnostic X-Rays: An oral evaluation warrants that we have recent diagnostic x-rays to detect decay, bone loss and hard tissue abnormalities on all patients. We will take a panoramic x-ray and bitewing x-rays or a full mouth series of x-rays on all New Patients to facilitate our initial evaluation. If you have a panoramic x-ray or full mouth series of x-rays that have been taken within the last three (3) years by another dentist, we will need you to request them from your previous dentist to save you the additional expense of taking new films. New films will be taken every three years. Panoramic x-rays will be taken every three years to evaluate bone health and bitewing x-rays will be taken annually to detect interproximal decay.

Continuing Care: A postcard, email and text message will be sent to you one (1) month prior to your dental exam and cleaning or periodontal therapy appointment to remind you of your scheduled dental visit. If you did not pre-appoint for these services, you will receive a postcard and text message notifying

you that you are due for preventive of periodontal care and to please call for an appointment. Remember, preventive care is your best insurance against decay, periodontal disease, tooth loss and unnecessary expense.

Cosmetic Services: One of our greatest joys is helping patients achieve the smile of their dreams! It is amazing to us how much even the simplest of cosmetic procedures can elevate a patient's self-image and improve the quality of their life. Please feel free to express any interest you may have in enhancing your smile. We will be happy to share our recommendations, discuss your treatment options, quote a fee and explain financing options without pressure.

Insurance: If you have insurance, we will be happy to file your insurance claim as a courtesy. However, you will be responsible for your deductible and coinsurance at each visit. Our computer software makes an estimate of what your insurance will cover and your "out of pocket" portion. This is only an estimate and final amounts may vary once the insurance has processed your claim. Any remaining balance will be your responsibility to pay.

Financial Policy: Thank you for choosing our office for your dental needs. At Snellville Family Dental we make every effort to curb the cost of your dental care. You can assist us by both keeping your appointments and by paying at time of service to cut down on billing costs. Of course preventing problems before they develop is the simplest and most economical way to maintain good oral health. We realize that every person's financial situation is different. For this reason, we have worked hard to provide a variety of payment options to help you receive the dental care you need and deserve which allows you to enjoy a healthy, beautiful smile with respect to your budget. Dental treatment is an excellent investment in an individual's medical and psychological health. To maintain practice operations and prevent potential misunderstandings, we ask patients to accept and adhere to the following financial policies regarding their dental treatment. We offer several payment options: We accept payment by Cash, Debit or Credit Card. We accept MasterCard, Visa, American Express and Discover. Extended payments can often be arranged through Care Credit. All major treatment involving a laboratory procedure will require an appropriate down-payment. If your treatment plan requires several visits you will be given a written estimate of your financial obligation and asked to discuss and sign a definitive financial agreement with our financial coordinator.

Finance Charges: Finance charges, at a rate of 1.5% per month, will be assessed to any account that lapses 30 days without a personal payment. As witnessed by my signature, I hereby acknowledge I have been advised of the Office Policies of Snellville Family Dental.

Patient Name: _____

Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

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

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____