NEW PATIENT DOCUMENTATION

CLEVELAND FAMILY DENTAL CENTER
3777 HIGHWAY 129 SOUTH, CLEVELAND, GA 30628
PH: (706) 219-0033 FAX: (706) 219-0048

Patient Information

Name: _____

I prefer to be called: _____

Birthday: _____

Social Security #: _____

Address: _____

City / State / Zip: _____

Home Phone: _____

Work Phone: _____

Other Phone: _____

Email Address: _____

Sex: [ ] Male [ ] Female

Marital Status: S M W D

Emergency Contact Name: _____

Emergency Contact Phone: _____

Referred by: _____

Primary Dental Insurance

Insured's Name: _____

Patient's relation to insured: _____

Insured's Birthday: _____

Insured's SS#: _____

Insurance Company: _____

Insured's Employer: _____

Parent / Legal Guardian Info

Name: _____

Billing Address: _____

Home Phone: _____

Work Phone: _____

Social Security #: _____

To the best of my knowledge, all above answers are correct. I am aware that I am responsible for all charges for services rendered on this account and that payment is due at time of service. I authorize the assignment of insurance benefits to the dentists.

Date: _____

Signature: _____

Health Questionnaire

What is your major concern about your mouth / teeth?

_____

_____

Are you pregnant? [ ] Yes [ ] No

Name, Address & Ph# of Health Provider / Physician:

_____

_____

_____

List all medications you are taking (or supposed to take) including over the counter medications, aspirin, birth control pills or hormones (if none, so state):

Medication, Dosage, Times/Day

_____

_____

_____

_____

HEALTH QUESTIONNAIRE

PLEASE ANSWER THE FOLLOWING QUESTIONS. THIS INFORMATION IS CONSIDERED CONFIDENTIAL

HEART/CARDIOVASCULAR:	**General Medical**
101. [ ] Yes [ ] No Heart Murmur/Mitral Valve Prolapse	161. [ ] Yes [ ] No Change in your health in the last year
102. [ ] Yes [ ] No Rheumatic heart disease/rheumatic fever	162. [ ] Yes [ ] No Hospitalization/operation/serious illness
103. [ ] Yes [ ] No Damaged heart valves/artificial heart valves	163. [ ] Yes [ ] No Cancer/radiation treatment/chemotherapy
104. [ ] Yes [ ] No Congenital heart lesions	164. [ ] Yes [ ] No Diabetes/frequent urination
105. [ ] Yes [ ] No High blood pressure	165. [ ] Yes [ ] No Thyroid disease/other endocrine disease
106. [ ] Yes [ ] No Low blood pressure	166. [ ] Yes [ ] No Excessive tiredness/swollen ankles
107. [ ] Yes [ ] No Atherosclerosis/high cholesterol	167. [ ] Yes [ ] No Weight control medication (fen/phen/others)
108. [ ] Yes [ ] No Chest pain/angina/heart attack	168. [ ] Yes [ ] No Kidney trouble/dialysis/renal implant
109. [ ] Yes [ ] No Angioplasty/bypass/vascular/ heart surgery	169. [ ] Yes [ ] No Hepatitis/jaundice/liver disease/cirrhosis
110. [ ] Yes [ ] No Irregular or rapid heart beat/heart pacemaker	170. [ ] Yes [ ] No Stomach problems/ulcer
111. [ ] Yes [ ] No Heart failure	171. [ ] Yes [ ] No Skin disease/rash/hives
112. [ ] Yes [ ] No Stroke	172. [ ] Yes [ ] No Eye disease/glaucoma/ear disorder
113. [ ] Yes [ ] No Other heart problem(s)	173. [ ] Yes [ ] No Lupus/autoimmune disease
Breathing/Lungs/Sinuses:	174. [ ] Yes [ ] No Over the counter health foods/vitamins/ herbal supplements
121. [ ] Yes [ ] No Do you smoke? How long ____yrs ___packs/day	
122. [ ] Yes [ ] No Asthma/hay fever	175. [ ] Yes [ ] No Alcohol consumption/smokeless tobacco
123. [ ] Yes [ ] No Shortness of breath/breathing problems	176. [ ] Yes [ ] No Venereal disease/Sexually transmitted disease
124. [ ] Yes [ ] No Emphysema/COPD	177. [ ] Yes [ ] No Have you EVER taken Bisphosphonates ie:
125. [ ] Yes [ ] No Tuberculosis/persistent cough	Fosomax, Actonel, Boniva, Aredia, Bonefos, Zometa
126. [ ] Yes [ ] No Sinus problems / seasonal allergies or nose or throat disorders	178. [ ] Yes [ ] No Any other condition not covered on this form
	Mouth/Teeth:
Allergies to:	201. [ ] Yes [ ] No Toothache/tooth sensitivity/broken restorations
131. [ ] Yes [ ] No Penicillin/other antibiotics	202. [ ] Yes [ ] No Gums bleed easily, periodontal disease
132. [ ] Yes [ ] No Aspirin/codeine/other pain medication	203. [ ] Yes [ ] No Wear removable dentures/how long? _____
133. [ ] Yes [ ] No Dental anesthetics	204. [ ] Yes [ ] No Bad breath/change or loss of taste
134. [ ] Yes [ ] No Metals (nickel, rings, earrings)	205. [ ] Yes [ ] No Dry mouth/burning mouth
135. [ ] Yes [ ] No Latex	206. [ ] Yes [ ] No Fear/difficulty with dental treatment
136. [ ] Yes [ ] No Other food/drug/or any other allergies	207. [ ] Yes [ ] No Clench or grit teeth/jaw joint pain
Blood Conditions:	208. [ ] Yes [ ] No Inability to open wide/opening limited
141. [ ] Yes [ ] No Anemia	209. [ ] Yes [ ] No Does your jaw pop/lock
142. [ ] Yes [ ] No Leukemia	210. [ ] Yes [ ] No Wake up with sore teeth/tired muscles
143. [ ] Yes [ ] No Sickle cell trait/disease	211. [ ] Yes [ ] No Pain/ringing in/around ear
144. [ ] Yes [ ] No Hemophilia/excessive bleeding/bruise easily	212. [ ] Yes [ ] No Other oral conditions not included
145. [ ] Yes [ ] No Blood transfusion	213. [ ] Yes [ ] No History of trauma to mouth
146. [ ] Yes [ ] No HIV positive/Aids	214. [ ] Yes [ ] No Broken teeth/jaw due to automobile accident
Joints/Bones/Muscles/Nerves:	
151. [ ] Yes [ ] No Arthritis/rheumatism/bone disorder	
152. [ ] Yes [ ] No Joint replacement/bone implants	
153. [ ] Yes [ ] No Epilepsy/fainting spells/seizures	
154. [ ] Yes [ ] No Numbness/tingling/paralysis	
155. [ ] Yes [ ] No Frequent or severe headaches/migraines	
156. [ ] Yes [ ] No Anxiety/depression//memory loss	
157. [ ] Yes [ ] No Psychiatric treatment	
158. [ ] Yes [ ] No Parkinson's disease/multiple sclerosis	
159. [ ] Yes [ ] No Any other neurological disorder	

Dentist's Comments:

These answers, to the best of my knowledge, are true & correct. If any changes in my health status or medication(s) occur, I will inform my dentist of them. I have read & understand this questionnaire.

Patient or Guardian Signature: Date:

Dentist Signature: Date:

Cleveland Family Dental Center
Financial Policy

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your responsibility.

- Please read and sign prior to seeing the doctor.
- We accept cash, check, Visa, Mastercard, and American Express.
- Payment is due at time of service.
- Insurance will be accepted for initial cleaning and exam appointments. However, payment is due at time of service for initial emergency appointments.

On subsequent visits, we will accept your insurance if you obtain approval from our office staff prior to the date of service. When we accept your insurance, we require at least 20% of the total charges at the time of service (some procedures require 50% payment). We will file your insurance claims as a courtesy to you. Several insurance companies send the dental reimbursement checks directly to the patient. These payments are due immediately on your outstanding dental bill. By applying these payments promptly to your account, we will be able to continue to file your insurance. Otherwise, we will ask you to pay in full at the time of service and let your insurance company reimburse you. If your insurance company has not paid the full balance within 45 days, arrangements will need to be made with our office to satisfy this balance within 15 days. If your insurance company pays more than the balance due, we will refund the difference.

Insurance is a contract between you and your insurance company. We are not a party of this contract. We file insurance claims as a courtesy to our patients. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, “usual & customary” charges, etc., other than to supply factual information as necessary. You are responsible for the timely payment on your account. Regarding minors: The adult accompanying a minor will be responsible for payment of services. Minors must always be accompanied by an adult.

<u>If we send your account to collections you will be responsible for all fees associated with collecting the debt.</u>

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

_____ _____

Signature Date

Cleveland Family Dental Center
3777 Highway 129 South
Cleveland, GA 30528
706-219-0033

Health Care Authorization Form

Patient's Name: _____
Patient's SS#: _____-_____-_____ Date of Birth: _____

THE PATIENT IDENTIFIED ABOVE AUTHORIZES COMPREHENSIVE DENTAL CARE TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION (PHI) IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

_____ I give permission to Cleveland Family Dental Center to use my address, phone number, and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, information about treatment alternatives or other health related information.

_____If Cleveland Family Dental Center contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.

_____I give Cleveland Family Dental Center permission to disclose protected health information in the presence of anyone accompanying me into a treatment room or consultation room by my request.

_____ By signing this form you are giving Cleveland Family Dental Center permission to use and disclose your protected health information in accordance with the directives listed above.

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke the AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of Cleveland Family Dental Center. The written notice must contain the following information: Your name, SS#, and date of birth; a clear statement of your intent to revoke this AUTHORIZATION; the date of your request, and signature.

The revocation is not effective until it is received by the Privacy Official.

This AUTHORIZATION is requested by Cleveland Family Dental Center for its own use/disclosure of (PHI) (minimum necessary standards apply).

You have a right to inspect or copy the (PHI) to be used / disclosed.

A COPY OF THE SIGNED AUTHORIZATION WILL BE PROVIDED TO YOU UPON REQUEST

Print patient name: _____ Date: _____

Print name of children: _____

Signature of patient or person held responsible: _____