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Roswell Dental Care Patient Information

Patient's Name_____ Today's date_____

Birthdate _____ Age _____ Gender _____ SSN_____

Address _____

_____ Marital Status _____

Referred by_____

Contact Information: Please provide at least 2 ways to be contacted.

Home _____Cell_____Work_____

Email _____

Employer _____

Employer's Address _____

Occupation _____ Length of employment _____

Spouse Information

Name_____ Date of Birth _____

Employer _____ Occupation _____

Cell Phone _____ Work Phone _____

Person Responsible for Account _____ Date of Birth _____

Employer _____ Occupation _____

Cell Phone _____ Work Phone _____

Emergency Contact _____ Relationship_____

Cell Phone _____ Work Phone _____

PRIMARY DENTAL INSURANCE INFORMATION

Insurance Company Name _____

Insurance Company Address _____ Phone _____

Insured's Name_____ **Date of Birth** _____ **SSN** _____

Insured's Employer_____ Address _____

Group Number_____ ID Number _____

SECONDARY DENTAL INSURANCE INFORMATION

Insurance Company Name _____

Insurance Company Address _____ Phone _____

Insured's Name_____ **Date of Birth** _____ **SSN** _____

Insured's Employer_____ Address _____

Group Number_____ ID Number _____

MEDICAL HEALTH HISTORY *DATE: / /*

NAME: _____DATE OF BIRTH: _____

Please list all current **MEDICATIONS, PRESCRIPTION AND OVER THE COUNTER,** Including Vitamins and Supplements:_____

_____

_____

Please list **DRUG ALLERGIES**, Including **ALLERGY REACTIONS**:

PENICILLIN	YES	NO	NOT SURE
ASPIRIN	YES	NO	NOT SURE
CODEINE	YES	NO	NOT SURE
LOCAL ANESTHETIC	YES	NO	NOT SURE
COW MILK PROTEIN	YES	NO	NOT SURE
LATEX	YES	NO	NOT SURE
OTHER:	YES	NO	NOT SURE

Please check any of the following conditions that apply to your health history:

____Anemia
____Arthritis
____Asthma
____Cancer
____Chest Pain with Exertion
____Diabetes Type I; Type II
____Emphysema
____Epilepsy
____Fainting Spells
____Gastric Reflux
____Glaucoma
____Heart Disease
____Heart Murmur
____Heart Valve Replacement
____Hepatitis or Jaundice
____High Blood Pressure
____History of Alcoholism
____HIV Positive
____Intestinal Problems
____ Joint Replacement….Hip, Knee, Shoulder, etc.
____ Kidney or Bladder Disease
____ Low Blood Pressure
____ Nervous Disorder
____ Osteoporosis
____ Pacemaker OR Defibrillator
____ Pregnant or Nursing
____ Prolonged Bleeding
____ Rheumatic Fever
____ Shortness of Breath
____ Sleep Apnea
____ Swollen Ankles
____ Thyroid Disease
____ Tobacco Use
____ Tuberculosis
____ Sjogren's Syndrome
____ STD'S
____ X-ray Therapy to Head or Neck
Any other condition:_____

Have you been told that you need to Pre-Med before dental appointments? _____
Have you been treated for any other condition in the past year? _____
Have you been hospitalized in the past 5 years? If so, why? _____
Are you taking any medications to treat bone loss? _____

Dental Health History:

Are you currently experiencing dental pain or discomfort?	YES	NO
Do you brush or scrape your tongue?	YES	NO
Do you have dry mouth?	YES	NO
Do your gums bleed when you brush or floss?	YES	NO
Have you had any periodontal (gum) treatments?	YES	NO
Do you grind or clench your teeth?	YES	NO
Do you have a clicking, popping or discomfort in your jaw?	YES	NO
Do you have a history of snoring?	YES	NO
Do you have trouble sleeping?	YES	NO
Are you interested in Dysport (Botox) or facial fillers?	YES	NO
Do we have permission to use Nitrous Oxide (laughing gas)?	YES	NO
Are you interested in whiter teeth?	YES	NO

Previous Dentist_____ Primary Care _____
When was your last dental exam? _____ cleaning? _____ x-rays? _____

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

I understand that under the **Health Insurance Portability and Accountability Act of 1996 (HIPAA)**, I have certain rights to privacy regarding my health information. I understand these rights and understand that the Notice of Privacy Practices containing a description of the uses and disclosures of my health information is available for my review.

PATIENT NAME (PLEASE PRINT): _____

RELATIONSHIP TO PATIENT: _____

SIGNATURE: _____DATE:_____

I have attempted to obtain the patient's signature in acknowledgement of this notice, but was unable to do so as documented below:

NAME:_____DATE:_____

REASON:_____

INSURANCE AND FINANCIAL POLICY AND AGREEMENT

PATIENT NAME_____

DATE OF BIRTH_____

Payment for services is expected at the time of service unless other arrangements have been made with our office.

As a courtesy, we will submit your insurance on your behalf. You will be responsible for any co-payments at the time of service.

We request that you pay your pre-determined patient portion at the time of service. When your insurance company pays us, any remaining balance will be your responsibility.

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.

I understand I am responsible for any financial obligation for treatment on myself or aforementioned patient.

I understand a credit verification can be requested if treatment is financed.

I understand a fee will be assessed for recovery if I fail to meet my financial obligation.

I affirm that the information I have given today is correct to the best of my knowledge and I understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes.

PRINT NAME:_____

SIGNATURE:_____ Date:_____

ROSWELL DENTAL CARE
CANCELLATION POLICY

Broken appointments or last minute cancellations leave open time on our schedule that could have been used by another patient. We make every effort to inform you of your appointment, including text messages, phone calls and emails. Unless you have a real emergency or illness, we ask that you give a 48 hour notice to change your appointment time.

*Our fee for no show appointments and last minute cancellations is $75 per hour of time reserved.

(2 hours = $150.) We do this because your appointment is a contract between you and our office for our time. Time lost can never be recovered and ultimately increases the cost of dentistry to all patients.

PLEASE SIGN BELOW TO CONFIRM YOUR ACKNOWLEDGEMENT OF THIS POLICY:

Signature: _____Date:_____