New Patient Form (English)

PATIENT INFORMATION

Patient First Name:

Middle Name:

Last Name:

Date of Birth:

Social Security Number:

Preferred Name?

Address:

Marital Status:

City:

State:

Zip:

Home Phone#:

Cell Phone#:

Email:

How did you hear about our practice?:

Driver's License (front)
No File Uploaded

Driver's License (front)
No File Uploaded

INSURANCE INFORMATION

PRIMARY INSURANCE (Policyholder)
`Fill-in "none" if no insurance`

Subscriber Name:

Subscriber ID:

DOB:

Relationship to Subscriber:

Employer Name:

Insurance Company:

Insurance Group:

Insurance Phone#:

Insurance card (front)
No File Uploaded

Insurance card (back)
No File Uploaded

SECONDARY INSURANCE (Policyholder)
`Fill-in "none" if no insurance`

Subscriber Name:

Subscriber ID:

DOB:

Relationship to Subscriber:

Employer Name:

Insurance Company:

Insurance Group:

Insurance Phone#:

Insurance card (front)
No File Uploaded

Insurance card (back)
No File Uploaded

RESPONSIBLE PARTY (if minor)

First Name:

Middle Name:

Last Name:

DOB:

Email:

Address (If different):

City:

State:

Zip Code:

Home Phone#:

Cell Phone#:

Work Phone#:

EMERGENCY CONTACT

First Name:

Middle Name:

Last Name:

Home Phone#:

Cell Phone#:

Work Phone#:

AUTHORIZATION

I consent to the diagnostic procedures and dental treatment performed by my dentist, and to the release of information concerning my(or my child's)healthcare,advice, and treatment to another dentist, or for evaluating and administering any claims for insurance benefits. I consent to the direct payment of my insurance benefits to dentist or dental group and understand that my insurance benefits may pay less than the actual bill for services and that I am responsible for any services not paid or covered by my insurance benefits and any account balance.

ELECTRONIC COMMUNICATIONS:

I consent to receiving HIPAA-compliant electronic communications, such as email and text messages regarding treatment, payment and healthcare operations. I understand that there is no obligation to receive these electronic communications.Message/data rates may apply,and I may opt-out of receiving electronic communications at any time by clicking the unsubscribe link provided in emails, or by replying STOP via text to 98269. Go to www.greatexpressions.com for more information. I attest to the accuracy of the information on this page.

Signature (Responsible Party, if under 18):

Date:

Sign

Medical History

Do you require pre-medication with antibiotics before dental treatment?

○ Yes

○ No

Are you taking blood thinners?

○ Yes

○ No

If yes, which blood thinner and last dose:

Are you taking any medications?

○ Yes

○ No

Please list ALL medications that you are taking:

ALL TREATMENT IS BY APPOINTMENT ONLY. A NO-SHOW FEE of $50 WILL BE CHARGED FOR MISSED APPOINTMENTS.

Signature of Responsible Party:

DATE:

RELATIONSHIP TO PATIENT(S):

Sign

Although dental personnel primarily treat the area in and around your mouth your mouth is a part of your entire body. Health problems that you may have or medication that you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?

○ Yes ○ No

If Yes

Have you ever been hospitalized or had a major operation?

○ Yes ○ No

If Yes

Have you ever had a serious head or neck injury?

○ Yes ○ No

If Yes

Are you taking any medications pills or drugs?

○ Yes ○ No

If Yes

Do you take or have you taken Phen-Fen or Redux?

○ Yes ○ No

If Yes

Have you ever taken Fosamax Boniva Actonel or any other medications containing bisphosphonates?

○ Yes ○ No

If Yes

Are you on a special diet?

○ Yes ○ No

If Yes

Do you use tobacco?

○ Yes ○ No

If Yes

Do you use controlled substances?

○ Yes ○ No

If Yes

Women: Are you...

☐ Nursing?
☐ Pregnant/Trying to get pregnant?
☐ Taking oral contraceptives?

Are you allergic to any of the following?

- ☐ Acrylic
- ☐ Aspirin
- ☐ Codeine
- ☐ Latex
- ☐ Local Anesthetics
- ☐ Metal
- ☐ Penicillin
- ☐ Sulfa Drugs

Other?

☐ Yes

Comment

Do you have or have you had any of the following?

	Yes	No
AIDS/HIV Positive	○	○
Alzheimer's Disease	○	○
Anaphylaxis	○	○
Anemia	○	○
Angina	○	○
Arthritis/Gout	○	○
Artificial Heart Valve	○	○
Artificial Joint	○	○
Asthma	○	○
Blood Disease	○	○
Blood Transfusion	○	○
Breathing Problems	○	○
Bruise Easily	○	○
Cancer	○	○
Chemotherapy	○	○
Chest Pains	○	○
Cold Sores/Fever Blisters	○	○
Congenital Heart Disorder	○	○
Convulsions	○	○
Cortisone Medicine	○	○
Diabetes	○	○
Drug Addiction	○	○
Easily Winded	○	○
Emphysema	○	○
Epilepsy or Seizures	○	○
Excessive Bleeding	○	○
Excessive Thirst	○	○
Fainting Spells/Dizziness	○	○
Frequent Cough	○	○
Frequent Diarrhea	○	○
Frequent Headaches	○	○
Genital Herpes	○	○
Glaucoma	○	○
Hay Fever	○	○

Heart Attack/Failure	○	○
Heart Murmur	○	○
Heart Pacemaker	○	○
Heart Trouble/Disease	○	○
Hemophilia	○	○
Hepatitis A	○	○
Hepatitis B or C	○	○
Herpes	○	○
High Blood Pressure	○	○
High Cholesterol	○	○
Hives or Rash	○	○
Hypoglycemia	○	○
Irregular Heartbeat	○	○
Kidney Problems	○	○
Leukemia	○	○
Liver Disease	○	○
Low Blood Pressure	○	○
Lung Disease	○	○
Mitral Valve Prolapse	○	○
Osteoporosis	○	○
Pain in Jaw Joints	○	○
Parathyroid Disease	○	○
Psychiatric Care	○	○
Radiation Treatments	○	○
Recent Weight Loss	○	○
Renal Dialysis	○	○
Rheumatic Fever	○	○
Rheumatism	○	○
Scarlet Fever	○	○
Shingles	○	○
Sickle Cell Disease	○	○
Sinus Trouble	○	○
Spina Bifida	○	○
Stomach/Intestinal Disease	○	○
Stroke	○	○
Swelling of Limbs	○	○
Thyroid Disease	○	○
Tonsillitis	○	○
Tuberculosis	○	○
Tumors or Growths	○	○
Ulcers	○	○
Venereal Disease	○	○
Yellow Jaundice	○	○

Have you ever had any serious illness not listed above?

○ Yes ○ No

If Yes

Comments:

undefined

To the best of my knowledge the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient`s) health. It is my responsibility to inform the dental office of any changes in medical status.

DENTAL HISTORY

Are you having any dental problems that require immediate attention?

○ Yes

○ No

Reason for today's visit:

Date of last dental visit:

Date of last dental x-rays:

Please check if you have/had any of the following:

If "Yes" to any above, please explain:

	Yes	No
Bad breath	○	○
Blisters on lips or mouth	○	○
Burning sensation on tongue	○	○
Chew on one side of mouth	○	○
Cigarette, pipe, or cigar smoking	○	○
Smokeless tobacco ("dip")	○	○
Dry mouth	○	○
Food collection between teeth	○	○
Clench or grind teeth	○	○
Growths or sore spots in your mouth	○	○
Gums swollen, tender or bleeding	○	○
Head, neck, jaw pain, or aches	○	○
Lip or cheek biting	○	○
Loose teeth or broken fillings	○	○
Mouth breathing	○	○
Orthodontic treatment ("braces")	○	○
Periodontal treatment ("deep cleaning")	○	○
Sensitivity to pressure or irritants (cold, heat, sweets)	○	○

How often do you floss?

How often do you brush?

Have you had periodontal or gum treatment? ("Deep cleaning" or "Scaling and Root Planing")

Last treatment date:

- ○ Yes
- ○ No

Have you ever had orthodontic treatment (braces)?

- ○ Yes
- ○ No

Last treatment date:

Have you ever had an allergic reaction to Novocaine, local, or general anesthetics?

- ○ Yes
- ○ No

If Yes, please explain:

Have you ever had trouble from previous dental care?

- ○ Yes
- ○ No

If Yes, please explain:

How do you feel about the appearance of your smile?

AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowledge.

Patient/Guardian Signature:

Sign

DENTAL HEALTH HISTORY – UPDATE AND EXCEPTIONS

- ☐ I have reviewed my dental history and confirm that it adequately states past and present conditions to the best of my knowledge.

HIPAA - NOTICE OF PRIVACY

PATIENT CONSENT OF INFORMATION

TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent:

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices:

You have the right to read the Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting: Compliance Officer: Dr. Mike Jin Telephone: 770-251-8767 Address: 65 Oak Hill Blvd. Newnan, GA 30265

Right to Revoke:

You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation.

- ☐ I have had full opportunity to read and consider the contents of this Consent form and the Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and heath care operations.
- ☐ I understand that by signing this Consent form, I am giving my consent to to disclose and discuss my protected health information to carry out treatment, payment activities and health care operations with the following family member:

Family member(s):

RESTRICTION OF PROTECTED HEALTH INFORMATION (PHI)

I request the office to restrict the disclosure of my PHI to those specified below:

Patient Signature or Personal Representative

Sign

If this Consent is signed by a personal representative (parent/guardian) on behalf of the patient, complete the following:

Personal Representative's Name:

Relationship to Patient:

FINANCIAL POLICY

Thank you for choosing Oak Hill Family Dentistry. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment options to choose from:

• Cash, Check, Visa, Mastercard, American Express, and Discover • Flexible payment plans - Must be arranged prior to treatment • Convenient Monthly Payment Plans* from Care Credit * Allow you to pay over time * No annual fees or pre-payment penalties * Subject to credit approval

Please note:

• Oak Hill Family Dentistry requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is completed your refund will be determined upon review of your case. • For patients with dental insurance, we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment. • A fee of $50.00 is charged for patients who miss or cancel an appointment without 24-hour notice. • Oak Hill Family Dentistry charges $35.00 for returned checks. • Effective January 2019, all accounts placed for collection will be assessed a 30% collection fee. If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need!

ADULT PATIENTS

Adult patients are responsible for full payment at time of service.

MINORS ACCOMPANIED BY AN ADULT

The adult accompanying a minor, his/her parents or guardians, are responsible for full payment at time of service.

UNACCOMPANIED MINORS

The parents or guardians are responsible for full payment at time of service. Non-emergency treatment will be denied unless charges have been pre authorized to an approved credit plan, or to Visa, Master Card, American Express, or Discover.

INSURANCE

We provide insurance company billing as a courtesy to our patients. The patient portion of a particular dental service(s) is estimated and due at the time of service. This amount may be subject to adjustment when the dental service(s) claim(s) are adjudicated by the insurance company. In addition, certain insurance companies have annual limitation for the amount of dental services that can be reimbursed within each plan year. If you or your family exceed these annual limitations in any plan year, you will be responsible for the full amount of dental services that exceed the particular plan’s limitations. The patient is responsible for monitoring the amount of his/her remaining benefits for any annual benefit period. The patient may not rely upon any information provided by our team regarding his/her remaining benefit in any such benefit period. The claims we submit to insurance companies indicate that you have assigned those benefits to Oak Hill Family Dentistry. However, if you are paid directly by the insurance company instead of Oak Hill Family Dentistry, it is the patient's responsibility for the total account balance. You may bring the signed insurance check to our office, or remit payment directly to Oak Hill Family Dentistry. If you or your family has more than one dental insurance program, we will assist you in obtaining the maximum benefits available. You as the patient will be responsible for all charges not covered by your insurance company.

Thank you for understanding and accepting our Financial Policy. Please let us know if you have any questions or concerns.

Responsible Party Signature: Date:

Sign