# PATIENT INFORMATION

*Welcome to Associates of Family Dentistry! To assist us in serving you, please complete the following confidential form. The information provided is important to your dental health.*

Patient's Legal name _____ ❑ Married ❑ Single ❑ Minor ❑ Male ❑ Female

Preferred name _____ If minor, Parents names _____

Patient Birthday:_____ Cell phone _____ Other _____

Mailing address _____ City _____State _____ Zip _____

Person to contact in case of emergency: _____ Phone: _____

Email address: _____ Do you receive text messages? _____

Pharmacy _____

Whom may we thank for referring you to our office? _____ ❑ Internet/Website

## MEDICAL HEALTH HISTORY

Do you **have** or have **had** any of the following?
(Please check any that apply)

- ❑ Cancer or tumor (circle one)
- ❑ Heart ailment or angina
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Artificial joint or valve
- ❑ High Blood Pressure
- ❑ Pacemaker
- ❑ Tuberculosis or other lung problems
- ❑ Kidney disease
- ❑ Hepatitis or other liver disease
- ❑ COUMADIN Patient
- ❑ Blood transfusion
- ❑ Diabetes
- ❑ Neurologic condition
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Anxiety
- ❑ Arthritis
- ❑ Herpes, cold sores, fever blisters
- ❑ AIDS or HIV positive
- ❑ Migraine headaches or frequent headaches
- ❑ Anemia or blood disorders
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Hay fever or sinus trouble
- ❑ Allergies or hives
- ❑ Asthma

Do you use any tobacco? ❑ yes ❑ no

Are you interested in whitening? ❑ yes ❑ no

Do you need Pre-Med? ❑ yes ❑ no

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Latex materials
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics ("Novocain")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other:_____

Are you taking any of the following?

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners)
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Insulin, Orinase, or other diabetes drug
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medicine
- ❑ Other:_____
  _____

Women:

- ❑ Are you pregnant or may be pregnant?
  Expected delivery date: _____
- ❑ Taking hormones or contraceptive

Do you have any disease, condition, or problem not listed above? _____

Please list medications:_____

_____

**AUTHORIZATION:**

I herby authorize payment directly to Associates of Family Dentistry of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize Associates of Family Dentistry to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on the medical/dental histories is correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals.

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Patient or Responsible Party for payment

# Dental Treatment Consent:

1. **Health Information:** I agree to disclose all previous illness and medical history. Undisclosed medical information and current medication, allergies or illness are risk factors.
2. **Drugs, Latex and Medicines:** I understand that antibiotics and other medicines can cause allergic reactions and even life-threatening anaphylaxis. Also, some antibiotics interfere with birth-control pills. Epinephrine increases heartbeat, and depending on my health, may be dangerous to me. Our office does not have anything containing LATEX.
3. **Needle Stick:** If someone is inadvertently struck with a needle used on me, I consent to have my blood drawn for analysis.
4. **Fillings, Crowns, and Un-anticipated Root Canals:** Some teeth may need a root canal even after a simple filling. Fillings and crowns do take away tooth structure and a percentage of these teeth end up needing a root canal after the filling or crown is done.
5. **Root Canals can Fail:** Root Canals can fail and may require additional treatment or I may end up having the tooth extracted.
6. **Porcelain Crowns, Veneers, Bonding, and Cosmetic Fillings:** Porcelain crowns, veneers, cosmetic bonding and composite fillings are esthetically pleasing. However, I understand that if they chip or break after in use successfully, I am responsible for repairs or remakes. Once a crown, veneer, bonding or filling is placed, I understand the color cannot be changed.
7. **Gum Treatment and Requesting *"Just a Cleaning"*:** If I don't floss or if I smoke, I can expect to have deteriorating gum condition. I agree that if I need gum treatment, I will not insist that I simply get a cleaning (prophylaxis).
8. **Extractions and Surgery:** I understand that all dental extractions or surgeries carry risks. Some are minor like a dry socket following an extraction. Some are life threatening such as post-surgical infection or anaphylaxis.
9. **Fee for Additional or Specialty Care:** I understand that I may need treatment beyond what was originally planned (a crowned tooth becomes painful and will need a root canal), or I may be referred to a specialist for additional care (root canal was not successful). I agree to be financially responsible for what insurance does not cover.
10. **Limitations of Insurance Coverage:** There are charges beyond what insurance will pay, e.g. composite fillings instead of amalgam (silver) fillings, temporary dentures, tapping off crowns or bridges, bleaching or cosmetic work. Also, as a service to patients, this office will file insurance claims on their behalf. I understand that what may be quoted as my portion is only an estimate. I agree to be financially responsible for what the insurance does not cover.
11. **48 Hour Notice for Cancellation:** I agree to give 48-hour notice for cancellations or pay the broken appointment fee of $25.00. I understand that leaving a message after the office closed the day (or weekend) before is not sufficient notice.
12. **Dental Appointments:** If I am more than 15 minutes late for my dental appointment, I will either take my remaining time only or reschedule and pay a broken appointment fee. I do not expect guarantees in dental care. I have read the above and consent to treatment. I hereby acknowledge that I have read this document and have had the opportunity to ask any questions about anything that I do not fully understand.

_____ _____

Patient or Parent/Guardian Signature Date

_____

Witness

**Associates of Family Dentistry**
166 Quillian Street
Cleveland, GA 30528
706.865.2248

In order for us to stay within the HIPAA guidelines, please list below anyone that you authorize us to disclose information to regarding your Protected Health Information. It is not mandatory that you list anyone. **(You do not need to list any of your doctors)**

| **Name** | **Relationship** | **Best number to contact** |
|---|---|---|
| 1._____ | _____ | _____ |
| 2._____ | _____ | _____ |
| 3._____ | _____ | _____ |

Do we have your permission to leave information on your **answering machine** or **voicemail** if we are unable to reach you? ____ Yes ____ No

HIPAA PRIVACY FORM

# Acknowledgement of Receipt of Notice of Privacy Practices

**Purpose:** This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

**ACKNOWLEDGEMENT OF RECEIPT OF**
**NOTICE OF PRIVACY PRACTICES**
****You May Refuse to Sign this Acknowledgement****

I, _____ have received a copy of this office's Notice of Privacy Practices.
(Please Print Patient Name)

_____ _____
Patient or Parent/Guardian Signature Today's Date

☐ Check here if patient refuses to sign acknowledgement