NEW PATIENT INFORMATION

Date____________________

Patient's Name____

Date of Birth ________________________ Sex M☐ F☐ Social Security # ________________________

Address____

City______________________________________ State____________ Zip code_____________________

Home Phone #____________________________ Cellphone #___________________________________

E-mail____

Emergency Contact

Name____

Phone Number____

Relationship____

Dental Insurance Information

Insurance Company Name____

Subscriber's Name_____________________________________ Date of Birth________________________

ID#______________________________________ Social Security #_________________________________

Employer Name____________________________ Relationship to Patient__________________________

REFERRED BY: INTERNET☐ FACEBOOK☐ FAMILY MEMBER/FRIEND☐ _____________________

OTHER☐__________________________________

I HAVE READ THE ABOVE INFORMATION AND AUTHORIZE THE PAYMENT TO THE DOCTOR NAMED ABOVE. I AUTHORIZE AND GIVE MY CONSENT FOR TREATMENT TO BE RENDERED BY THE DOCTOR NAMED ABOVE. I ALSO AUTHORIZE DENTISTA DE LA COMUNIDAD TO SUBMIT ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY DENTAL INSURANCE CLAIMS.

Signature____ Date________________________

OFFICE POLICIES

Welcome to our practice! We appreciate the trust you have placed in us.

Insurance

Professional services are rendered and charged to you, not your insurance company. Please understand that the contract is between you and the insurance company and payment for the services is your responsibility. We will accept assignment of claims for primary insurance. All deductibles and fee amounts not covered by insurance are due at time of treatment.

Our office will not enter into a dispute with your insurance company over your claim. This is your responsibility and obligation**. If at the end of 90 days, your insurance company has not paid, you are responsible for the entire balance.** Upon request, we will supply you with a copy of the claim so that you can resubmit if necessary.

In order to honor any insurance benefits, you must provide insurance identification and we must be able to verify the current benefits available**. Please be advised that you may be billed for services that your insurance will not cover due to exclusions or plan limitations.**

Office Fees

Payment is expected at the time service is rendered. We accept cash, Visa, MasterCard, American express, and Care Credit. **Our office does not take any personal checks**. If your account has been turned over to our collection agency a 4O% collection fee will be added to your account for the entire balance.

If you break an appointment with our practice, we ask for a 24 hour notice of cancellation. If we do not receive a 24 hour notice, you may be charged a $30 fee for the scheduled appointment. This fee cannot be charged to your insurance company.

I have read and understand the statements outlined above.

Signed____Date__________________

Notice of Privacy Practices

Patient Acknowledgement

Patient Name____

Date of Birth____

I have received and understand this practice's Notice of Privacy Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. If changes to the policy occur, this practice will provide me with a revised Notice of Privacy Practices upon request.

Signature:_________________________ Date:_______________

Patient Advisory and Acknowledgment Receiving Dental Treatment

Patient Name ______________________________ Date ____

In order to reduce the risk of spreading COVID 19, please complete a number of screening questions below. **For the safety of our team, other patients, and yourself, please be truthful and candid in your answers.**

Have you or anyone close to you experienced flu-like symptoms within the past 14 - 21 days such as:

Cough – wet or dry ________yes ________no
Fever or felt hot / feverish ________yes ________no
Shortness of Breath / Difficulty Breathing ______yes ________no
Sore Throat ________yes ________no
Muscle/Body Aches ________yes ________no
Nausea/Vomiting/Stomach upset ________yes ________no
Fatigue or Headache ________yes ________no
A recent loss of taste or smell ________yes ________no
Runny Nose ________yes ________no

Have you, or anyone you have come into contact with, traveled out of state or outside of the country within the last 21 days? If yes,
where?____

Have you come into contact with anyone who has tested positive for COVID-19? ________yes ________no

Have you been vaccinated for COVID-19? ____yes _____no

Have you been tested for COVID-19, with either a positive or negative result? ________yes ________no

Do you have an autoimmune disorder or are on an immune suppressing medication or steroids? ________yes _______no

Have you been diagnosed and /or treated for heart disease, lung related disease, kidney disease, cancer, diabetes or autoimmune disorder? ________yes ________no If yes, please specify:
____

Do you currently smoke/vape or have you stopped those activities within the past 2 years? __yes __no

Persons over 65 are at a higher risk. Are you over the age of 65? ________yes ________no

Our practice complies with State Health Department and the CDC infection control guidelines to prevent the spread of the COVID-19 virus; however, we cannot make any guarantees. Our team is screened daily and, to the best of their knowledge, have not been exposed to the virus. We are a place of public accommodation, and other persons (including other patients) could be infected, with or without their knowledge. I hereby knowingly and willingly consent to have dental treatment completed at this time. I will hold harmless and indemnify, the doctor, practice, associates, employees, successors, assigns, legal representatives, organizers, sponsors, and supervisors, against any claims, and actions, in exchange for dental treatment during the events of COVID-19 National Emergency. I make this decision of my own free will relying upon my knowledge and judgement of any injury I may have sustained or possible transmission of COVID-19 during treatment and my decision to release has not been affected by any false statements or representations pertaining to those injuries. I have carefully read this release and understand its contents, and I am signing it of my own free act.

Patient Name ____ Date ___________________________Signature____

TIME 10:43 AM DATE 7/12/2011

MEDICAL HISTORY

PATIENT NAME ____ Birth Date ___________________________________

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, please explain: ______________________

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: ______________________

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: ______________________

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: ______________________

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No ______________________

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No ______________________

Are you on a special diet? ◯ Yes ◯ No

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Women: Are you

Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: ______________________

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

AIDS/HIV Positive ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No
Angina ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No
Asthma ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No
Cancer ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No
Cortisone Medicine ◯ Yes ◯ No
Diabetes ◯ Yes ◯ No
Drug Addiction ◯ Yes ◯ No
Easily Winded ◯ Yes ◯ No
Emphysema ◯ Yes ◯ No
Epilepsy or Seizures ◯ Yes ◯ No
Excessive Bleeding ◯ Yes ◯ No
Excessive Thirst ◯ Yes ◯ No
Fainting Spells/Dizziness ◯ Yes ◯ No
Frequent Cough ◯ Yes ◯ No
Frequent Diarrhea ◯ Yes ◯ No
Frequent Headaches ◯ Yes ◯ No
Genital Herpes ◯ Yes ◯ No
Glaucoma ◯ Yes ◯ No
Hay Fever ◯ Yes ◯ No
Heart Attack/Failure ◯ Yes ◯ No
Heart Murmur ◯ Yes ◯ No
Heart Pacemaker ◯ Yes ◯ No
Heart Trouble/Disease ◯ Yes ◯ No
Hemophilia ◯ Yes ◯ No
Hepatitis A ◯ Yes ◯ No
Hepatitis B or C ◯ Yes ◯ No
Herpes ◯ Yes ◯ No
High Blood Pressure ◯ Yes ◯ No
High Cholesterol ◯ Yes ◯ No
Hives or Rash ◯ Yes ◯ No
Hypoglycemia ◯ Yes ◯ No
Irregular Heartbeat ◯ Yes ◯ No
Kidney Problems ◯ Yes ◯ No
Leukemia ◯ Yes ◯ No
Liver Disease ◯ Yes ◯ No
Low Blood Pressure ◯ Yes ◯ No
Lung Disease ◯ Yes ◯ No
Mitral Valve Prolapse ◯ Yes ◯ No
Osteoporosis ◯ Yes ◯ No
Pain in Jaw Joints ◯ Yes ◯ No
Parathyroid Disease ◯ Yes ◯ No
Psychiatric Care ◯ Yes ◯ No
Radiation Treatments ◯ Yes ◯ No
Recent Weight Loss ◯ Yes ◯ No
Renal Dialysis ◯ Yes ◯ No
Rheumatic Fever ◯ Yes ◯ No
Rheumatism ◯ Yes ◯ No
Scarlet Fever ◯ Yes ◯ No
Shingles ◯ Yes ◯ No
Sickle Cell Disease ◯ Yes ◯ No
Sinus Trouble ◯ Yes ◯ No
Spina Bifida ◯ Yes ◯ No
Stomach/Intestinal Disease ◯ Yes ◯ No
Stroke ◯ Yes ◯ No
Swelling of Limbs ◯ Yes ◯ No
Thyroid Disease ◯ Yes ◯ No
Tonsillitis ◯ Yes ◯ No
Tuberculosis ◯ Yes ◯ No
Tumors or Growths ◯ Yes ◯ No
Ulcers ◯ Yes ◯ No
Venereal Disease ◯ Yes ◯ No
Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No ______________________

Comments: ____

____

____

____

____

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.

____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN ______________________________ DATE ________________

DENTISTRY
AT THE MILLS

1860 Duluth Highway Suite 401

Lawrenceville, GA 30043

Phone: 678-226-9063 Fax:678-226-9445

dentistryatthemills@gmail.com

Cancellation/No show fee

We understand that you may sometimes need to reschedule appointments. When we make your appointment, please understand that we are reserving time for you to see a provider. This courtesy makes it possible to give the best service here at Dentistry at the Mills. If you need to reschedule an appointment, please call our office as soon as possible or call at least 48 hours in advance.

If you have no showed for your appointment more than 1 time you will be charged a $50 no show fee.

We thank you for your trust here at Dentistry at the Mills.

Patient Signature Date

-------------------------------- -------------------------