Patient Information

Patient Name: _____ Date: _____

. Last, First, MI (Preferred Name) Gender: _____

Social Security #: _____ Birth Date: _____ Marital Status: S M D W Child

Phone (Home): _____ ____(Work): _____ Ext: _____

(Cell) _____ E-Mail: _____

Best Place for confirmation calls: Home____ Work____ Cell_____ Text Message _____ Email_____

Street Address: _____ Apt#: _____

City: _____ State: _____ Zip Code: _____

Health Information

Date of Last Dental Visit: _____ Reason For This Visit: _____

Have you ever had any of the following? Please check those that apply:

☐AIDS
☐Allergies_____
_____
☐Anemia
☐Arthritis
☐Artificial Joints
Date_____
☐Asthma
☐Blood Disease
☐Cancer
☐Codeine Allergy
☐Diabetes
☐Dizziness
☐Epilepsy
☐Excessive Bleeding

☐Fainting
☐Glaucoma
☐Growths
☐Hay Fever
☐Head Injuries
☐Heart Disease
☐Heart Murmur
☐Hepatitis
☐High Blood Pressure
☐Jaundice
☐Kidney Disease
☐Liver Disease

☐Mental Disorders
☐Nervous Disorders
☐Pacemaker
☐Penicillin Allergy
☐Currently Pregnant
Due Date:_____
☐Radiation Treatment
☐Respiratory Problems
☐Rheumatic Fever
☐Rheumatism
☐Sinus Problems
☐Smoker

☐Stomach Problems
☐Stroke
☐Tuberculosis
☐Tumors
☐Ulcers
☐Venereal Disease
☐Plavix/Coumadin
☐Bisphosphonates (ex. Fosamax, Boniva, Actonel)
OTHER:
☐_____
☐_____

- Have you ever had a history of drug or alcohol abuse ☐Yes ☐No
If yes, please explain: _____

- Have you been admitted to a hospital or needed emergency care during the past two years? ☐Yes ☐No
If yes, please explain: _____

- Are you now under the care of a physician for a particular medical condition? ☐Yes ☐No
If yes, please explain: _____

- Name of Physician: _____ Phone: _____

- Do you have any health problems that need further clarifications? ☐Yes ☐No
If yes, please explain: _____

- List any medications and doses you area currently taking: _____
_____

To the best of my knowledge, all of the preceding answers and information are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of Patient, Parent, or Guardian: _____ Date: _____

Referral Information

Whom may we thank for referring you to our practice? ☐Another Patient, Friend ☐Another Patient, Relative
☐Dental Office ☐Yellow Pages ☐Internet ☐School ☐Insurance ☐Other_____
Name of person or office referring you to our practice: _____

Responsible Party or Parent/Guardian Information

The following is for: ☐ The Patient ☐The Patient's Spouse ☐ Parent/Guardian

Name:_____ Relationship to patient_____

☐Married ☐Single ☐Other_____ ☐ Male ☐ Female

Social Security #:_____ Birth Date:_____

Home Phone: _____Work:_____Ext:_____(Cell)_____

Street Address: _____Apt #:_____

City: _____State:_____Zip Code:_____

Employment Information

The following is for: ☐The Patient ☐Parent/Guardian

Employer Name:_____ Phone #_____

Street Address: _____

City: _____State:_____Zip:_____

Insurance Information

Primary Ins.
Name of Policy Holder: _____

Policy Holder's DOB: _____ Member Id#:_____ Social Security # _____

Name of Insurance Company: _____

Insurance Company's Address:_____

City: _____State:_____Zip Code:_____

Employers Name:_____

Patient's Relationship to Insured: ☐Self ☐Spouse ☐Child ☐Other_____

Simply Dental

4460 Atlanta Hwy
Loganville, GA 30052
770-554-3700

Consent for Services

I hereby authorize the doctor or designated staff to take X-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs.

Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives, and other medication as necessary (including nitrous oxide). I fully understand that using such anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand and agree that I am responsible for any portion of my bill that my insurance company does not pay within sixty days of claim submission. I understand payment is due at the time of service. In the event that payments are not received by agreed upon dates, I understand that a late charge of 1.5% (18%) may be added to my account.

If this account must be turned over to collections, then you would be responsible for all collection fees charged by the agency.

_____ _____ _____

Signature of Patient, or Guardian Date Relation to Patient

Acknowledgement of Receipt of Privacy Practices and HIPPA Statement.

I have received a copy of the Notice of Privacy Practices and a copy of the HIPPA statement for the above named practice.

_____ _____ _____

Signature of Patient, or Guardian Date Relation to Patient

Insurance Authorization

I authorize release of information to all my insurance carriers

I understand that I am responsible for treatment not paid by my insurance within 60 days after claim submission.

I authorize payment directly to my doctor

I authorize my doctor to act as my agent in helping me obtain payment from my insurance

We reserve your appointment time on our schedule. We ask your consideration in keeping your Appointments. If you must miss you're appointment, please call 24 in advance so that we may be able to fill that time slot with another patient. If you miss or cancel 2 appointments without giving proper notice you will be given a referral to another office and will be dismissed from our practice.

_____	_____	_____
Signature of Patient, or Guardian	Date	Relation to Patient

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Financial Policy

We are committed to providing you with the best possible care. If you have dental or medical insurance, we are anxious to help you receive your maximum allowable benefits, in order to achieve these goals, we need your assistance and your understanding of our payment policy.

Payment for services is due at the time services are rendered. We will accept cash, checks, and all major credit cards. We also accept Care Credit payment plans. We will be happy to help you process your insurance claim. Any such request must be accompanied by a completed insurance form and any updates at each visit.

Returned checks and balances older than 60 days will be subject to a $25 charge and additional collections fees

We will gladly discuss your proposed treatment and answer any questions relating to your insurance.

You must realize that:

1. Your insurance is a contract between you, your employer, and your insurance company. We are not party to that contract.
2. Our fees are generally considered to fall within the acceptable range by most insurance companies and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies that pay a percentage (such as 50% or 80%) of U.C.R. which is defined as usual, customary, and reasonable.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
4. You will be fully responsible for any balance not paid by insurance within sixty days after your claim has been submitted. You will receive a bill from us showing the outstanding balance. We will be happy to provide any documentation to help assist you in collecting reimbursement from your insurance company directly.

We emphasize that as dental care providers, our relationship is with you, NOT your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the service was provided. We realized that temporary financial problems may affect timely payment of your account. If such problems arise, we encourage you to contact us promptly for assistance in the management of your account.

Our goal is to provide the best possible treatment for you and your family. That is not the goal of most insurance companies. This is an important thing to consider because we may recommend treatment that is in your best interest even though it may not be covered by your insurance plan.

If you have any questions about the above information or any uncertainty regarding your insurance coverage, please do not hesitate to ask.

I have read and understand the financial policy:

Signature of patient, parent, or guardian: _____ Date: _____