Premier Dental Care of Buckhead

MAKING SMILES...ONE PATIENT AT A TIME

Name: _____ Birthdate: _____

Street Address: _____ City _____ Zip _____

Cell Phone #: _____ Work Phone # _____

Email: _____ Emergency Contact: _____

Consent Agreement:

1. I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctors to make a thorough diagnosis of my dental and health needs.
2. Upon such diagnosis, I authorize the doctor to preform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I consent to the use of appropriate medication and therapy as deemed necessary. I fully understand that using anesthetic agents embodies certain risks.

Financial Policies/Insurance Agreement:

Financial Policies: We accept Visa, Mastercard, Discover and American Express.
*We are a **fee-for-service office**, so our patients ***pay up front at the time of the visit***, and then we *will file the insurance claim for you*. After we file the insurance claim, the insurance company will reimburse you directly for however much they cover on the treatment you've received. If you have not received payment from them after 4-6 weeks, we are happy to refile the claim for you again, just give us a call. It will ultimately be your responsibility to phone your insurance company to follow up on payments not received.
Insurance: We do accept all insurance plans as long as your specific plan allows you to visit an out-of-network provider. We are not in network with any insurance companies, so you will want to make sure your plan, possibly a PPO plan, will allow you to go out of network and will pay out-of-network dental benefits. As with many medical providers, our fees may exceed the amount insurance carriers will pay. Every dental insurance plan has different stipulations regarding access to care and payment for services rendered. Within the same insurance company, benefits may differ depending upon what type of contract employers negotiate with that carrier on an employee's behalf. Ultimately, it is important for the patient to understand his/her dental benefits including specific inclusions and exclusions. Our office asks that you realize we do not work for or with any insurance company. However, we do work 100% for our patients. The treatment recommended to you at our office, as well as the fees, are always based on individual needs, and not your insurance coverage.

Signature: _____ **Date**: _____

MEDICAL AND DENTAL HISTORY

Please fill in the spaces below as accurately as possible. For your safety, it is necessary as part of any complete examination to know about your general health. This material will, of course, be held confidential.

NAME_____ Date of Birth_____

1. Are you under a physicians care?_____ Family physician_____
2. Are you taking any type of medication?_____ Please list_____

_____

3. What is your sensitivity to medications? I need ( ) More ( ) Less ( ) Same dose of medication compared to others.
4. Are you allergic to any of the following? (Please check)
   Codeine ( ) Aspirin ( ) Novocaine ( ) Penicillin ( ) Latex ( ) Other_____
5. Have you ever had or do you have: (Please check)

Heart Trouble	( )	Bleeding or Clotting Problem	( )	Sinus Trouble	( )	Arthritis	( )
Heart Attack	( )	Shortness of Breath	( )	Persistent Cough	( )	Physical Handicap	( )
Stroke	( )	Hepatitis (Jaundice)	( )	Lung Trouble	( )	Cancer	( )
Anemia	( )	Tuberculosis	( )	Asthma	( )	Kidney Trouble	( )
Chest Pains	( )	Diabetes	( )	Emphysema	( )	Thyroid Problems	( )
Osteoporosis	( )	High Blood Pressure	( )	Fainting Spells	( )	Epilepsy	( )
Seizure	( )	Low Blood Pressure	( )	Allergies	( )	Leukemia	( )
Liver Trouble	( )	AIDS /HIV +)	( )	Glaucoma	( )	Venereal Disease	( )
				Stomach Ulcers	( )	Chemical Dependency	( )

6. Height _____ Weight _____
7. Have you had any serious illness or been hospitalized in the last 5 years?_____

   Describe_____
8. Have you ever been given anesthesia before (put to sleep)? YES NO

   Describe_____
9. Do you smoke? YES NO Do you chew tobacco? YES NO
10. (Women) Are you pregnant? YES NO Are you taking birth control pills? YES NO

11. When was your last visit to the dentist?_____
12. Have you ever had or do you now have: (Please check)

Problems with dental treatment	( )	Bleeding Gums	( )	Problems with anesthetics	( )
Pain in teeth or jaws	( )	Periodontal disease	( )	Food catching between teeth	( )
Clench or Grind your teeth	( )	Bruise easily	( )	Injuries to teeth or jaw	( )
Clicking or pain in the jaw joint	( )	Gag easily	( )	Sensitivity to sweets, biting	( )
Headaches	( )	Snoring Problem	( )	Sensitivity to hot or cold	( )
Jewelry or metal sensitivity	( )				

13. How often do you brush your teeth?_____ Floss them?_____
    What type of toothpaste do you use? _____ Mouthwash? _____
14. Do you have missing teeth?_____ Why were they not replaced?_____
15. Have you ever had a bad experience in a dental office?_____
16. What part of dentistry do you find most unpleasant?_____
17. Please describe any dental problem that is bothering you at this time._____

_____

BP _____ _____ Signature of patient or guardian _____ Date

Insurance Information

*It is important to have **all of the information** so that you can be reimbursed by your insurance company in a timely manner.

Please be aware some of the information is not on your card and will require you to call and obtain this information by phone to complete this form. Thank you.

Policy Holder Name: _____ **DOB**: _____

Employer of Insured: _____

Insurance Company: _____

Insurance claims address : _____

_____

Phone Number of Insurance Company: _____

Member ID#: _____

Group #: _____

Payor Id # _____

This form can be emailed back to: info@pdcofbuckhead.com

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HIPPA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

-Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)

-Obtaining payment from third party payers (I.E. my insurance company)

-The day-to-day healthcare operations of your practice

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and rights under HIPPA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

- Please note o.ur Notice of Privacy Practice is posted by the front desk.

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____ Date: _____