Stockbridge Dental

NEW PATIENT PACKET 1

PATIENT INFORMATION

Patient First Name:	
Middle Name:	
Last Name:	
Date of Birth:	
SSN #:	
Address:	
City:	
State:	
Zip Code:	
Email:	
Preferred method of contact:	◯ Text ◯ Email ◯ Call
Marital Status:	
Gender:	
Employer:	
Occupation:	
Cell Phone:	
Home Phone:	
Work Phone:	
Emergency Contact Name:	
Number:	
Relationship :	
Who may we thank for referring you?	◯ Location ◯ Internet ◯ Patient referral/other:
.	

IF PATIENT IS A MINOR

Parent's Name:	
Parent's Name:	
Address (If different from above):	
Address (If different from above):	
Date of Birth:	
Date of Birth:	
SS#:	
SS#:	
Employer:	
Employer:	

RESPONSIBLE PARTY

If patient is under the age of 18

Person Responsible for Account:	
Relation to patient:	
Address (If different from above):	
Birthdate:	
Home #:	
Cell #:	
Is this person a patient in our office?	◯ Yes ◯ No

DENTAL BENEFIT INFORMATION

Primary Ins. Company:	
Secondary Ins. Company:	
Insured's Name:	
Insured's Name:	
SS # or Member ID:	
SS # or Member ID:	
Policy#/Employer:	
Policy#/Employer:	

MEDICAL HISTORY

Patient's Name:	

Birthdate:	
Do you have a Primary Physician?	◯ Yes ◯ No
Physician's Name:	
Phone #:	
Are you taking any medications, pills, or prescription drugs?	◯ Yes ◯ No
If yes, please list each one:	
Have you had any metal rods, pins or implants placed?	◯ Yes ◯ No
If yes, please explain:	
Do you use tobacco of any form?	◯ Yes ◯ No
If yes, how often:	

WOMEN

Are you taking Birth Control Pills?	◯ Yes ◯ No
Are you nursing?	◯ Yes ◯ No

Are you pregnant?	◯ Yes ◯ No
If yes, # of weeks:	
Do you have, or have you ever had, any of the following?	☐ Anemia ☐ Apnea/Snoring ☐ Arthritis ☐ Artificial Joints ☐ Asthma ☐ Blood Disease ☐ Blood Transfusion ☐ Cancer ☐ Diabetes ☐ Drug Addiction ☐ Epilepsy ☐ Excessive Bleeding ☐ Fainting ☐ Glaucoma ☐ Heart Attack/Failure ☐ Heart Disease ☐ Heart Murmur ☐ Hepatitis ☐ Herpes ☐ High Blood Pressure ☐ HIV ☐ Kidney Disease ☐ Liver Disease ☐ Radiation Treatment ☐ Rheumatic Fever ☐ Rheumatism ☐ Sinus Problems ☐ Stroke ☐ Tonsillitis ☐ Tuberculosis ☐ Tumors ☐ Ulcers ☐ Venereal Disease
.	☐ AIDS/ HIV Positive ☐ Alzheimer's Disease ☐ Artificial Heart Valve ☐ Breathing Problems ☐ Bruise Easily ☐ Chemotherapy ☐ Chest Pains ☐ Cold Sores/Fever Blisters ☐ Congenital Heart Failure ☐ Parathyroid Disease ☐ Sickle Cell Disease ☐ Shingles
.	☐ Easily Winded ☐ Emphysema ☐ Excessive Thirst ☐ Frequent Cough ☐ Frequent Headaches ☐ Genital Herpes ☐ Heart Pacemaker ☐ Hemophilia ☐ Hepatitis A ☐ Psychiatric Care ☐ Spina Bifida ☐ Stomach/Intestinal Disease
.	☐ Hepatitis B or C ☐ Hypoglycemia ☐ Irregular Heartbeat ☐ Leukemia ☐ Low Blood Pressure ☐ Lung Disease ☐ Pain in Jaw Joints ☐ Mitral Valve Prolapse ☐ Pain in Jaw Joints ☐ Renal Dialysis ☐ Swelling of Limbs ☐ Thyroid Disease
Are you allergic to any of the following?	☐ Aspirin ☐ Codeine ☐ Latex ☐ Penicillin ☐ Sulfa
.	☐ Acrylic ☐ Metal ☐ Local Anesthetics ☐ Other (Please specify):

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I certify that I have read and answered the above information to best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I understand that this information will be held in the strictest confidence and it is my responsibility to inform Newnan Dentistry any changes to my medical history.
OFFICE USE ONLY

Medical History Reviewed:	
Sign:	
Patient Signature:	

DENTAL HISTORY

Patient's Name:	
Birthdate:	
What is the reason for your visit today?	
Date of Last Dental Visit:	
Last Dental Cleaning:	
Previous Dentist's Name:	
Address:	
City:	
State:	
Zip code:	
Have you had a negative dental experience associated with previous dental care?	◯ Yes ◯ No
If yes, please explain:	
Are you fearful of dentistry or have anxiety associated with dental treatment?	◯ Yes ◯ No
If yes, please explain:	
Have you ever been pre-medicated for dental treatment?	◯ Yes ◯ No
If yes, please explain:	
Have you ever had a reaction to anesthetic used with your dental treatment?	◯ Yes ◯ No
If yes, please explain:	
Please check any of the following problems that apply to you:	◯ Sensitivity (hot, cold, sweet) ◯ Tooth pain or discomfort when chewing ◯ Headaches, earaches, neck pain ◯ Jaw joint pain ◯ Teeth or fillings breaking ◯ Grinding or clenching teeth ◯ Bleeding, swollen or irritated gums ◯ Loose, tipped or shifting teeth ◯ Bad breath or bad taste in

	your mouth
If you could change your smile, you would:Close spaces	◯ Make it brighter ◯ Make it straighter ◯ Close spaces ◯ Replace metal fillings with tooth colored ◯ Repair chipped teeth ◯ Replace missing teeth ◯ Replace old crowns that don't match ◯ Have a Smile Makeover
We offer a wide variety of services to enhance and keep your smile healthy and beautiful. Please select any services below you would like our friendly staff to discuss with you during your visit:	◯ In office Teeth Whitening ◯ Smile Makeover ◯ Botox for cosmetic or therapeutic purposes ◯ Veneers/Lumineers ◯ Partials/Dentures ◯ Dermal Fillers ◯ Orthodontic Treatment ◯ Night Guards
I certify that I have read and understand the above and that the information given on this dental history form is accurate. I understand the importance of a truthful dental history and that Newnan Dentistry will rely on this information to treat me. I acknowledge that my questions, if any, related to the above have been answered to my satisfaction	
Patient Signature:	

FINANCIAL AGREEMENT

Thank you for choosing our office for your dental needs. We are committed to providing you with excellent care and convenient financial options. We realize you may be requiring some dental care and it is easy to forget that a doctor's office is also a small business. In the interest of both good patient care and good business, we believe it is best to communicate our policy to avoid any misunderstandings later. We thank you in advance for your compliance and cooperation. Please feel free to discuss any concerns or questions with the front office staff!

Payment: Payment in full is required at the time of service. For your convenience, we accept cash, checks, debit, and credit cards including Visa, Mastercard, Discover, and American Express. Our office also offers No Interest and Extended Payment Plans, upon approved credit, through Care Credit and Greensky. Checks returned for insufficient funds will be subject to a $40 service fee.	
Initial:	
Aged Account: The total balance on your account, after claim settlement, is due upon receipt of statement. Failure to keep this account current may result in Newnan Dentistry being not able to provide additional dental services. In the event of default, I agree that any information collected can be used to collect on my account, and I agree to pay all costs incurred in the attempt to collect on this account, including late fees of 10% or $30 (whichever is greater), finance charges, service and/or collection agency fees, attorney's fees, and court costs.	
Initial:	
Dental Benefits: Dental Insurance rarely pays for 100% of all dental services. It is generally designed for preventing pain and providing what may be described as "average financial assistance" for some dental procedures. Most insurance policies only pay a percentage of your investment and include a deductible, which must be paid by the patient before any insurance benefit will be provided. Please note that this office does not determine the amounts and limits of your dental benefits. They are determined contractually between your employer and their chosen insurance provider. Please understand that dental benefit policies vary greatly, therefore, we can only estimate your coverage in good faith, but cannot guarantee coverage due to the complexities of insurance contracts. We do not work for, belong to, or take direction from any managed care or contracted plans and are considered as an "Out of Network" provider. As a courtesy, we will bill your dental benefit provider for your care, providing you give us the needed information for claim submission. Your estimated co-pays are due at time of service and any balance unpaid after the claim settles is due within 14 days of receipt of statement.	
Initial:	

Assignment of Benefits:

I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to Newnan Dentistry. I understand that I am financially responsible for all charges regardless of benefit coverage and payment. I hereby authorize the Dentist to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Initial:	
I understand and agree to this patient agreement:	
Signature of Person Responsible for Account:	

APPOINTMENT POLICY

It is the aim of this office to provide quality dental care to patients and to use clinical time effectively. Since mutual understanding is the basis for good relationships, it is important for you to understand the nature of our office policies related to appointments. These are detailed below.

Timeliness:

We are committed to seeing you on-time and request you be on-time for your visits as well. This way, we can ensure all our patients are seen when promised.

Initial:	

Emergencies:

If you have what you believe to be a dental emergency, please contact us as soon as possible, preferably by telephone, so that we may properly assign an appointment time to handle your problem. Please be aware that we may have several emergencies at the same time. If we are unable to see you in a timely manner, we will refer you to a colleague, specialist, or emergency medical center.

Initial:	

Reminder Calls:

We have implemented an automated texting service to help patients reserve their appointments in their calendars. If opted in, when you make an appointment, you will get a text confirming your appointment time.

Because we know you are busy and our patients keep their commitments, we do not disturb you with multiple reminder calls. If we do not receive a reply through the automated texting service, we will attempt to contact you through your preferred method of communication with our office. Please be sure to give us a number where you can be reached or that has an answering machine or voicemail so that we may leave a message if you are unable to answer.

Initial:	

Broken Appointments:

We do not over-book our schedule. This means your appointment time is reserved especially for you. If you do not come, not only is your own care delayed, but no one else is able to be treated during that time. When appointments are not kept, dental costs increase for everyone and emergency patients that may have been treated must needlessly wait.

If you absolutely must reschedule, please give at least 48 hours notice (before 9 am Thursday for Monday appointments) to avoid possible broken appointment fees. In some cases, especially for large appointment space, you may be asked to give greater notice. There is generally no charge for the first missed appointment without 48 hours notice. To discourage repetitive broken appointments, we may assess a broken appointment charge for the second and each subsequent occurrence. The charges are dependent on how much time was reserved for your appointment.

Initial:	

Appointment Deposit:

We may ask you to reserve your appointment with a deposit toward your treatment, especially for longer appointments. This allows us to exclusively reserve your appointment time as well as helps patients spread out the expense of treatment over several visits if necessary. This deposit is fully refundable if the cancellation policy of 48 hours notice is maintained by our patients. If you fail to attend your appointment or give notice that you need to reschedule, the broken appointment fee will be assessed and some or all the deposit will be lost, and you will need to make another deposit to make another appointment for that amount of time.

If you would like to not place a deposit to reserve your appointment, we may be able to place you on a Priority List, as described below.

We realize there is always a good reason for not keeping a scheduled appointment. It is not our intent to "punish" anyone for failing to come for treatment. We have found, however, that it is best to be open and honest about what is expected, so that we may provide the highest quality dental treatment at the most reasonable cost possible. Some practices charge hidden fees or higher prices to cover lost time due to broken appointments, and some schedule more patients than can be treated in a day. This results in rescheduling patients, incomplete treatment, and / or excessive patient wait time. We do not resort to any of these tactics to cover our costs for broken appointment times. In return, we ask our patients to honor their commitment to an appointment scheduled.

Initial:	

Priority List:

Some patients, due to the nature of their job, health, etc., just cannot know until the last minute if they will be able to keep their appointment. If you are in this category, we maintain a list of patients that can come on short notice when time becomes available. Please advise the staff if you would like to be on this list. If you are contacted when a shortnotice appointment is available, you may accept the appointment or decline. If you decline, we will try again later.

Initial:	

Making Appointments for Others:

Occasionally, an appointment will wish to be made for a spouse, older child, elderly relative, etc. We prefer that patients make their own appointments to prevent any miscommunication regarding date, time, or treatment to be provided. We will accept these appointments, but they are subject to all the other rules and expectations of appointments made personally. Please be sure that the patient(s) for whom you are making the appointment(s) understand they must keep the commitment you are making for them.

Initial:	

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed. To see how you can get access to this information, please review it carefully. The privacy of your health information is important to us. Consent for use and disclosure of health 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 out Notice of Privacy Practices before you decide whether to sign this consent. Out notice provides a description of our treatment, payment activities, and healthcare operations, of the used 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 out privacy practices as described in our Notice of Privacy Practices. If we change out privacy practices, we will

issue a revised Notice of Privacy Practices, which will contain the changes. Those changes apply to any of your protected health information that we maintain.

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 office. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

Our Legal Duty:

We are required by applicable federal and state law to maintain the privacy of your health information We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect April 14, 2003 and will remain in effect until we replace it. We reserve the right to change our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change the Notice and provide the new Notice.

Uses and Disclosures of Health Information:

We use and disclose health information about you for your treatment, payment, and healthcare operations.

For example:

Treatment:

We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment:

We may use and disclose your health information to obtain payment for services we provide for you.

Healthcare Operations:

We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualification of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your Authorization:

In addition to our use of your health information for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot us or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends:

We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care:

We may use only that information which is directly relevant to the persons involvement in your healthcare. We will also use our professional judgement and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.
Required by Law: We may use or disclose your health information when we are required to do so by law.
Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim or abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.
National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal official's health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.
Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement of receipt of our Privacy Practices or to document our good faith effort to obtain that acknowledgement.	
YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT	
I,	
, have received a copy of this office's Notice of Privacy Practices.	
Signature:	
Many of our patients allow family members such as their spouse, parents, or others to call and request medical or billing information. Under the requirements of HIPAA, we are not allowed to give this information to anyone without the patients consent. Please list below those that you give permission to discuss your health information.	
Please Print Name	
Relationship (Example: Spouse, Child, Caretaker)	
Please Print Name	
Relationship (Example: Spouse, Child, Caretaker)	
Please Print Name	
Relationship (Example: Spouse, Child, Caretaker)	

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:	◯ Individual refused to sign ◯ Communication barriers prohibited obtaining the acknowledgement ◯ An emergency situation prevented us from obtaining acknowledgement ◯ Others (Please Specify)
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