



Patient Information (Confidential)	Dental Insurance Information Only
Name _____ <div style="display: flex; justify-content: space-between; font-size: small;"> <span>First</span> <span>Middle</span> <span>Last</span> <span>M F Sex</span> </div>	Name of Insured _____
Address _____ City _____	Relationship to Patient _____ Home Phone _____
State _____ Zip _____ Email _____	Birthdate _____ SS# _____
SS# _____ Birthdate _____ Age _____	Date Employed _____ Employer Name _____
Phone: Home _____ Work _____	Union or Local # _____ Work Phone _____
Check Appropriate Box: <input type="checkbox"/> Minor <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated	Employer's Address _____
If College Student, <input type="checkbox"/> Full time <input type="checkbox"/> Part time	City _____ State _____ Zip _____
School Name _____ City _____ State _____	Insurance Co. _____ Tel. # _____
Patient's or Parent's Employer _____	Ins. Group # _____ Policy / ID # _____
Business Address _____	Ins. Co. Address _____ City _____
City _____ State _____ Zip _____	State _____ Zip _____ Max. Annual Benefit? _____
Spouse or Parent's Name _____	How much is your deductible? _____
Employer _____ Work Phone _____	How much have you used this year? _____
Emergency Contact _____	Do you have any additional insurance <input type="checkbox"/> Yes <input type="checkbox"/> No
Phone _____	

### Responsible Party

Name of Person Responsible For This Account \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Address \_\_\_\_\_

Home Phone \_\_\_\_\_ SS# \_\_\_\_\_ Driver's License # \_\_\_\_\_

Birthdate \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Is this person currently a patient in our office?  Y  N

X

Signature of Patient or Parent if Minor

Date



# Patient Medical History

Name \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_

- |  | YES | NO  |
|--|-----|-----|
| 1. Are you in good health?   | ___ | ___ |
| 2. Have there been any changes in your general health within the past year?  | ___ | ___ |
| 3. Date of your last physical exam: _____  |     |     |
| 4. Physician's Name _____<br>Address _____<br>Phone No. _____  |     |     |
| 5. Are you now under the care of a physician? ___  | ___ | ___ |
| 6. Have you ever been hospitalized for any surgical operation or serious illness? ___<br>Please explain, _____   | ___ | ___ |
| 7. Are you taking any medicines including nonprescription medicines? ___<br>If yes, what are you taking _____<br>_____   | ___ | ___ |
| 8. Bruise easily or abnormal bleeding?   | ___ | ___ |
| 9. Have you ever required a blood transfusion ___  | ___ | ___ |
| 10. Have you had a recent weight loss?   | ___ | ___ |
| 11. Have you ever taken Fen-Phen or Redux? ___   | ___ | ___ |
| 12. Have you ever had biphosphonate drugs for Cancer or Osteoporosis ___   | ___ | ___ |
| 13. Do you use tobacco?  | ___ | ___ |
| 14. Do you or have you used controlled drugs? ___  | ___ | ___ |
| 15. Are you wearing contact lenses?  | ___ | ___ |
| 16. Do you have any disease, condition or problem not listed above that you think I should know about?   | ___ | ___ |
| 17. Women: Are you pregnant or nursing? ___<br>Taking birth control pills? ___   | ___ | ___ |
| 18. Are you allergic to or have you had serious reactions<br>Local anesthetics like Novocain ___<br>Penicillin or other antibiotics ___<br>Sulfa drugs ___<br>Barbiturates, sedatives or sleeping pills ___<br>Aspirin or similar NSAIA's ___<br>Iodine or shellfish ___<br>Latex / rubber or any metal ___<br>Other (please list) _____ | ___ | ___ |
| 19. Do you have or have you had the following:<br>Rheumatic heart disease or rheumatic fever ___<br>Scarlet fever ___<br>Heart defect/murmur, Mitral valve prolapse ___<br>Heart surgery, trouble, attack, or angina ___<br>Any family history of heart disease ___  | ___ | ___ |
| 20. Chest pain, shortness of breath, pacemaker ___<br>High / low blood pressure ___<br>Hepatitis, jaundice or liver disease ___  | ___ | ___ |

- | YES | NO  |  |
|-----|-----|--|
| ___ | ___ | Stroke                                   |
| ___ | ___ | Sinus trouble                            |
| ___ | ___ | Lung or breathing problems               |
| ___ | ___ | Asthma or hay fever                      |
| ___ | ___ | Hives or skin rash                       |
| ___ | ___ | Fainting or dizzy spells                 |
| ___ | ___ | Diabetes (you or a family member)        |
| ___ | ___ | AIDS or HIV infection                    |
| ___ | ___ | Thyroid problems                         |
| ___ | ___ | Allergies                                |
| ___ | ___ | Arthritis, rheumatism, fibromyalgia      |
| ___ | ___ | Joint replacement or any implant         |
| ___ | ___ | Stomach ulcer, reflux, IBS, Crohn's      |
| ___ | ___ | Kidney trouble                           |
| ___ | ___ | Tuberculosis, persistent or bloody cough |
| ___ | ___ | Chemotherapy for cancer or leukemia      |
| ___ | ___ | Sexually transmitted disease             |
| ___ | ___ | Epilepsy or seizures, M.S.               |
| ___ | ___ | Anemia or blood disorders                |
| ___ | ___ | Glaucoma                                 |
| ___ | ___ | Nervousness or phobias                   |
| ___ | ___ | Tumors or Cancer                         |
| ___ | ___ | Mental health care: Diagnosis _____      |
| ___ | ___ | Back problems                            |
| ___ | ___ | Chemical dependency, addictions          |
| ___ | ___ | Cortisone treatment                      |
| ___ | ___ | Cold sores / fever treatment             |
| ___ | ___ | Hypoglycemia                             |
| ___ | ___ | Eating disorders, bulimia, anorexia      |
| ___ | ___ | Chronic pain condition                   |
| ___ | ___ | Head or neck trauma, whiplash            |
| ___ | ___ | Hyperchondriosis                         |
| ___ | ___ | OTHER (please list) _____                |

## Patient Dental History

Reason for this visit \_\_\_\_\_

Date of last dental visit \_\_\_\_\_ What was done? \_\_\_\_\_

Previous dentist name / location \_\_\_\_\_

Date of last complete series of dental x-rays \_\_\_\_\_

**Circle all that you are concerned about / currently have:**

- |                      |                 |                     |      |        |
|----------------------|-----------------|---------------------|------|--------|
| Tooth pain/ache      | Sensitivity to: | Hot                 | Cold | Sweets |
| Cavities             | Gum disease     | Pain to bite        |      |        |
| Broken teeth         | Broken fillings | Missing teeth       |      |        |
| Dark teeth           | Ugly teeth      | Crooked teeth       |      |        |
| Bad breath           | Clicking jaw    | Fear of dentists    |      |        |
| Loose teeth          | Spacing         | Grinding/clenching  |      |        |
| Jaw or face pain     | Headaches       | Want whiter teeth   |      |        |
| Want to save teeth   | Poor dentistry  | Want gentle dentist |      |        |
| Dream teeth fall out | Recession       | Cosmetic dentistry  |      |        |
| Snoring / Apnea      | Nothing         | Bleeding gums       |      |        |



### Dental History

### Personal Interest Info

**I am changing dentists because:** Check any that apply

- Recently moved into this area from \_\_\_\_\_
- Dr/staff personality / communication problem
- Inadequate care     Fee concern
- I 'm fleeing managed care / don't want a "list" dentist
- To find a dentist team who understands my needs

**Circle how you first heard about us?** Check any that apply

- Convenient location (Saw sign on the road)     Google.com
- Family member already comes here (who?) \_\_\_\_\_
- Referred by a friend (Who?) \_\_\_\_\_
- I got your brochure in the mail     Suwaneedentalcare.us
- I got one a Mini-CD Roms     Christian Living Magazine
- Yellow Pages     Yahoo.com     North Gwinnett Schools
- DoctorOogle.com     ATL Home & Style TV     1818 Club
- Suwaneedental.com Website     Video in Email
- I dreamt I should come here     "I Love Suwanee" Blog
- Gwinnett Gladiators Hockey Team Dentist     Kudzu.com
- Best of Gwinnett 2003- 2008 in Gwinnett Magazine
- Gwinnett Chamber of Commerce Other \_\_\_\_\_
- Get the Smile you've always wanted infomercial
- WWEV Victory 91.5 Radio     104.7 The Fish Radio
- Zoom     BriteSmile     Invisalign     Gwinnett Ballet
- I prayed for help and here I am     SHUMC     12 Stone

**I have avoided dental care in the past because:**

- Fear of \_\_\_\_\_
- Time commitment                       No perceived need
- Financial commitment                       Trust factor

If you could change anything about **your smile**, what would you change? \_\_\_\_\_

- Where are you from originally? \_\_\_\_\_
- Your occupation and job \_\_\_\_\_
- Schools attended \_\_\_\_\_
- Spouse's name & occupation \_\_\_\_\_
- Children's names, ages \_\_\_\_\_
- What's more fun than dental visits? \_\_\_\_\_

**Are you interested in exploring** (check any that apply):

- Dental wellness & Anti-Aging (go beyond good health)
- Ways to reduce or eliminate periodontal surgery
- Invisalign invisible orthodontic aligners
- BriteSmile & ZOOM whitening     Deep Bleaching
- The best dental home care systems (CloSysII)
- A good church in the area
- Info on helping snoring or sleep apnea in your home
- Kenya / Honduras/ Other Dental Mission Trips
- Sedation Dentistry (taking a pill) options
- Smile Makeover -- Smile Analysis & Design
- Why dental infections cause heart & other diseases

### Authorization & Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I agree to dental examination and any necessary records that are necessary for an accurate diagnosis. I authorize the dentist to use any treatment records, x-rays , models, or photos for scientific, teaching or promotional purposes.

X \_\_\_\_\_ Date \_\_\_\_\_  
Signature of Patient or Parent if Minor

#### Doctor's Notes:

Pt. Chief concerns  
Dr. Chief concerns

Tx Priorities    Q    I    II    III    IV  
Guarded prognosis # \_\_\_\_\_  
Urgency of Tx: Low    Med    High

#### Conditions

PD 2 3 4    BL    G    Rec    Cav    WOD    Abfrac    Abcess    Pulp    Phobia  
MT    BC    Attrition    TMJ    Click    Pain    Ortho    Cr    Sp    XB    Cosmetic

#### Goals

SNTG    TTLGFGWWAC    Wellness    Cosmetic    Phased    Ideal

#### Options

Pro    NST 2 3 4    PS    Q1 2 3 4    BG    FGG    CTG    Fren    Fl    Premed  
Ext    RCT    PC    Apico    Biopsy    Implant    SA    CrL 1 2 Q  
TMJ Ex    DxC    Tomo    K7    T-Scan    Equil    NG    SG    NTI    Cerec  
AER    Inlay    Onlay    Cr    Br    RPD    CD    OD    S    OrthoEx    Invis    RWB  
Smile Analysis    FB    DxWax    CTemp    Veneers    C    WT    Sedation

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_



## SUWANEE DENTAL CARE

In order to accommodate the needs and requests of our patients, Suwanee Dental Care does file dental insurance. We are not contracted with any insurance companies. While we are pleased to be able to provide this service to you, it is not possible for our staff to keep track of all the individual requirements of each plan. Every plan has different stipulations regarding access to care and payment for services received. Within the same insurance company, benefits may differ depending upon what type of contract your employer negotiated with that carrier on your behalf.

It is the insured person's responsibility to understand their benefits. We do not wish that your insurance company comes between you and your doctor. You must do your part in understanding the limitations of insurance policies and what your company has purchased for you. Dental benefits differ greatly from medical benefits. In 1959, most dental benefit plans had a yearly maximum cap of \$1,000. There has been no significant increase in the yearly maximum cap in 40 years! However, there have been significant increases in your premiums. Dental benefit plans will never pay for completion of your dental care. It is only meant to assist you.

Many people receive notification from their insurance company that dental fees are "above usual and customary." An insurance company determines their reimbursement level by surveying a geographical area, calculating the average fee, then determines that 80% of the average fee is customary. Included in this survey are discounted dental clinics and managed care facilities, which have severely reduced dental fees that bring down the average. Any doctor in private practice will have fees that insurance companies define as "higher than usual and customary." Our fees reflect the quality you receive.

Many dental benefit plans tell their participants that they will be covered "up to 80% or 100%" but do not clearly specify the plan fee schedule allowance, annual maximum or limitations. It is more realistic to expect dental benefit plans to cover between 25% to 40% of dental services. Remember that the amount a plan reimburses is determined by how much your employer has paid for your dental benefit plan. You will get back only what your employer has put in, less the insurance company's profit margin.

Insurance companies do NOT cover many routine and newer dental services. We bill your insurance as a courtesy. If insurance does not pay within 60 days, Suwanee Dental reserves the right to request payment in full for services from you and let you collect the insurance funds that are due to you. This is rare but it is important that you recognize that the insurance you have is a legal contract between YOU and YOUR insurance company. Our office is not, and cannot be a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office. You will be charged interest at the rate of 1.5% on your account balance. In the event your account is turned over to an outside agency for collections, you will be responsible for all collection fees, costs and such additional sums as the court may adjudge reasonable...such as court costs, attorney fees, service of process in said suite or action.

If you do not inform us of any special requirements in your insurance contract, such as referrals or pre-authorization for treatment, and we subsequently complete services that are not covered, we will have no choice but to bill you directly for those charges. In the event that services are provided and your insurance coverage is not in effect on that day or has a waiting period, or a missing tooth clause, your carrier will probably deny payment for services received. Suwanee Dental Care can only estimate what your carrier will pay on a specific treatment, if your insurance carrier pays a lesser amount than estimated you will be billed for the difference. It is your responsibility to keep up with the maximum amount of benefits you have used in a calendar year. Please remember that you, the patient, are ultimately responsible for payment on your account.

Our team members will gladly assist you in filling out the necessary forms to maximize your dental benefits and discuss your financial options. Excellent dental care is available with or without dental benefits. We welcome you to our family and look forward to helping you get the healthy, beautiful smile you've always wanted. We hope you will choose the best that dentistry has to offer.

I have read, and understand, and accept the terms of the about outlined policies for insurance and financial commitments that may incur as a result of treatment at Suwanee Dental Care.

Signature \_\_\_\_\_

Date \_\_\_\_\_