SUWANEE DENTAL CARE COMPREHENSIVE DENTISTRY

Patient Information (Confidential)

Name_____ _M F_
First Middle Last Sex

Address_____City_____

State_____Zip_____Email_____

SS#_____Birthdate_____Age_____

Phone: Home_____Work_____

Check Appropriate Box: __ Minor __ Single __ Married
__ Divorced __Widowed __ Separated

If College Student, __ Full time __ Part time

School Name_____City_____State_____

Patient's or Parent's Employer_____

Business Address_____

City_____State_____Zip_____

Spouse or Parent's Name_____

Employer_____Work Phone_____

Emergency Contact_____

Phone_____

Dental Insurance Information Only

Name of Insured_____

Relationship to Patient_____Home Phone_____

Birthdate_____SS#_____

Date Employed_____Employer Name_____

Union or Local #_____Work Phone_____

Employer's Address_____

City_____State_____Zip_____

Insurance Co._____Tel. #_____

Ins. Group #_____Policy / ID #_____

Ins. Co. Address_____City_____

State_____Zip_____Max. Annual Benefit?_____

How much is your deductible?_____

How much have you used this year? _____

Do you have any additional insurance ____ Yes ____ No

Responsible Party

Name of Person Responsible For This Account_____

Relationship to Patient_____Address_____

Home Phone_____SS#_____Driver's Liscense #_____

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 or **N**O

____ ____Are you in good health?
____ ____Have there been any changes in your general health within the past year?
Date of your last physical exam: _____
Physician's Name_____
Address_____
Phone No. _____
____ ____ Are you now under the care of a physician?
____ ____Have you ever been hospitalized for any surgical operation or serious illness?
Please explain, _____
____ ____Are you taking any medicines including nonprescription medicines?
If yes, what are you taking_____
_____
_____
____ ____ Bruise easily or abnormal bleeding?
____ ____ Have you ever required a blood transfusion
____ ____Have you had a recent unintended weight loss/gain
____ ____Have you ever needed deep cleaning/SRP?
____ ____Have you ever had bisphosphonate drugs (for Cancer or Osteoporosis)
____ ____Do you use tobacco? How much? Quit date?
____ ____ Do you or have you ever had history of alcohol or substance abuse?
____ ____Are you wearing contact lenses?
____ ____Have you been diagnosed with Gum disease?
____ ____Women: Are you pregnant?
____ ____Are you nursing?
____ ____Taking birth control pills
Are you allergic to or have you had serious reactions (other than stomach upset) to:
____ ____Local anesthetics like Novocaine
____ ____Penicillin or other antibiotics
____ ____Barbiturates, sedatives or sleeping pills
____ ____Aspirin or similar NSAIDs
____ ____Any metals
____ ____Latex / Rubber/ Adhesive
Other (please list) _____
Do you have or have you had the following:

Cardiovascular

____ ____ Rheumatic heart disease or fever
____ ____ Scarlet fever
____ ____ Heart defect/murmur, Mitral valve prolapse
____ ____ Stroke
____ ____ Heart surgery, trouble, attack, or angina
____ ____ Chest pain, shortness of breath
____ ____ High / low blood pressure
____ ____ Pacemaker
____ ____ Fainting or dizzy spells
____ ____ Anemia or blood disorders

Pulmonary

____ ____ Sinus issues
____ ____ Seasonal Allergies
____ ____ Lung or breathing problems
____ ____ Asthma or hay fever
____ ____ Tuberculosis, persistent or bloody cough
____ ____ COPD

Endocrine

____ ____ Hepatitis(A,B,C), jaundice or liver disease
____ ____ Stomach ulcer, reflux, IBS, Crohn's
____ ____ Hypoglycemia
____ ____ Kidney trouble
____ ____ Hives or skin rash
____ ____ Diabetes
____ ____ Thyroid problems

Neuromuscular

____ ____ Arthritis, rheumatism, fibromyalgia
____ ____ Epilepsy or seizures
____ ____ Back problems
____ ____ Chronic pain condition
____ ____ Cortisone treatment
____ ____ Glaucoma (Narrow/Wide)

Skeletal

____ ____ Joint replacement or any implants?
Date_____
____ ____ Head or neck trauma, whiplash

Systemic

____ ____ Sexually transmitted disease
____ ____ AIDS or HIV infection
____ ____ Lupus
____ ____ M.S.
____ ____ Cold sores / fever blisters

Cancer

____ ____ Chemotherapy for cancer or leukemia
What kind?
Diagnosis date?
____ ____Radiation
____ ____Surgery

Neurological

____ ____ Nervousness or phobias
____ ____ Chemical dependency, addictions
____ ____ Hypochondriasis
____ ____ Eating disorders, bulimia, anorexia
____ ____ ADHD
____ ____ OCD
____ ____ Bipolar/Schizophrenia
____ ____ Sleep disorder
____ ____Do you have any disease, condition or problem not listed? Please explain

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:
Sensitivity to: Hot Cold Sweets

Cavities	Fear of dentistry	Headaches
Gum disease	Clicking jaw	Want whiter teeth
Broken teeth	Loose teeth	Want to save teeth
Broken fillings	Spacing	Poor dentistry
Missing teeth	Grinding/clenching	Want gentle dentist
Dark/Ugly teeth	Snoring / Apnea	Recession
Crooked teeth	Bleeding gums	Cosmetic dentistry
Bad breath	Jaw or face pain	Nothing

Dental History

We would like to get to know you better…
I am changing dentists because:
Check any that apply
___ Recently moved into this area from_____
___ Dr/staff personality ___ Communication problem
___ Inadequate care ___ Fee concern ___ Insurance
___ Need a second opinion or better option on dental care
___ To find a dentist team who understands my needs
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? _____
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?

_____

Are you interested in exploring (check any that apply):
___ Sleep apnea or Snoring Treatment Options to CPAP
___ Implants
___ I.V. Sedation and Sleep Dentistry
___ Oral Sedation(pill) and gas options
___ Smile Makeover -- Smile Analysis & Design
___ Why dental infections cause heart & other diseases
___ Ways to reduce or eliminate periodontal surgery (lasers)
___ Invisalign invisible orthodontic aligners
___ BriteSmile & ZOOM office whitening or home whitening
___ The best dental home care systems (CloSys)

How did you first hear about us? Check any that apply
___ Convenient location (Saw sign on the road)
___ Family member already comes here_____
___ Referred by a friend? Who?_____
___ I received your welcome letter/brochure in the mail
___ Yelp ___ Community Profiles Radio Show
___ Google.com ___ Other site(name) _____
___ Saw your Internet web site at Suwaneedental.com
___ Social media links: _____ Facebook ____ LinkedIn
___ Deserving Diva Contest ___ Free Dentistry Day
___ Suwanee Magazine____ Suwanee or Duluth Days
___ Best of Gwinnett 2003- 2016 / Gwinnett Magazine
___ Victory 91.5 Christian Radio ____ 920AM Talk Radio

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

Sleep Disorder Questionnaire

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired?
This refers to your usual way of life in recent times. Even if you haven't done some of these things recently try to work out how they would have affected you.
Use the following scale to choose the most appropriate number for each situation:
0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing
Situation Chance of Dozing (0-3)

1. Sitting and reading
   _____
2. Watching TV
   _____
3. Sitting, inactive in a public place (e.g. theatre or a meeting)
   _____
4. As a passenger in a car for an hour without a break
   _____
5. Lying down to rest in the afternoon when circumstances permit
   _____
6. Sitting and talking to someone
   _____
7. Sitting quietly after a lunch without alcohol
   _____
8. In a car, while stopped for a few minutes in the traffic
   _____

Total:

_____

Interpretation:
0-7:It is unlikely that you are abnormally sleepy.
8-9:You have an average amount of daytime sleepiness.
10-15:You may be excessively sleepy depending on the situation. You may want to consider seeking medical attention.
16-24:You are excessively sleepy and should consider seeking medical attention

Doctor Notes:

- Health History Concerns
- Referrals
- Priorities
- Patient preferences

_____Date_____
Doctor signature

SUWANEE DENTAL CARE

Financial Policies

In order to accommodate the needs and requests of our patients, Suwanee Dental Care does file dental insurance. 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 individual requirements of each plan. Dental benefit plans will never pay for completion of your dental care; it is only meant to assist you. We are not contracted with all insurance companies. It is the insured person's responsibility to understand their benefits and confirm that our dental providers are in their network. Suwanee Dental Care can only provide an ***estimate*** of what your insurance will pay on a specific treatment and it is not a guarantee of payment. Secondary insurance can also be filed for our patients; however secondary insurance benefits are not taken into consideration when estimating coverage. If your insurance carrier pays a lesser amount than estimated, you will be billed for the difference.

Please initial on each line.

_____ All co-payments, estimated co-insurance, and deductibles are due at the time of service, or before your procedures. We accept cash, check, all credit cards and outside patient financing. Any check dishonored by your bank will result in a $35.00 returned check charge added to your account.

_____ If your insurance company does not pay within 60days, Suwanee Dental Care reserves the right to request payment in full for services from you and let you collect the insurance funds that are due to you.

_____ It is your responsibility to provide us with your current address, telephone number, and insurance information at each visit. If you do not have proof of active insurance at your visit, you will be considered a self-pay patient for that visit and payment will be due in full that same day.

_____ It is your responsibility to provide us with any legal documentation or divorce decree dictating a specific parent/guardian responsible for primary dental coverage.

_____ 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, you will be billed directly for those charges.

In the event your account is turned over to an outside agency for collections, you will be responsible for all collection fees, cost and such additional sums as the court may adjudge responsible.

Our team members will gladly assist you in filling out 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.

I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to Suwanee Dental Care.

By signing below, you are authorizing us to call you at any number you provide including calls to mobile/cellular or similar devices for any lawful purpose. You agree to any fees or charges that you may incur for an incoming call from us, and/or outgoing calls to us, to or from any such number, without reimbursement from us.

_____ _____

Patient Signature (Parent if Child) **Date**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

Authorization to Release Information

Purpose: This form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself.

I, _____, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

_____	_____
{Please Print Name}	Relationship
_____	_____
{Please Print Name}	Relationship
_____	_____
{Please Print Name}	Relationship

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
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

SUWANEE DENTAL CARE

Broken Appointment Policy

We attempt to make confirmation calls, send texts, as well as emails at least 48 hours in advance of your scheduled appointment as a courtesy. We will leave reminder messages on your answering machine if you have one. Therefore, we ask that our patients kindly give us a 24 hour notice if there is a need to cancel or reschedule an appointment. A one-time consideration will be made for failure to give notice. Any cancellation or no shows after that will be charged a **$25.00 fee.**

Thank you for your understanding of this matter, as we strive to provide the best quality care for our patients.

I have read the above Broken Appointment Policy, and I understand that I will be charged if I fail to show up for my scheduled appointment.

_____

Patient Name (Printed)

_____

Patient Signature (Parent if Child)

_____

Date

Consent to receive electronic communications

We know you are busy. Let us help by sending automated reminders and more. Our office is now able to send email and text messages to patients to confirm appointments, let you know of upcoming events, and provide additional communication notifications! This is a great tool to utilize when a phone call isn't possible. However, we understand that some patients prefer to be called.

Please indicate if you would like to receive email and text message appointment confirmation and reminders, newsletters, marketing material, account updates and opportunities to provide feedback.

We may also use your information for direct and indirect marketing, including audience targeting.

You can withdraw your consent to receive electronic communications at any time by calling our office. Please note that you are responsible for providing our office with any updates to your email address and/or cell phone number.

Date

Printed name

Signature

Parent/ Guardian

Email address

Cell phone number

- ◯ Yes, I would like to receive electronic communications.
- ◯ No, please do not send me electronic communications.