PATIENT REGISTRATION

ID: Chart ID: **(Required Information)**

First Name:______________ Last Name:______________ Middle Initial:______

Preferred Name:______________

Patient is : □ Responsible Party □ Policy Holder

Responsible Party: (if someone other than the patient)

First Name:______________ Last Name:______________ Middle Initial:______

Address:______________________________

City:__________ State:__________ Zip:__________

Home Phone:____-____-____ Work Phone:____-____-____ Cell Phone:____-____-____

Birth date:____/____/____ Social Security #:______________ Drivers Lic#& State:______________

○ Responsible Party is also Policy Holder for Patient ○ Primary Policy Holder ○ Secondary Policy Holder

Patient Information:

Address:______________________________

City:__________ State:__________ Zip:__________

Home Phone:____-____-____ Work Phone:____-____-____ Cell Phone:____-____-____

Sex: ○ Female ○ Male Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth date:____/____/____ Social Security #:______________ Drivers Lic#& State:______________

E-mail:______________________ □ I would like to receive email correspondences

Patient Information (section 2):

Employment Status: ○ Full Time ○ Part Time ○ Self Employed ○ Retired ○ Unemployed

Student Status: ○Full Time ○ Part Time

Preferred Pharmacy:______________ Pharmacy Phone #:______________

Emergency Contact:______________ Emergency #:______________

Primary Insurance Information:

Name of Insured:______________ Relationship to Insured: ○Self ○Spouse ○Child ○ Other

Member ID:______________ Group ID #:______________

Insured Social Security #:______________ Insured Birth date:______________

Employer:______________ Insurance Company:______________

Secondary Insurance Information: (If Applicable)

Name of Insured:______________ Relationship to Insured: ○Self ○Spouse ○Child ○ Other

Member ID:______________ Group ID #:______________

Insured Social Security #:______________ Insured Birth date:______________

Employer:______________ Insurance Company:______________

TIME 11:30 AM

Gentle Dental Care

DATE 3/8/2012

MEDICAL HISTORY

PATIENT NAME ______________________ Birth Date ______________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: ______________

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: ______________

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: ______________

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: ______________

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No ______________

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No ______________

Are you on a special diet? ◯ Yes ◯ No

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Women: Are you

Pregnant/Trying to get pregnant? ◯ Yes ◯ No   Taking oral contraceptives? ◯ Yes ◯ No   Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: ______________

Do you have, or have you had, any of the following?

Condition		Condition		Condition		Condition	
AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Easily Winded	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Angina	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Excessive Thirst	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No
Blood Transfusion	◯ Yes ◯ No	Frequent Diarrhea	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No
Breathing Problem	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Genital Herpes	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No
Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Convulsions	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No
						Yellow Jaundice	◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No ______________

Comments: ______________

____

____

____

____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN ______________________ DATE ______________

Insurance Disclaimer

As a service to our patients, our practice accepts most dental insurance programs, including non-managed care and indemnity (traditional). We are not part of any managed care network, DMO or DHMO plans. Our accounting staff will prepare all the necessary forms for your dental benefits. However, we remind you that your specific policy is an agreement between you and your insurance company. **Please keep in mind that you are responsible for your total obligation should your insurance benefits result in less coverage than anticipated.** Our staff will gladly submit a pre-treatment estimate to your insurance company so that you will know what your benefits will be.

The fees charged for services rendered to those who are insured are the usual and customary fees charged to all our patients for similar services. Your policy may base its allowances on a fixed fee schedule, which may or may not coincide with our usual fees. You should be aware that different insurance companies vary greatly in the types of coverage available. Also, some companies take care of claims promptly while others delay payment for several months. All co-payments must be made at time of service. Patient financing is available with approved credit with third party vendors.

I understand this statement.

Signature_______________________ Date_____________

Gentle Dental Care and Georgia Dental Implant Center

Financial Policy

1. Payment is due at time of service for all services.
2. Full payment for surgery is due at our office seven (7) days prior to surgery.
3. A **NO-SHOW fee** of **$35.00** may be assessed for each regular appointment missed. Notify us at least 24 hours in advance to reschedule your appointment.
4. Any dishonored check will result in a **$35 return check** charge.
5. If your balance becomes 60 days delinquent, your account is subject to collections and you will be responsible for all costs associated with collecting the balance.
6. **Payment options**

   A: Cash or Check

   B: All Major Credit Cards – Visa, Master Card, Discover, AMEX

   C: Care Credit, Wells Fargo Health Advantage, Lending Club: gives you convenient low monthly payment options so you can get the procedure you want now. This involves a simple one page application and immediate approval online. There are no up-front costs, no pre-payment penalties and no annual fees.
7. **Insurance Cases**

   A: For cases covered by insurance, all **co-payments** are due at time of service.

   B: It is your responsibility to confirm our doctors participate in your insurance plan. If you see one of our doctors that is not on your plan, you are responsible for all charges in full.
8. **Dental Records**

   All Dental records requests must be in writing and received 72 hours prior to the date needed. Records over 10 pages will be mailed (NOT FAXED) and an administrative fee will be assessed to cover the time and expense of re-producing the documents.
9. **Surgery Cancellation Policy**

   We understand that a situation may arise that could force you to reschedule, postpone or cancel your surgery. Please understand that such changes affect not only your surgeon and staff, but other patients as well. We require a minimum of 7 days prior to your date of surgery to reschedule or cancel. We appreciate the courtesy of notification as early as possible in order to make time available to other patients.

Signed:____________________________________ Date:____________________

HIPAA NOTICE OF PRIVACY PRACTICES

Gentle Dental Care
5490 Crossroads Drive, Acworth, GA 30102
Office: 770-926-2784 Fax: 770-9268662
www.georgiagdic.com
Steve Hahn DMD, MS   Gregory Doneff DDS

This notice describes how your personal, dental and medical information may be used or disclosed and how you can get access to this information. Please review it carefully.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatments, payment for services and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. Your PHI is information about you, including demographic information, that may identify you and that relates to your past, present or future oral and physical condition and related health care services.

USES AND DISCLOSURES of PROTECTED HEALTH INFORMATION

Your PHI may be used and disclosed by your dentist, the office & clinical staff and others outside our offices that are involved in your care and treatment for the purpose of providing dental services to you, to pay your dental care bills, to support the operation of the dentist's practice and any other uses required by law.

TREATMENT

We will use and disclose your PHI to provide, coordinate or manage your dental care and any related service. This includes the coordination or management of your dental care to a third party. For example, we would disclose your PHI, as necessary, to a third party payer, a dental lab, or specialty office to which you have been referred, that provides services to you. Only information that will be disclosed is that which is required to diagnose or treat you.

PAYMENTS

Your PHI will be used, as needed, to obtain payment for your dental services. Your PHI will be shared with your insurance carrier or any outside service necessary to collect payment for your dental services.

HEALTH CARE OPERATIONS

We may use or disclose, as needed, your PHI in order to support the business activities of your dental practices . These activities include, but are not limited to, quality assessment activities, employee review activities, staff training, licensing and conducting or arranging for other business activities. We may use a sign in sheet at registration where you may be asked to sign your name and indicate your doctor, we may also call your name out in the reception room when you doctor or hygienist is ready to see you. We may also use your PHI, as necessary, to contact you to reminding you of your upcoming appointment(s).

We may disclose your PHI in the following situations without your authorization. The situations include: as required by law, Public Health Issues, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration Requirements, Legal Proceedings, Law Enforcement , Military Activity and National Security, Workers' Compensation. Under the law, we must disclose to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164-500.

PATIENTS AUTHORIZATION TO RELEASE INFORMATION

I, ______________________________, authorize the release of my PHI to the following:

____

I understand that unless listed above, NO PHI can or will be released, under any circumstances unless listed above as an exception. Before any information may be released to a spouse, sibling or friend, they must be listed above or the patient listed above must notify the office IN WRITING of authorization to release your PHI.

I have read and understand the above statements.

______________________________   ____________________

Patient / Guardian   Date