Welcome to Middle Georgia Center for Cosmetic Dentistry

Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

Name _____ Date ___/___/___ ❑Married ❑Single ❑Minor ❑Male ❑Female
First Last MI

Address _____ DOB _____/_____/_____
Street Apt # City State Zip Month Day Year

Social Security # _____-_____-_____ Email _____

Telephone Home: ( )_____ Work: ( )_____ Cell: ( )_____

Employer:_____ Occupation:_____

Student: ❑ Full Time ❑ Part Time

Whom may we thank for referring you to our dental practice?_____

Insurance Information

Primary Dental Insurance:_____ Group #:_____

Insurance Co. Phone: ( )_____ Policy Holder's Name:_____

Policy Holder's DOB: _____/_____/_____ Policy Holder's SSN#:_____-_____-_____ Relationship to Patient: _____
Month Day Year

Secondary Dental Insurance:_____ Group #:_____

Insurance Co. Phone: ( )_____ Policy Holder's Name:_____

Policy Holder's DOB: _____/_____/_____ Policy Holder's SSN#:_____-_____-_____ Relationship to Patient: _____
Month Day Year

Family Information

Circle one: Husband / Father of Child Patient / None

Name:_____
Last First MI

Address:_____
Street Apt #

_____
City State Zip Code

Telephone:_____
Home Cell Work

DOB:_____/_____/_____ SSN: _____-_____-_____
Month Day Year

Circle one: Wife / Mother of Child Patient / None

Name:_____
Last First MI

Address:_____
Street Apt #

_____
City State Zip Code

Telephone:_____
Home Cell Work

DOB:_____/_____/_____ SSN: _____-_____-_____
Month Day Year

Acknowledgment and Authority

- I hereby authorize the Dentist to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care.
- I hereby authorize payment directly to the dental office of the group insurance benefit
- I grant the right to the dentist to release my dental records and other information about my dental treatment to third party payors and/or other health professionals, as appropriate under the circumstances.
- I also acknowledge full responsibility for the payment of fees for such services and agree to pay for them, in full by the time of service, understanding that 50% of my responsibility is to be paid in advance for procedures that exceed $100 of my responsibility and the remainder is to be paid at the date of service.
- I have received a copy of the HIPAA Privacy Policy as required by law
- I grant the dental office permission to use the email address given above to contact me with respect to my dental care and to confirm any dental appointments scheduled
- I grant the dental office permission to use the cell phone number given above to contact me via text message to confirm any dental appointments scheduled.

X_____
❑Adult Patient ❑Father ❑Mother
❑ Guardian

Person Responsible for Account

Please check one
❑Patient ❑Husband ❑Father ❑Guardian ❑Wife ❑Mother

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA

Oral Health Information

1. Any known dental problems at this time?..... ❑Yes ❑No _____
2. Are any of your teeth sensitive to hot, cold, biting, pressure, or sweets?..... ❑Yes ❑No _____
3. Do your gums bleed when you brush or floss?..... ❑Yes ❑No _____
4. Have you ever been told you have periodontal (gum) disease?..... ❑Yes ❑No _____
5. Are there areas in your mouth you avoid chewing on?..... ❑Yes ❑No _____
6. Have you had complete set of cavity finding x-rays in the past year?..... ❑Yes ❑No _____
7. Do your jaw joints (TMJ) click, pop, or cause pain?..... ❑Yes ❑No _____
8. Are you aware of any nighttime clenching or grinding of your teeth?..... ❑Yes ❑No _____
9. Have you had your wisdom teeth removed?..... ❑Yes ❑No _____
10. Do your teeth show signs of chipping and /or wear..... ❑Yes ❑No _____
11. Are you missing any other teeth?..... ❑Yes ❑No _____
12. Do you have a replacement for missing teeth?..... ❑Yes ❑No _____

Medical Health Information

1. Physician's Name_____ Date last seen _____
2. Are you under a physician's care now?.....❑Yes ❑No Discuss _____
3. Any hospitalizations in the past 5 yrs.....❑Yes ❑No
4. Have you had any serious illnesses or operations?.....❑Yes ❑No
5. **Do you have to take pre-medication antibiotics prior to dental visits?**.....❑Yes ❑No
6. Are you taking any medications, pills or drugs?.....❑Yes ❑No (Please list below)

_____

_____

7. **Are you allergic to any medication or substances?**

❑Aspirin ❑Penicillin ❑Codeine ❑Latex ❑Sulfa ❑Dental Anesthetics ❑Erythromycin ❑Tetracycline ❑None
❑Other:_____

8. **WOMEN** (Please check if applicable) ❑Pregnant (Due Date _____) ❑Nursing
9. **Do you have, or have you ever had, any of the following? (Please check below):**

Yes	No		Yes	No		Yes	No		Yes	No	
❑	❑	Anemia	❑	❑	Artificial bones/ Joints	❑	❑	Artificial Valves	❑	❑	Colitis
❑	❑	Asthma	❑	❑	Arthritis	❑	❑	Cancer	❑	❑	Chemotherapy
❑	❑	Blood Transfusions	❑	❑	Congenital Heart Defect	❑	❑	Diabetes	❑	❑	Tuberculosis
❑	❑	Drug/ Alcohol use	❑	❑	Emphysema	❑	❑	Glaucoma	❑	❑	Epilepsy
❑	❑	Fainting spells	❑	❑	Fever Blisters	❑	❑	Herpes	❑	❑	Heart Attack
❑	❑	Stroke	❑	❑	Heart Murmur	❑	❑	Heart Surgery	❑	❑	Pacemaker
❑	❑	Hemophilia	❑	❑	Abnormal Bleeding	❑	❑	Hepatitis	❑	❑	Psychiatric Issues
❑	❑	LB Pressure	❑	❑	HIV+ Aids	❑	❑	Kidney Problems	❑	❑	MVP
❑	❑	HB Pressure	❑	❑	Rheumatic Fever	❑	❑	Scarlett Fever	❑	❑	Migraines
❑	❑	Shingles	❑	❑	Sinus problems	❑	❑	Ulcers	❑	❑	Venereal disease

9. Please List any other serious/pertinent Medical conditions that you have ever had: _____

_____

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medications change, I shall inform the dentist and staff at the next appointment without fail.

X_____ Date _____
Patient's Signature (Parent or Guardian)

Below this line is office use only

Medical Health Information

Date	Changes		Patient's signature	Staff Initials
_____	_____	❑ NONE	_____	_____
_____	_____	❑ NONE	_____	_____
_____	_____	❑ NONE	_____	_____

Our Financial Policy

Thank you for choosing *Middle Georgia Center for Cosmetic Dentistry* as your dental health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment.

FULL PAYMENT IS DUE AT TIME OF SERVICE

WE ACCEPT CASH, VISA, MASTERCARD, DISCOVER, AND AMERICAN EXPRESS
WE ALSO OFFER PAYMENT PLANS THROUGH CHASE ADVANCE, AND CARE CREDIT ONLY

_____
Patient's Initials

Regarding Insurance
We accept multiple insurance benefit plans and we will file all claims as a courtesy for your primary dental insurance and your secondary dental insurance. If your insurance plan does not pay for the estimated amount, **you the patient will be responsible for the difference.** Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under your dental insurance plan. It will be your responsibility to know your insurance coverage policy. We will do our best to help you obtain any information needed. Your insurance policy is a contract between you and your insurance company; we are not a party to that contract.

_____
Patient's Initials

Scheduling Dental Treatment
To schedule any dental treatment a deposit, of at least 50% of the cost, will need to be placed on the appt for any service other than preventative that exceeds $100.

_____
Patient's Initials

Usual and Customary Rates
Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary.

_____
Patient's Initials

Fee estimates
The treatment fees we quote are only generated estimates governed by our contract with participating insurance companies. The insurance company has the right to downgrade any treatment to a less costly procedure, where you the patient would be responsible for the difference.

_____
Patient's Initials

Adult and Minor Patients
Adult patients are responsible for full payment at the time of service. The parent or guardian accompanying a minor is responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been paid prior to treatment. **Note: For divorced families, we will NOT split the bill between both parties. We will send the bill to the head of house, which will be the parent who holds majority custody. All billing issues with a split family will be handled outside of our office.**

_____
Patient's Initials

Late Notice Cancellations and No Shows
We require at least 48 hours notice for cancelling a scheduled appointment. For all appointments cancelled within 48 hours of their appointment there will be a $50 inconvenience fee applied to the patients account. Please understand for us to continue giving our patients excellent service we need adequate time to fill the broken appointment slots. For no show patients, a $50 inconvenience fee will be applied to the account, and future appointed times will require a deposit to be placed down.

_____
Patient's Initials

Returned Checks
There will be a $25 charge added to your account for any returned checks. Returned check amount and the service fee must be paid in cash or money order.

Consent of Services

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the value of said services to the Doctor at the time services are rendered. I understand that all charges are ultimately my responsibility even if I have insurance coverage, and after 45 days if my insurance company does not pay I will be billed for the entire balance. I understand that should I breach this policy a suit could be brought against me I agree to pay all costs and attorney fees if a suit is filed. In the event that my account should be turned over to an outside collection agency, I agree to pay all costs incurred by said collection agency.

_____ _____
Signature of Patient or Responsible Party Date

HIPAA Regulation Form
Patient Consent

Patient Name: _____DOB:_____

Address: _____ Apt: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____-_____-_____ Sex: M / F

Status:

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed

(Please Print)

I, _____, hereby authorize the release of my patient information, i.e., appointment dates and times, account balance, and/or needed treatment, to the person/s below:

Name: _____Relationship:_____

Name: _____Relationship:_____

Name: _____Relationship:_____

Name: _____Relationship:_____

(Please Print)

Patient Signature: _____

Date: ____/____/_____

Witness Signature: _____

Date: ____/____/_____