Decatur Family Dental

T. James Brown DMD

Welcome to our office

The confidence you place in us is greatly appreciated. We will make every effort to cater to all your dental needs, with the understanding and compassion you deserve. We take pride in our office. Our courteous, well trained staff is here to help you. Please feel free to call upon them if you have any questions or concerns.

Please take a few moments to complete the attached forms. The information you provide will assist us in providing the comprehensive, quality care we all desire. If this is your first visit to our office, please let us know how you heard about us.

Referred by

__ Another Patient ______________________

__ Google

__ Yelp

__ Your Insurance Company ______________________

__ Your Physician ______________________

Your estimated portion is due at the time of the service. For your convenience we accept Cash, Check, Money Order, Visa, Mastercard, Discover and American Express. We are no longer able to accept flexible benefits cards. Documentation will be provided so that you may submit for reimbursement.

Finally, it is very important that you understand our cancellation policy. While we try to be very flexible when scheduling your appointment, please remember that you are booking a time that is reserved especially for you. When you cancel an appointment without 24 hours notice it is rare that the appointment can be rebooked effectively. Therefore all appointments cancelled without a 24 hour prior notice will be charged a minimum $50 broken appointment fee and must be paid prior to rescheduling.

814 Church Street, Decatur, Georgia 30030

Phone (404) 373 5366   Fax (404) 373 5358

Patient Registration

First Name: ______________________ Last Name: ___________________________

Preferred Name: ______________________ Male _____ Female _____

Address: ____

City: _______________________ State: _______________ Zip: ___________________

Best Contact Number: ________________________________ (Home/Work/Cell)

Alternate Phone Number: _________________________________ (Home/Work/Cell)

Date of Birth: _________________________

Social Security Number: ___________________________________

Driver's License Number: __________________________________

E-Mail Address: ____

Emergency Contact:

Name: ____

Relationship to Patient: _____________________________

Emergency Phone Number: __________________________

Insurance:

Policy Holder Name: ____

Policy Holder Social Security Number: ______________________________

Policy Holder Date of Birth: ______________________________________

Insurance Company Name: _______________________________________

Employer: ____

Group Number: ________________________ Member ID: __________________________

Insurance Company Phone Number: _______________________________

*Filing Insurance Claims is a service we provide as a courtesy to our patients. When possible, we try to estimate your expected insurance benefit for each procedure planned. Remember that these estimates are to the best of our ability. Insurance is a contract between the patient and the insurance company. **It is your responsibility to know your benefit coverage limitations and provisions.**

TIME 10:43 AM

DATE 7/12/2011

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 ______________

Admission to the Practice
Agreement

I consent to routine dental procedures as well as treatment and diagnostic test deemed necessary in the dental professional's judgment.

I authorize the dentist and staff of Decatur Family Dental to take and record any photographs of me for records, teaching, research and publication purposes. I understand that in any publication my name will not be identified.

I authorize Decatur Family Dental to take any x-rays necessary for the detection and diagnosis of oral diseases, and I authorize the release of any other information to my insurance company necessary for processing of my dental claim (if applicable).

I authorize Decatur Family Dental to administer local anesthetics and medically indicated drugs as necessary for treatment.

I Authorize payment of my group insurance benefits, otherwise payable to me, to Decatur Family Dental.

I understand that I am responsible for payment of my treatments, regardless of insurance coverage. I understand that Decatur Family Dental as a courtesy to me, may estimate my expected insurance portion, **but this is not a guarantee of payment from my insurance company.**

I acknowledge that I have been given the opportunity to review the Notice of Privacy Practices. I hereby give authorization and consent.

______________________________ __________________
Signature (Patient or Legal Guardian) Date

Insurance

Decatur Family Dental will be happy to file any insurance as a courtesy to you. When possible, we try to estimate your expected insurance benefit for each procedure planned. Remember that these are ESTIMATES. Insurance is a contract between the patient and the insurance company. It is your responsibility to know your benefit coverage limitations and provisions.