Georgia Smile Team Patient Information Worksheet

Name _____ **Date** _____

Please Circle One: Married Single Child Male Female

Social Security # _____ **Date of Birth:** _____

Address _____
Street Apt# City State Zip

Telephone _____
Home Work Cell Email

Name of Employer _____

Person Responsible for Account - *Please Circle One:* Patient Guardian Mother Father Spouse

INSURANCE INFORMATION

Primary Insured / *If non-insured please complete for* ***Responsible Party***

_____
LAST **FIRST** **MI**

_____
STREET **CITY** **STATE** **ZIP**

DATE OF BIRTH _____RELATIONSHIP TO PATIENT _____

EMPLOYER _____DENTAL INSURANCE _____

SS# _____ SUBSCRIBER # _____

Emergency Contact

Name _____ Telephone # _____ Relationship to patient_____

**Whom may we thank for referring you to our office? _____

Authorization
I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the dental office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the Dental/Medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals

X_____ _____ _____
Patient or Responsible Party Signature Date

METHOD OF PAYMENT: Payment in full at each appointment, Cash, or Check
Payment in full at each appointment, Visa, MasterCard or other
Care Credit Monthly Payment Options

SERVICE CHARGE:
If I do not pay the entire new balance within sixty (60) days of the monthly billing date, a service charge of 1.9% per month (23% annual percentage rate) will be added to the account for the current monthly billing period. In case of default of payment, I promise to pay any legal fees and or interest collection fees that could be 40% of the balance due, with any collections costs and reasonable attorney fees incurred to effect collections of this account or future outstanding accounts.

**** There will be a charge for all appointments missed or cancelled without 48 hours' notice $50.00 - $200.00*

X_____ _____ _____
Responsible Party Signature Date

Georgia Smile Team
Smile Analysis

Last Name _____ First Name_____ ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms.

1. Date of last dental visit _____/_____/_____ Date of last dental xrays _____/_____/_____

2. What was the reason for your for last dental visit? _____

3. Do you have any concerns about previous dental care or this dental visit? _____

_____

4. On a scale of 1 to 10 (10 being the highest) how important is it for you to keep your teeth for the rest of your life? __

5. Are you happy with your smile? (Please circle your response) Yes No

Please Explain: _____

_____

6. Do your gums bleed? Yes No

7. Are your teeth loose? Yes No

8. Have you ever been told that you have bad breath? Yes No

9. Are your teeth sensitive to (circle all that apply) Sweets Cold Heat Pressure

10. Do you like the color of your teeth? Yes No

11. Do you feel your teeth are starting to get longer? Yes No

12. Do you get food stuck between your teeth easily? Yes No

13. Do you ever experience tooth pain that is relieved by biting down on the affected area? Yes No

14. What would you change about the condition of your mouth? _____

_____

Patient Signature _____ Date _____

If you have completed this form for another person, please print your name and sign below along with your relationship to the patient:

Print _____ Relationship _____

Signature _____ Date _____

Georgia Smile Team

578 South Enota Dr., NE
Gainesville, GA 30501
770.536.3254

Georgia Smile Team

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 presently taking vitamins, herbs, or grape fruit juice? ◯ Yes ◯ No If yes, please explain: _____
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?

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 _____

OUR FINANCIAL ALLIANCE
Georgia Smile Team

Our Philosophy

Our goal in discussing financial arrangements with you is straightforward:

To create an understanding and partnership in the settlement of your account.

It is important to us that the quality of our business services matches the quality of our dentistry. We want the handling of your account at each and every visit to be perceived as an extension of the dental care that we provide you and your family.

Patient's Role

As with any partnership, both parties have a role to play. Our role is to provide you with quality service. In turn, your role is to pay for treatment in a timely manner. Our team will work with you to determine the financial arrangements that make sense for both of us. With an agreement in place, our joint follow-through will result in a win for everyone.

In developing a financial arrangement, it is important to remember your dental future. Our experience has shown that when an account lingers, patients are likely to defer their appointments. It is discouraging to add new charges to an account when trying to pay off old charges. With this in mind, we will concentrate our efforts on clearing your account in as short a time as is comfortable for both of us.

WE ACCEPT CASH, CHECKS, MASTERCARD, VISA, DISCOVER & AMERICAN EXPRESS

12 MONTHS INTEREST-FREE PAYMENT PLANS AVAILABLE (WITH CREDIT APPROVAL)

Regarding Insurance

We may accept assignment of insurance benefits; however, all fees for services provided are your responsibility regardless of insurance coverage.

Please be sure to give us your complete dental insurance information so that we can bill your insurance company. As part of the financial arrangement process, we will estimate what your insurance company will pay, and ask that you pay the uninsured portion upon receipt of services.

It is important to remember that your insurance policy is a contract between you and your insurance company, and we are not a party to that contract. If your insurance company has not paid your claim within **30 days**, the full balance will automatically be transferred to you, and the entire balance will be due upon billing.

In the event that your insurance company denies payment of a service, you are responsible for that fee. Any unpaid balance after insurance pays or denies a claim is due within 10 days.

What is your preferred method of payment at the time of service?

□ ***Cash*** □ ***Check*** □ ***Credit Card*** □ ***I would like to apply for 12 Months Interest-Free Payments***

Any unpaid balance that is past due by 60 days will incur interest of 23% annually, with charges assessed monthly at the rate of 1.9% of the unpaid balance. You will be responsible for any and all incurred expenses required to collect the total balance due, including but not limited to, collection fees, court costs, attorney's fees and employees' or doctor's time away from the practice to settle this account.

Thank you **for reading our financial alliance. Please let us know if you have any questions or concerns.**

I HAVE READ THE FINANCIAL ALLIANCE. I UNDERSTAND, ACCEPT AND AGREE TO THE ABOVE POLICIES AND TERMS.

x _____ **x**_____

Signature of Patient or Responsible Party **Date**