FAMILY DENTAL CENTER

familydentalcenterofmacon.com
admin@fdcofmacon.com
155 College St. | Suite 2 • Macon, GA 31201
(478)474-2557

Welcome to our Practice

Questions marked with an asterisk (*) are REQUIRED.

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ○ Male ○ Female **Family Status:** ○ Married ○ Single ○ Child ○ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Whom may we thank for referring you to our practice?

_____

In an emergency who should be notified? Please enter Name and Phone number below:

Emergency Contact: * _____

Relationship to Patient: _____

Phone Number: * _____

Employment Information*

Employer Name: _____ **Phone:** _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Responsible Party Information:*

Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ○ Male ○ Female **Family Status:** ○ Married ○ Single ○ Child ○ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** ___-__-____ **DL#:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Insurance Authorization:

☐ *By checking this box,
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of my electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Dental Information

What is your immediate concern?

_____

_____

Previous Dentist Name and Phone Number:

_____

_____

Date of most recent dental exam and dental x-rays:

_____

_____

Check all that apply:

☐ Had complications from past dental treatment
☐ Had trouble getting numb
☐ Had any reactions to local anesthetic
☐ Had/have braces, orthodontic treatment
☐ Experience dry mouth
☐ Teeth sensitive to hot, cold, biting, sweets or avoid brushing any part of your mouth
☐ Food gets trapped between any teeth
☐ Have whitened or bleached your teeth
☐ Popping and/or clicking of your jaw joint
☐ Difficulty chewing
☐ Clench or grind your teeth
☐ Wear or have worn a bite appliance
☐ Gums bleed when brushing or flossing
☐ Treated for gum disease or were told you have lost bone around your teeth
☐ Unpleasant taste or odor in your mouth
☐ Gum recession
☐ Teeth have become loose on their own (without injury)
☐ Burning sensation in your mouth
☐ Snoring or wake up frequently during the night

If any of the checked boxes need further explanation, please describe:

_____

_____

_____

_____

_____

Consent for Services and Financial Policy

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. Our office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, our dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by Family Dental Center, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

☐ * **By checking this box, I understand the above information and agree with its contents, and this will serve as my signature for the Administration Form.**

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality,

I allow this practice to disclose my Protective Health Information to the following individuals: (This information could include: Name, Diagnosis, Test Results, Images and Account Information.)

Name and Relationship to Patient:

_____

_____

☐ * **By checking this box, I understand the above information and agree with its contents, and this will serve as my signature for the HIPAA Disclosure Form.**

By initialling below, I agree to a $75 broken appoint charge if the office is not given a 24-hour notice for a missed appointment.
_____(Initials)

By initialling below, I understand that as a courtesy to others, Family Dental Center reserves the right to reschedule my appointment if I am more than 15 minutes late.
_____(Initials)

Signature _____ **Date** _____

Response Date: _____

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Medical History

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Indicate which of the following conditions you have or have had. Checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

- ☐ ADHD
- ☐ Allergy Amoxicillin
- ☐ Anemia
- ☐ Artificial Joints
- ☐ Autism Traits
- ☐ Bipolar Disorder
- ☐ Cardiovascular Disease
- ☐ Chronic Back Pain
- ☐ Coronary Occlusion/Insufficiency
- ☐ Depression
- ☐ Emphysema
- ☐ Free Bleeder
- ☐ Hay Fever
- ☐ Heart Murmur
- ☐ Hepatitis C
- ☐ Hypothyroidism
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lupus
- ☐ Narcolepsy
- ☐ Parkinson's Disease
- ☐ Pregnant Due date: ___/___/___
- ☐ Rheumatoid Arthritis
- ☐ Shortness of breath after mild exercise/lie down
- ☐ Smoker/Tobacco Use
- ☐ Supraventricular tachycardia
- ☐ Tuberculosis Carrier
- ☐ AIDS
- ☐ Allergy Codeine
- ☐ Anxiety
- ☐ Asthma
- ☐ Autoimmune Disease
- ☐ Blood Disease
- ☐ Cerebral Palsy
- ☐ Chronic Obstructive Pulmonary Disease(COPD)
- ☐ Cystic Fibrosis
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Gag Reflex
- ☐ Head Injuries
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Stones
- ☐ Liver Failure
- ☐ Mental Disorders
- ☐ Osteoporosis
- ☐ Persistent Cough/Cough up Blood
- ☐ Radiation Treatment
- ☐ Scarlet Fever
- ☐ Sickle Cell
- ☐ Stomach Problems
- ☐ Tachycardia
- ☐ Tumors/ Malignancies
- ☐ Acid Reflux
- ☐ Allergy Novocaine
- ☐ Arteriosclerosis
- ☐ Atrial Fibrillation(A-fib)
- ☐ Bells Palsy
- ☐ Bradycardia
- ☐ Chemotherapy
- ☐ Congenital Heart Defect
- ☐ Defibrillator
- ☐ Dizziness
- ☐ Excessive Bleeding
- ☐ Gastroesophageal Reflux Disease (GERD)
- ☐ Headaches
- ☐ Hepatitis A
- ☐ High Cholesterol
- ☐ Job Exposure to Radiation
- ☐ Kidney Trouble
- ☐ Low Blood Pressure
- ☐ Migraines
- ☐ PVC
- ☐ Post-Traumatic Stress Disorder (PTSD)
- ☐ Respiratory Problems
- ☐ Seizures
- ☐ Sickle Cell Trait
- ☐ Stroke
- ☐ Traumatic brain injury
- ☐ Venereal Disease
- ☐ Alcohol Abuse
- ☐ Allergy Penicillin
- ☐ Arthritis
- ☐ Autism
- ☐ Cancer
- ☐ Chest Pain w/ exertion
- ☐ Congestive Heart Failure
- ☐ Dental Anxiety
- ☐ Drug Addiction
- ☐ Fainting Spells
- ☐ HIV
- ☐ Heart Attack
- ☐ Hepatitis B
- ☐ Human Papillomavirus (HPV)
- ☐ Joint Replacement
- ☐ Leukemia
- ☐ Lung Disease
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Pre-Med for Dental Treatment
- ☐ Rheumatic Fever/Rheumatic Heart Disease
- ☐ Shingles
- ☐ Sleep Apnea
- ☐ Substance Abuse
- ☐ Tuberculosis

Please list any other medical conditions not listed in the section prior that you think may affect your dental treatment:

Allergies not listed:

Do you take antibiotic premedication for your dental visits? If yes, please explain below: * ○ Yes ○ No

Reason for Pre-Med/Date of Procedure: *

Name of your Physician and Phone Number: *

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment below:

Preferred Pharmacy and Phone Number: *

Are you currently taking any medications (prescription and non-prescription) including regular doses of aspirin? *

○ Yes ○ No

Please list any medications you are currently taking, one medication per line:

☐ ***By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes. This will serve as my signature.**

Signature _____ **Date** _____