Gentle
Dentistry
of
Newnan, PC

PATIENT REGISTRATION

Patient Full Name: _____

Preferred Nickname: (if any)_____Sex: M __ F __ Date of Birth _____

Home Phone No.: _____ Work __ _____ Cell _____

E-mail Address: _____

Preferred Contact Method (please check one): Home ___ Work ___ Cell ___ E-mail ___

Home Address:_____ City: _____ State:_____Zip:_____

Social Security No.: _____D.L. #: _____

Single __ Married __ Divorced __ Separated __ Widowed __

Employer Name:_____

ACCOUNT INFORMATION (Policy Holder)

Who is responsible for this account: _____

Relationship to patient: _____ SS #: _____

Dental Insurance?: Yes ____ No ____ D.O.B. _____

Name of Dental Insurance Co.:_____

Group No.: _____ I.D. No.: _____

Phone No. of Insurance Co.: _____

Address: _____City _____ State:_____ Zip:_____

Employer:_____Employer Phone No.: _____

Names of Covered Dependents: _____

*Whom may we thank for inviting you to our practice?*_____

EMERGENCY CONTACT: _____

37-G Calumet Parkway Suite #201, Newnan, Georgia, 30263
770-683-6030

Gentle Dentistry Of Newnan, PC

Medical History

Patient Name:_____ Birth Date:_____ Date Created:_____

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? If yes, please provide doctors name and phone number.	◯ Yes ◯ No	If yes	
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes	
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes	
Are you taking any medications, pills, or drugs? If yes, please list all medications.	◯ Yes ◯ No	If yes	
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes	
Do you use tobacco?	◯ Yes ◯ No		
Do you use controlled substances?	◯ Yes ◯ No	If yes	
Have you had any metal, pins, plates or screws placed? If yes, please provide doctors name and phone number.	◯ Yes ◯ No	If yes	

Comments:

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

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

Other? ☐ If yes

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 Problems ◯ 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 If yes

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:

X _____ Date:_____

Gentle Dentistry of Newnan P.C

IMPORTANT INFORMATION

Appointments

We consider it a firm commitment when you schedule an appointment with our office as we have reserved space for you on our schedule. As a courtesy we also contact you prior to the appointment to remind you. If you are not able to keep this appointment, we require that you call us 24 hours in advance so that we may utilize this time for the benefit of our other patients. Please be sure to confirm your appointment, otherwise it may not be guaranteed. We do charge$50 for a missed appointment. However, should you miss/cancel multiple appointments we will need to consider other options, such as $50 to $100 dollars deposit to re-schedule. If you are 15 minutes late for any appointment, we reserve the right to reschedule you.

Health Information

Your health information will be used only for the purpose of providing treatment and obtaining payment from your insurance company. Our HIPPA Privacy Policy is available for your review. If you desire a hard copy, please notify our front desk. By my signature below, I acknowledge that I have been made aware of the HIPPA policy for Gentle Dentistry of Newnan, PC.

Payment Policy/Insurance Policy

As a courtesy, we will file your primary insurance for you. Should your insurance company fail to pay us within 65 days for reasons beyond our control, you will be responsible for your charges. Your estimated portion is due at the time of your treatment. By my signature below, I acknowledge that I agree to this policy.

Amalgam/Composite Fillings

We do NOT use amalgam (silver) fillings at Gentle Dentistry of Newnan, PC as they require more aggressive removal of tooth structure. Gentle Dentistry of Newnan, PC does Composite (tooth colored) fillings which are slightly higher in cost but preserve more of your tooth. Your insurance company may choose to pay for amalgam fillings only. You will be responsible for this cost difference, if applicable. Insurance coverage is ONLY an estimation. Guarantor is responsible for ALL treatment NOT covered by insurance.

_____

Signature Required Date

Gentle Dentistry of Newnan P.C

Statement of Financial Policy for Professional Services

1. Our relationship and our contract is with you. We do not provide dental services to your insurance company and have no responsibility to the insurance company. We will not compromise your dental care to satisfy insurance company recommendations. **Initials**_____

2. As a courtesy**,** we will file your claims with your primary insurance policy. If you have a second insurance, once you have received a response from your primary insurance company you should then send a copy of this response to your second insurance, they will pay you directly. **Initials**_____

3. Cancellation Policy: We require you to inform our office of the cancellation or rescheduling of any appointments at least 24-hour business day before the appointment Upon a broken or second canceled appointment, there is $50 to $100 dollar deposit required to reschedule. Due to the nature of dentistry and the advance planning of treatment, such notice is mandatory. Shorter notices prevent us from efficiently operating our practice and unfairly prevent other patients from receiving needed care. **Initials**_____

4. The patient understands and agrees that he/she is responsible for all amounts due. After 90 days past due we turn all accounts over to an outside debt collection service which may negatively impact your credit score. **Initials**_____

5. Customer Pricing Notice: There is a 3.5% surcharge applied on all credit card transactions, exceptions are debit cards and flex spending cards.

I have read and understand the above. I understand that I may receive a copy of this form upon request.

Patient Name: _____

Signature of Patient or Guardian: _____

Date: _____

37-G Calumet Parkway Sui t e # 201, Newnan, Georgia, 30263 770-6 83-6 030