WELCOME!

We appreciate you choosing our office for your dental needs. The following information will be held in strict confidence and will never be released without your written consent.

PATIENT INFORMATION

Name_____ **(M F) Mr. Mrs. Ms. Dr. Nickname**_____

Birth Date_____**Social Security #**_____ **DL#:**_____

Home Address_____ **City**_____ **State**_____ **Zip** _____

Email_____

Home phone_____**Work** _____**Mobile** _____

Occupation:_____**Employer**_____

Name of Spouse_____ **Spouse's Employer**_____

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

Emergency Contact:_____**Relationship:**_____ **Phone:**_____

If you are completing this form for another person, what is your name/relationship to that person?
Name:_____**Relationship:**_____

ACCOUNTS FOR CHILDREN

If patient is under 18 years old, please complete the following. Please be aware that the parent who brings the child to the appointment is responsible for the account.

Parent bringing child:_____ **Date of birth**_____
Home phone_____ **Work phone**_____ **Social Security #**_____
Address: _____**City**_____**State**_____**Zip** _____
Cell phone: _____ **Email:** _____

I authorize the dental staff to perform the necessary dental services my child may need:

_____ _____
Signature of parent or guardian Date

DENTAL INSURANCE INFORMATION

Insured Employee_____ **Employer**_____

Subscriber ID #_____ **Date of birth**_____ **Group #** _____

Insurance Company_____ **Insurance company phone number**_____

Claims address_____ **City**_____ **Zip**_____
Are you covered by a second carrier / insurance plan?_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Your privacy is assured here in our office, and your health records will never be released without your consent. Along with your forms you have been provided a copy of our Privacy Policies as required by the HIPPA Privacy Act (proposed by the US Dept of Health and Human Services – effective April 1, 2003). Please sign this so that we know you have received a copy of our privacy practices.

PATIENT/ GUARDIAN SIGNATURE:_____DATE:_____

PHOTOGRAPHY RELEASE

I authorize the office of Dameron Family Dentistry to take photographs of my face, jaws and teeth. I understand that any of these are used in educational purposes or as part of a demonstration. My name or any other identifying information will be kept confidential. I do not expect compensation, financial or otherwise for the use of these photographs.

PATIENT/ GUARDIAN SIGNATURE:_____DATE:_____

DAMERON FAMILY DENTISTRY

Consent for use or Disclosure of Patient's Protected Health Information
Consent must be given to use or disclose your protected health information for the purpose of treatment and financial reimbursement.
I **Patient/Guardian**_____ **Date of Birth**_____ authorize Dameron Family Dentistry to discuss my personal health information which may include treatment, prescriptions, dental services including other dental professionals, and/or financials used to pay for treatment.

Name:_____Relationship_____Phone#_____

Name:_____Relationship_____Phone#_____

Financial Information
The following is a statement of our financial policy which we require that you read and sign prior to any treatment. For those patients not covered by dental insurance, full payment is due at the time of treatment. We accept cash, checks ($35 fee for returned checks), and credit cards. If you have insurance coverage, please be aware that your estimated portion will be due on the day of treatment, and we can never guarantee an exact amount that your carrier will pay. You will be financially responsible for any remaining amount not paid by your insurance carrier. Any insurance overpayment will be refunded directly to you. Please understand that we are not contracted/in-network with any insurance companies. For those interested in financing, we participate in the Care Credit Network. We offer the 6-month, no interest plan along with some of the extended payment plans.

We ask that you notify our office 48 hours in advance if you will be unable to keep your appointment. Without proper notice, there will be a $75 charge per missed appointment. Our office will send a monthly statement - this will reflect all payments posted to your account, including dental insurance benefits. After 90 days, any outstanding balance must be paid in full. We will consider all accounts that are over 90 days past due subject to a $5.00 or 1.5% of the balance (whichever is greater) monthly billing fee.

As a service to our patients, we accept the assignment of your insurance benefits directly to our office, upon verification of coverage. We try our best to estimate your patient portion based on the information given to us by your insurance carrier. Our estimates are not a guarantee of coverage. We would be happy to go over these in detail before your initial appointment.

I understand the above financial policy and assign directly to Dameron Family Dentistry, LLC all benefits that would be payable to me for dental services rendered. I hereby authorize this office to use this signature on all of my submissions and allow the release of any information necessary to secure the payment of benefits. I understand that I am responsible for any amounts not paid by my insurance company within sixty days.

We may contact you by using a letter, voicemail, text or e-mail.

Email Address: (Please Print)_____

Signature_____**Date**_____

HEALTH HISTORY

PATIENT'S NAME:_____ **DOB:**_____

In our office we like to treat people and not just teeth! We would like to give you dental care tailored to your individual needs and ask that you aid us in answering the following questions as completely as possible. Please remember that all of your records are held in strict confidence, and cannot be released to anyone without your written notice.

DENTAL HISTORY

Tell us what we can do for you today_____

Date of last dental visit:_____ Last cleaning:_____ Last x-rays:_____

Name of former dentist:_____Phone number:_____

What did you like and not like about your previous dental care:_____

_____

Have you ever had a bad experience at the dentist? _____

_____

Is there anything that concerns you about your mouth/gums/teeth/smile? _____

_____

What could we do to give you perfect dental visits: _____

Do you have any of the following:

	Y	N		Y	N
Bad breath	☐	☐	Clicking / Popping of jaw	☐	☐
Bleeding / sore gums	☐	☐	Sensitivity to hot / cold	☐	☐
Broken/loose teeth or fillings	☐	☐	Sensitivity to sweets	☐	☐
Dry mouth	☐	☐	Sensitivity to pressure/ biting	☐	☐
Wisdom teeth removed	☐	☐	Periodontal treatment / Gum treatment	☐	☐
Fever blisters / Canker sores	☐	☐	Orthodontic treatment/Braces	☐	☐
Discolorations/growths/sores in mouth	☐	☐	Jaw Surgery / Tooth removal	☐	☐
Burning sensation on tongue	☐	☐	Dental Implants	☐	☐
Grinding / Clenching of teeth	☐	☐	Dentures/Partials	☐	☐

How often do you brush? _____ How often do you floss? _____

Do you participate in active recreational activities/sports? _____Do you wear a mouth guard? _____

What is your main source of drinking water? City _____ Bottled _____ Well _____

Do you have fluoride in your drinking water? _____

DRUG/LATEX ALLERGIES

Do you have reactions or allergies to any of the following:

	Y	N		Y	N
Codeine/narcotics	☐	☐	Dental/local anesthetic	☐	☐
Barbiturates/sedatives	☐	☐	Nitrous oxide (laughing gas)	☐	☐
Penicillin/Amoxicillin	☐	☐	Latex	☐	☐
Other antibiotics	☐	☐	Metals (i.e. – nickel)	☐	☐
Sulfa drugs	☐	☐	Iodine	☐	☐
Aspirin	☐	☐	Food	☐	☐
NSAIDs	☐	☐	Other_____		

MEDICATIONS

Please list any prescription or non-prescription medication you currently take (or are supposed to be taking), dosage, and for what condition:

Medication	Dosage	Medication	Dosage
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?
Name of physician/dentist: _____Phone: _____
Have you ever taken any antiresorptive medications for osteoporosis/bone building/cancer?
(Fosamax/Actonel/Boniva/Zometa,etc.) _____
Have you taken Cortisone or any other steroids in the past 12 months?_____
Do you use tobacco (smoking/snuff/chew) or vaping products? _____How long?_____
Do you use any controlled substances or recreational drugs? If so, what? _____
(Recreational drugs can also interfere with your dental health and anesthetics we may use during your treatment. Please inform us before treatment if any have been used within a week of your appointments.)

MEDICAL HISTORY

Do you have or have you had any of the following:

	Y	N		Y	N
Heart disease / failure / attack	☐	☐	Hepatitis (Type_____)	☐	☐
Angina pectoris / chest pains	☐	☐	Liver disease / cirrhosis / jaundice	☐	☐
Pacemaker / defibrillator	☐	☐	Osteoporosis / osteopenia	☐	☐
High / low blood pressure	☐	☐	Sinus trouble	☐	☐
Rheumatic fever / heart disease	☐	☐	Breathing difficulties	☐	☐
Congenital heart defect / murmur	☐	☐	Asthma / emphysema / COPD	☐	☐
Artificial heart valve..(Year replaced _____)	☐	☐	Tuberculosis / cough that produces blood	☐	☐
Mitral valve prolapse	☐	☐	Arthritis	☐	☐
Congestive heart failure	☐	☐	Artificial joint (hip/ knee/etc.)…(Year replaced _____)	☐	☐
Previous endocarditis	☐	☐	Gastrointestinal disease / ulcers	☐	☐
Congenital heart disease/repair	☐	☐	GERD / reflux / persistent heartburn	☐	☐
Damaged heart valves	☐	☐	Eating disorder / malnutrition	☐	☐
Stroke / aneurysm	☐	☐	Diabetes (Type I or Type II)	☐	☐
Blood transfusion (Date_____)	☐	☐	Thryoid disease	☐	☐
Anemia / Sickle cell disease/hemophilia	☐	☐	Kidney problems / failure / dialysis	☐	☐
Abnormal bleeding or healing	☐	☐	Drug / alcohol addiction	☐	☐
Fainting / dizzy spells	☐	☐	Cancer / tumor…(Type_____/Year_____)	☐	☐
Severe headaches / migraines	☐	☐	Radiation / chemotherapy	☐	☐
Epilepsy / seizures / convulsions	☐	☐	Sleep disorder	☐	☐
Neurological disorders	☐	☐	Snoring	☐	☐
Possible exposure to communicable diseases	☐	☐	Autoimmune disease (MS, Lupus, etc.)	☐	☐
Sexually transmitted disease	☐	☐	Mental health disorders	☐	☐
HIV positive / AIDS	☐	☐	Behavioral disorders	☐	☐
Transplant.....(Type_____/Year_____)	☐	☐	Developmental delays/Autism	☐	☐
Glaucoma	☐	☐	WOMEN: Are you pregnant or nursing?	☐	☐

Have you had any operations, surgery or been hospitalized?_____
Do you have any other condition that would be of value to know:_____
Name of family physician:_____ Phone number:_____
Date of last visit with physician:_____
Dentist's comments:_____
_____

I certify that I have read and understand the above information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

PATIENT/GUARDIAN SIGNATURE_____ **DATE**_____

DENTIST'S SIGNATURE_____ **DATE**_____

Financial Policies

Thank you for choosing our office for your dental needs. We will be happy to work with you in planning your treatment to fit your budget. The following describes your financial responsibility to pay for the services received from Dameron Family Dentistry. This responsibility is not modified by whether any third party (insurance) pays for all or part of the fees.

- **Payment Options**
  We accept cash, checks ($35 fee for returned checks), and credit cards (Visa/Mastercard/Discover/American Express).
- **Patients not covered by Dental Insurance:**
  Full payment is due at the time of treatment.
- **Patients covered by Dental Insurance**
  Please understand that there are 2 different types of dental insurance. If your insurance is a PPO plan – you are allowed to choose your dentist while still having benefits for your dental care. Although we are not contracted with these companies, we are able to file claims and receive some reimbursement if your insurance is a PPO plan. If you have a DMO or discounted plan, we are not part of these networks - you will not receive coverage if you are seen in our office.
  As a courtesy, we are happy to accept assignment of your insurance benefits directly to our office (available for most insurance companies). Please be aware that your estimated portion will be due on the day of treatment, and we can never guarantee an exact amount that your carrier will pay. You will be financially responsible for any remaining amount not paid by your insurance carrier, including: deductibles, co-payments, services or charges denied by the carrier or amounts over your carrier's UCR allowances. We will also ask that you pay any claim not processed by your insurance company within 60 days (you will be notified after it is outstanding for over 30 days). Any insurance overpayment will be refunded directly to you.
- **Pre-Determination of Benefits**
  We always encourage you to check your benefits with your insurance company. If you need treatment beyond routine preventive care, we can file a pre-determination of benefits. This will give you the opportunity to know what your insurance company allows toward our services. Please ask us if you are interested in this service.
- **Financing**
  We do not offer in-house financing. However, we do participate in the Care Credit Network. This is a 3rd party company that extends credit that can only be used for dental/medical/veterinary expenses. We offer the 6-month, no interest plan along with some of the extended payment plans through this company. This allows you to finance your dental treatment if your needs are extensive. You can find out more information at www.carecredit.com.
- **Cancellation Policy**
  We understand that there are circumstances that arise that may result in you having to change your reserved appointment. We ask that you notify our office 2 business days in advance if you will be unable to keep your appointment. Please understand that these changes affect the doctor and other patients as well. Without proper notice, there will be a $75 charge per hour of scheduled time.

Our office will send out a statement each month to inform you of your balance. This statement will reflect all payments posted to your account, including dental insurance benefits. After 90 days, any outstanding balance must be paid in full. We will consider all accounts that are over 90 days past due subject to a $5.00 or 1.5% of the balance (whichever is greater) monthly billing fee. In the event of default, reasonable collection charges and/or attorney fees will be applied.

DAMERON FAMILY DENTISTRY

DAMERON FAMILY
DENTISTRY

3156 East Cherokee Drive
Canton, GA 30115

770-345-8646(phone) 770-345-5540(fax)

X-ray Release Form

I, _____, give authorization for the office of _____ to release my dental x-rays to the office of: Dameron Family Dentistry for my continued treatment.

_____ _____

Date Patient Name (Print)

_____

Patient Signature (Parent if Minor)

Please forward requested x-rays (in a .jpg format) to Dameron Family Dentistry to our email address: xrays@dameronsmiles.com. If x-rays are not digital, please send to above address.