10220 Medlock Bridge Rd. Suite 100
Johns Creek, Ga. 30097

WELCOME!

Patient Information:

Name:_____
Last First MI
Mailing Address:_____
_____
Phone #: (C) _____ (W)_____ (Other)_____
Date of Birth: _____
SSN: _____

Sex: ❑ Male ❑ Female
Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Minor

Email address: _____
Occupation: _____
Do you work for the Federal Government? ❑No ❑Yes (If yes please provide both medical **and** dental insurance information under the "Dental Insurance information" section)

How did you hear about our practice?
❑Another Patient? (Please provide name so we can say thanks!)
Name: _____
❑Other:_____

Emergency contact:_____ Relation:_____ Phone #:_____
Primary Care Physician: _____ Phone #: _____

Financially Responsible Party (For minors only)
Name:_____
Last First MI
Billing Address (if different from above): _____
Relationship to patient:_____ _____
Phone #: _____ _____

John's Creek Dental Associates

Dental Insurance Information (If not provided over the phone)

Do you have two dental policies? ❑No ❑Yes (If yes please provide a this information for both)
Insurance Company: _____
ID number: _____Group Number: _____
Insurance Company phone number:_____
Policy Holders Name: _____
Policy Holders SSN: _____
Policy Holders Date of Birth: _____
Policy Holders Employer: _____

Dental History

Date of Last Visit: _____
Previous Dentist: _____
How Many times do you brush daily: _____ Floss?:_____
What type of toothpaste do you use? _____
Do you use electric toothbrush? ❑Yes ❑No
Have you ever had gum disease therapy or deep cleaning? ❑Yes ❑ No
Do your gums bleed when brushing? ❑Yes ❑ No
Do you suffer from bad breath? ❑ Yes ❑ No
Are any of your teeth sensitive? ❑ Yes ❑ No
Do you grind or clench your teeth? ❑ Yes ❑ No
Do you snore or sleep with your mouth open? ❑Yes ❑No
Do you wake up with soreness in your jaw? ❑ Yes ❑ No
Would you be interested in teeth whitening? ❑ Yes ❑No
Would you be interested in cosmetically replacing older dark fillings with new tooth colored restorations? ❑ Yes ❑ No

We are introducing an advanced method of Oral Cancer screening, ideal for patients with history or family history of cancer, or those who use tobacco products**. Would you like additional information on this screening at your visit today?** ❑ Yes ❑ No

Which **two** of these are your top priorities for dental care?
❑ Longevity ❑ Function ❑ Cosmetic ❑ Comfort ❑ Value

Medical History

Are you currently under a physician's care? ❑ Yes ❑No
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
Have you ever had heart valve replacement? ❑ Yes ❑ No
Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates? ❑ Yes ❑ No
Are you taking any medications, pills, and/or drugs? ❑ Yes ❑ No
If so, please list _____
Has a doctor told you that you need antibiotics to premedicate for dental work? ❑ Yes ❑ No
If yes, why?_____
Are you on a special diet? ❑ Yes ❑No
Do you use tobacco? ❑ Yes ❑No
Do you use controlled substances? ❑ Yes ❑ No

WOMEN ONLY

Are you pregnant/ trying to get pregnant? ❑ Yes ❑No Are you nursing? ❑ Yes ❑ No
Are you taking oral contraceptives? ❑ Yes ❑No

Please check to indicate if you are allergic to any of the following:
❑ Aspirin ❑ Codeine ❑ Metal ❑ Local Anesthetics ❑ Penicillin ❑ Acrylic ❑ Latex
❑ Other (please list) _____

Please check to indicate if you have ever had any of the following:

❑ Aids/HIV positive	❑Cancer	❑Frequent Diarrhea	❑Kidney Problems	❑Scarlet Fever
❑Alzheimer's Disease	❑Chemotherapy	❑Genital Herpes	❑Leukemia	❑Shingles
❑Anaphylaxis	❑Chest Pains	❑Glaucoma	❑Liver Disease	❑Sickle Cell Disease
❑Anemia	❑Cold Sores/Fever Blisters	❑Hay Fever	❑Low Blood Pressure	❑Sinus Trouble
❑Angina	❑Congenital Heart Disorder	❑Heart Attack	❑Lung Disease	❑Spina Bifida
❑Appendicitis	❑ Convulsions	❑Heart Murmur	❑Mitral Valve Prolapse	❑Stomach/Intestinal Disease
❑Arthritis/Gout	❑ Cortisone Medicine	❑Heart Disease	❑Osteoporosis	❑Stroke
❑Artificial Heart Valve	❑Diabetes	❑Hemophilia	❑Pacemaker	❑Swelling of Limbs
❑Artificial Joint	❑Dizziness/Fainting Spells	❑Hepatitis A	❑Pain in Jaw Joints	❑Thyroid Disease
❑Asthma	❑Drug Addiction	❑Hepatitis B or C	❑Parathyroid Disease	❑Tonsilitis
❑Blood Disease	❑Easily Winded	❑Herpes	❑Psychiatric Care	❑Tuberculosis
❑Blood Transfusion	❑Emphysema	❑High Blood Pressure	❑Radiation Treatments	❑Tumors or Growths
❑Breathing Problems	❑Epilepsy or Seizures	❑High Cholestorol	❑Recent Weight Loss	❑Ulcers of the Mouth
❑Breast Lump	❑Excessive Bleeding	❑Hives or Rash	❑Renal Dialysis	❑Ulcers of the Stomach
❑Bronchitis	❑Excessive Thirst	❑Hypoglycemia	❑Rheumatic Fever	❑Venereal Disease
❑Bruise Easily	❑Frequent Cough	❑Irregular Heartbeat	❑Rheumatism	❑Yellow Jaundice

John's Creek Dental Associates

Dental Insurance Coverage

As a courtesy to our patients, we will file your insurance claims on your behalf. All insurance information must be COMPLETE and up to date if insurance is to be billed for you. Our office does verify coverage and benefits with your insurance company, but that does not mean payment by them is guaranteed. Any estimate of payment by the insurance company is just that, an estimate, and there is no guarantee of payment by your insurance company. The patient will be responsible for any balance not covered by their insurance. Any overpayment by the insurance company is made available as a credit or can be reimbursed by check by request. It is the patient's responsibility to call their insurance company to check on their coverage prior to the appointment, as well as getting an explanation of benefits (EOB) or claims status/payments after the appointment.

Please initial and sign below:

_____ I understand that estimates presented to me are not a guarantee of payment by my insurance company.
_____ I understand that I am responsible for payment for what my insurance company does not cover or pay in full.
_____ I agree to make payment for any insurance balance when it is brought to my attention.

Patient Name: _____ Signature: _____

Date: _____

Missed Appointment Policy

It is our wish that each and every one of our patients receive the very best care and service possible. We pride ourselves in offering you personalized care and reserve appointment times to accommodate your needs. Late arrivals, missed appointments, or cancelled appointments without sufficient notice create a gap in our providers' schedule. These are appointments that could have been offered to another patient in need.

Late Arrivals:

If a patient arrives **10 or more minutes** late for an appointment they will be asked to **reschedule** because the remaining time is not sufficient to complete the scheduled services. Late arrivals disrupt the daily schedule and result in delays for other patients who are on time. If an appointment must be rescheduled it may result in a **Broken Appointment**.

Broken Appointments:

We require 48 hour notice for any appointment changes, whether rescheduling or cancelling. As a courtesy to our patients we make multiple attempts to confirm all appointments. We do recognize that situations arise that are out of your control; however, it is imperative that you contact our office as soon as possible.

Appointments cancelled or rescheduled with less than a 48 hour notice or appointments missed entirely, **will be considered broken and will be subject to a $50.00 fee**. This fee may be waived as a courtesy if it is the first broken appointment.

Any appointment not confirmed within 24 hours may be forfeited in order to accommodate emergency appointments.

We appreciate your cooperation in scheduling and maintaining appointments in order to provide you with the best level of care.

I have read, understand, and agree to follow the above policy.

Patient Name:_____ Staff Witness:_____

Patient Signature: _____ Staff Signature:_____

Date: _____ Date:_____

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ DOB: _____

I acknowledge that I have reviewed the Notice of Privacy Practices of Johns Creek Dental Associates

(Please initial one of the following options and sign below.)

_____ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office.

_____ I wish to receive a paper copy of Privacy Notice.

_____ I wish to receive an electronic copy of Privacy Notice.

My email address is: _____@_____

Please initial below:

_____ I acknowledge that it is the policy of Johns Creek Dental Associates to leave reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

_____ I acknowledge that if I should have a problem or question in regard to my rights, I may speak with the office manager about my concerns.

_____ _____

Signature of Patient/Guardian Date

_____ _____

Witness (Office Staff) Date