PATIENT REGISTRATION

First Name: _____ Last Name: _____ Middle: _____

Preferred Name: _____

Patient is: □ Responsible Party □ Policy Holder

Responsible Party: (if someone other than the patient)

First Name: _____ Last Name: _____Middle Initial: _____

Address:_____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birth date: _____ Social Security #:_____ Drivers Lic#: _____

○ Responsible Party is Policy Holder for Patient ○ Primary Policy Holder ○ Secondary Policy Holder

Patient Information:

Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone:_____

Sex: ○ Female ○ Male Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth date: _____ Social Security #:_____ Drivers Lic#: _____

E-mail: □ I would like to receive email correspondences

Patient Information (section 2):

Preferred Pharmacy: _____ Referred By: _____

Previous Dentist: _____

Emergency Contact: _____ Phone #: _____

Primary Insurance Information:

Name of Insured: _____ Relationship to Insured: ○Self ○Spouse ○Child ○ Other

Employer ID: _____ Carrier ID: _____

Insured Social Security #: _____ Insured Birth date: _____

Employer: _____ Insurance Company: _____

Secondary Insurance Information:

Name of Insured: _____ Relationship to Insured: ○Self ○Spouse ○Child ○ Other

Employer ID: _____ Carrier ID: _____

Insured Social Security #: _____ Insured Birth date: _____

Employer: _____ Insurance Company: _____

Eagle's Landing

239 Village Center Pkwy
Suite 200
Stockbridge, GA 30281-0000
Ph: (678) 289-0382
E-MAIL: info@eagleslandingperio.com

Medical History Form

Patient Information

Name :
Gender :
DOB :
Phone :

Conditions						
AIDS or HIV Infection	Yes	☐	No	☐	Don't Know	☐
Alcohol / Drug Abuse	Yes	☐	No	☐	Don't Know	☐
Angina	Yes	☐	No	☐	Don't Know	☐
Antibiotic Premedication	Yes	☐	No	☐	Don't Know	☐
Arthritis	Yes	☐	No	☐	Don't Know	☐
Artificial (Prosthetic) Heart	Yes	☐	No	☐	Don't Know	☐
Artificial joint(s) less than 2 years old	Yes	☐	No	☐	Don't Know	☐
Which joint and when was surgery? *						
Artificial Joint(s) Older than 2 years.	Yes	☐	No	☐	Don't Know	☐
Which joint and when was the surgery?						
Asthma	Yes	☐	No	☐	Don't Know	☐
Autoimmune disease	Yes	☐	No	☐	Don't Know	☐
Describe *						

Bleeding Problems	Yes	☐	No	☐	Don't Know	☐
Breathing Problems	Yes	☐	No	☐	Don't Know	☐
Cancer	Yes	☐	No	☐	Don't Know	☐
What kind of cancer? *						
Cardiovascular Disease	Yes	☐	No	☐	Don't Know	☐
Chemo or Radiation Treatment	Yes	☐	No	☐	Don't Know	☐
Chronic pain	Yes	☐	No	☐	Don't Know	☐
Cold Sores	Yes	☐	No	☐	Don't Know	☐
Congenital heart disease (CHD)	Yes	☐	No	☐	Don't Know	☐
Please choose the specific congenital heart disease (CHD) that applies to you. *						
☐ Unrepaired, cyanotic CHD ☐ Repaired (completely) in last 6 months ☐ Repaired CHD with residual defects						
Congestive Heart Failure	Yes	☐	No	☐	Don't Know	☐
Damaged Valve In Transplant Heart	Yes	☐	No	☐	Don't Know	☐
Diabetes Type I or II	Yes	☐	No	☐	Don't Know	☐
Epilepsy	Yes	☐	No	☐	Don't Know	☐
Fainting spells or dizzy spell	Yes	☐	No	☐	Don't Know	☐
G.E. Reflux/persistent heartbu	Yes	☐	No	☐	Don't Know	☐
Glaucoma	Yes	☐	No	☐	Don't Know	☐
Hemophilia	Yes	☐	No	☐	Don't Know	☐
Hepatitis, jaundice or liver d	Yes	☐	No	☐	Don't Know	☐

High Blood Pressure	Yes	☐	No	☐	Don't Know	☐
Osteoporosis	Yes	☐	No	☐	Don't Know	☐

Are you taking medication for your osteoporosis? *

○ YES ○ NO

If yes, please specify the medication you are taking for your osteoporosis:

Pacemaker	Yes	☐	No	☐	Don't Know	☐
Previous Infective Endocarditi	Yes	☐	No	☐	Don't Know	☐
Severe headaches/ migraines	Yes	☐	No	☐	Don't Know	☐
Sexually transmitted disease	Yes	☐	No	☐	Don't Know	☐
Sinus Trouble	Yes	☐	No	☐	Don't Know	☐
Sleep Apnea	Yes	☐	No	☐	Don't Know	☐
Snoring	Yes	☐	No	☐	Don't Know	☐
Stroke	Yes	☐	No	☐	Don't Know	☐

Other Conditions

Allergies

Allergy to Latex / Rubber	Yes	☐	No	☐	Don't Know	☐
Allergy to Penicillin	Yes	☐	No	☐	Don't Know	☐

Other Allergies

Medical Questionnaire

Please list ALL Prescription and Over the Counter Medications, Vitamins and Dietary Supplements that you are currently taking.

In case of emergency, contact and phone number?

Do you have any of the following diseases or problems: *

- ☐ Active Tuberculosis
- ☐ Persistent cough greater than a 3 week duration
- ☐ Cough that produces blood
- ☐ Been exposed to anyone with tuberculosis
- ☐ None of the above

Are you now under the care of a physician? *

- ○ Yes
- ○ No

Physician's name and phone number:

Physician's Address/City/State/Zip:

Are you in good health?

- ○ Yes
- ○ No

If NO please describe why not:

Has there been any change in your general health within the past year? *

- ○ Yes
- ○ No

If yes, what condition is being treated?

Date of last physical exam:

Have you had a serious illness, operation or been hospitalized in the past 5 years? *

- ○ Yes
- ○ No

If yes, what was the illness or problem?

Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax® , Actonel® , Atelvia, Boniva® , Reclast, Prolia) for osteoporosis or Paget's disease? *

- ○ Yes
- ○ No

Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia® , Zometa® , XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? *

- ○ Yes
- ○ No

If yes, please specify the date treatment began:

Do you use controlled substances (drugs)? *

○ Yes ○ No

Do you use tobacco (smoking, snuff, chew, bidis)? *

○ Yes ○ No

If yes, please describe what you use and how much/often (tobacco is related to oral cancer).

Do you drink alcoholic beverages? *

○ Yes ○ No

If yes, please describe the amount of alcohol you drink per day/ per week (excess alcohol consuption is related to oral cancer).

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? *

○ Yes ○ No

If YES please describe why:

Do you have any disease, condition, or problem not listed above that you think the doctor should know about? *

○ Yes ○ No

If yes, please specify:

WOMEN ONLY

Are you pregnant?

○ NO ○ YES

If yes, number of weeks:

Taking birth control pills or hormonal replacement?

○ NO ○ YES

Nursing?

○ NO ○ YES

Dental Questionnaire

What is the reason for your dental visit today? *

Are you currently experiencing dental pain or discomfort? *

○ Yes ○ No

If yes, please explain and rate 1(least)-10(worst)

Date of your last dental exam:

What was done at that time?

Date of last dental x-rays:

How do you feel about your smile?

Dental Information

Do your gums bleed when you brush or floss? *

○ Yes ○ No

Are your teeth sensitive to cold, hot, sweets or pressure? *

○ Yes ○ No

Is your mouth dry? *

○ Yes ○ No

Have you had any periodotal (gum) treatments? *

○ Yes ○ No

Have you ever had orthodontic (braces) treatment? *

○ Yes ○ No

Have you had any problems associated with previous dental treatment? *

○ Yes ○ No

Do you have any clicking, popping or discomfort in the jaw? *

○ Yes ○ No

Do you brux or grind your teeth? *

○ Yes ○ No

Do you wear removable dentures or partials? *

○ Yes ○ No

Have you ever had a serious injury to your head or mouth? *

○ Yes ○ No

Are you interested in any of the following:

○ Whiter teeth ○ Repairing Chipped/broken teeth ○ Repairing worn teeth

○ Straighter teeth ○ Smile Makeover ○ Better Bite

○ Botox/Dermal filler/PDO threads ○ no

By signing below, I certify that all the above information is true to the best of my knowledge. I understand the importance of this information and that the practice will rely on this information for the treatment. I will not hold the practice or any member / staff of the practice, 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.

Signature of Patient or Responsible Party

Signed on

Patient consent to receive mail and/or telephone messages

Please print (Last Name) (First Name) (M.I.)

Email Address (please print)

Do we have your permission to?

Send a recall appointment reminder to your house: Y_____N____

Leave appointment, billing or dental information on

Your answering machine/voice mail/e-mail: Y_____N_____

I give permission to share appointment, billing information and medical information with the person/s named below:

~~Name~~ ~~relationship~~ ~~phone number~~

~~Name~~ ~~relationship~~ ~~phone number~~

~~Name~~ ~~relationship~~ ~~phone number~~

Please provide us with the best phone number (s) to reach you at in the event of bad weather.

Phone number(s)

Acknowledgment of Receipt of Notice of Privacy Practices

I have received copy of the notice of Privacy Practices with an effective date of April 14, 2003

Signature of Patient /Parent or Legal Guardian Date

Consent for Services

In consideration for the professional services rendered to me, or at my request by the Doctor, I agree to pay the reasonable value of said services to the Doctor. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. 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.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form or my treatment.

All emergency dental services, or any dental services performed without insurance confirmation of eligibility must be paid for in cash, check or card at the time services are performed.

You will be responsible for payment of your estimated amount, including deductibles and co-pays of your primary dental insurance.

I understand that when a treatment plan is given to me, that those fees will be honored for a 6 month period only. I understand that there may be an increase in fees from the date of the treatment plan.

I have read the above conditions of treatment and payment and agree to their content.

_____ _____

Signature of patient, parent or guardian **Date**

Appointments and Cancellations

When we make your appointment, we are reserving a room for your particular needs. We ask that if you must change or cancel an appointment, please give us at least **24-hour's notice** *(for any routine appointment)* **and/or 1 week notice** *(for any surgery appointment greater than **ONE** hour long)*. This courtesy makes it possible to give your reserved room to another patient who would like it.

If you cancel or fail to show for your confirmed SURGERY appointment, or if you arrive excessively late and treatment cannot be completed as planned, Dr. Faler reserves the right to recover lost opportunity and associated costs with a **BROKEN APPOINTMENT FEE OF $100 per ½ hour**** ; *(fee associated with ANY surgery appointment greater than 1 hour in length)*

One week prior to your appointment you will receive a phone call and/or an email requesting a verbal confirmation for your upcoming appointment. When you receive this message, please **CALL** us back to confirm the time that you have already reserved with us. **If we do not get a VERBAL confirmation from you 4-BUSINESS DAYS prior to your reserved time, we will take your appointment off of our schedule.**

Repeated cancellations or missed appointments will result in loss of future appointment privileges.

We feel that our patient's time is valuable. When your appointment is made, a room is reserved, your records are prepared, and special instruments are readied for your visit. Except for emergency treatment for another patient, you can expect us to be prompt; we, of course, would appreciate the same courtesy from you.

Late Arrival

If you are over **15 minutes** late for your appointment, we reserve the right to reschedule your appointment for a later time. Please understand that we strive to stay on time for your appointment as well as the patients that follow you. By signing below, you have read, and understand this agreement.

***We understand emergencies may arise and we will make allowances depending on the circumstances.*

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Signature of Patient or Parent **Date**

Financial Agreement

As a courtesy to our patients, we will file dental insurance claims for services rendered. However, you the patient are ultimately responsible for any incurred fees. We expect payment of deductibles, co-payments and balances to be made at the time services are rendered.

There are hundreds of dental insurance policies. Therefore, we are unable to know about all individual dental plans. In an effort to avoid confusion, we recommend the following:

- **Be familiar with your own policy.** Information to inquire about would be:
- Do you need to see a provider in your network?
- Does your policy have a yearly deductible and what is the amount?
- Does your policy have a waiting period or missing tooth clause?
- Know what your policy covers and what percentage of a procedure is covered.
- Know the frequency and timing of your preventative maintenance program (some policies cover two cleanings per calendar year and others only cover every six months)
- Know your policy year maximums and when the calendar year starts.
- **Bring correct insurance information to your appointment**.
    - Please provide us with your dental insurance ID card prior to the start of your appointment. We must have: policy, group and ID numbers to process your claim. We must also have the correct mailing address for your dental insurance carrier. If a claim is returned to us, you will be responsible for the fees and rendered services.
- **Let us know if a pre-authorization is required**. If a pre-treatment estimate is needed for treatment over $200, please inform us prior to starting the treatment. They usually take 6-8 weeks to respond to a claim.

Dr. Faler participates in Delta Dental, Cigna and Ameritas. Even these plans have many policies within them, so make sure to know your plan. If you do not see our name on your list of providers, then we do not participate in your plan. However, some network plans allow you to see providers outside their networks. Your out-of-pocket expense may be slightly higher.

Dental insurance is meant to be an "aid" in receiving dental care. Our office bases treatment on your needs, not what your insurance will pay. Insurance payment is determined by "UCR" fees (usual, customary, and reasonable fees). These fees are not always the same as our fees. Some insurance companies may pay less, some pay more. Whether you're insurance pays 100%, 80%, or 50% of a procedure, they are determining payment based on **their** fee schedule, **not the actual fee** our office has charges for the service.

Filing insurance is not a guarantee of payment for the service(s) performed. We have no way of knowing if, or what, your insurance company will pay until the actual claim is submitted. Therefore, all account balances which have not been paid within a 30 day period become due by the person/parent/guardian that is responsible.

I have read the above information and agree to its terms:

_____ _____

Signature **Date**