Brookhaven Dental ASSOCIATES
1407 Dresden Drive Suite 200
Atlanta, Georgia 30319

WELCOME

Date: _____

Patient Information

Name: _____
Last First MI

Email address: _____

Mailing Address: _____

_____

Phone # (H)_____ (W) _____ (Other) _____

Can we call you at work? ❑ Yes ❑ No

Date of Birth: _____ Sex: ❑ Male ❑ Female SS#: _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Minor

Occupation: _____ Employer: _____

Employer Address: _____ Phone: _____

How did you hear about our practice? _____

Emergency contact: Name: _____ Relation: _____ Phone #: _____

Phone #: (H) _____ (W) _____

Primary Care Physician: Name: _____ Fax Number: _____

Address: _____

_____

Financial Information

Name of person responsible for this account: _____

Relationship to patient (if other than self): _____ Phone # _____

License Number: _____

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Dental Insurance Information

Do you have Dental Coverage: ❑ Yes ❑No

Insurance Company: _____

Insurance Company address and phone # : _____

Policy Holders Name: _____

Policy Holders SSN: _____

Policy Holders Date of Birth: _____

Policy Holders Employer: _____

Group Number: _____ ID number: _____

Dental History

Previous Dentist: _____

Date of Last Visit: _____

How Many times do you brush daily: _____ Floss_____

Do you use electric toothbrush: _____

Do you wake up with soreness in your jaw? ❑ Yes ❑ No

Have you ever had gum disease therapy or deep cleaning? ❑Yes ❑ No

Do your gums bleed when brushing? ❑Yes ❑ No

What type of toothpaste do you use? _____

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

Would you be interested in cosmetically replacing older dark fillings with new tooth colored restorations? ❑ Yes ❑ No

Would you be interested in teeth whitening? ❑ Yes ❑No

Are you deeply concerned about the finances required to return your mouth to excellent dental health? ❑ Yes ❑ No

If you could change anything about your smile what would it be? _____

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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

Has a doctor told you that you need antibiotics to premedicate for dental work? ❑ Yes ❑ No

Are you on a special diet? ❑ Yes ❑No

Do you use tobacco? ❑ Yes ❑No

Do you use controlled substances? ❑ Yes ❑ No

Do you take, or have you taken, Phen-Fen or Redux? ❑ Yes ❑ No

Are you taking any medications, pills, and/or drugs? ❑ Yes ❑ No
If so, please list _____

WOMEN ONLY

Are you pregnant? ❑ Yes ❑No

Are you taking oral contraceptives? ❑ Yes ❑No

Are you nursing or trying to get pregnant? ❑ 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 Headaches	❑Kidney Problems	❑Sickle Cell Disease
❑ Alzheimer's Disease	❑Chest Pains	❑Genital Herpes	❑Leukemia	❑Sinus Trouble
❑ Anaphylaxis	❑ Cold Sores/Fever blisters	❑ Glaucoma	❑Liver Disease	❑Spina Bifida
❑ Anemia	❑ Congenital Heart Disease	❑ Hay Fever	❑Low Blood Pressure	❑Stomach Disease
❑ Angina	❑ Convulsions	❑ Heart Attack/Failure	❑Lung Disease	❑Stroke
❑ Appendicitis	❑ Cortisone Medicine	❑ Heart Murmur	❑Mitral Valve prolapse	❑Swelling of Limb
❑ Arthritis/ Gout	❑ Diabetes	❑ Heart Pace Maker	❑Pain in Jaw Joints	❑Thyroid Disease
❑Artificial Heart Valve	❑ Drug Addiction	❑ Heart Trouble/Disease	❑ Parathyroid Disease	❑Tonsillitis
❑Artificial Joint	❑ Easily Winded	❑ Hemophilia	❑Psychiatric Care	❑Tuberculosis
❑ Asthma	❑ Emphysema	❑ Hepatitis A	❑Radiation Treatment	❑Tumor or Growth
❑ Bleeding Disorders	❑ Epilepsy or Seizures	❑ Hepatitis B or C	❑ Recent Weight Loss	❑ Ulcers
❑ Breast Lump	❑ Excessive Bleeding	❑ Herpes	❑Renal Dialysis	❑ Venereal Disease
❑ Bronchitis	❑ Excessive Thirst	❑ High Blood Pressure	❑Rheumatic Fever	❑ Yellow Jaundice
❑Blood Disease	❑ Fainting spells/dizziness	❑ Hives or Rash	❑ Rheumatism	❑Other_____
❑Blood Transfusion	❑ Frequent Cough	❑ Hypoglycemia	❑ Scarlet Fever	_____

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❑Bruise Easily ❑ Frequent Diarrhea ❑ Irregular Heartbeat ❑Shingles _____

PATIENT MISSED APPOINTMENT POLICY

DEFINITIONS

POLICY- a way of managing affairs so as to achieve some purpose.

APPOINTMENT- a meeting with someone at a certain time and place.

MISSED- fail to keep, do, or be present at.

It is our wish that each and every one of our patients receive the very best care and service possible. **Your Treatment Program** consists of a specific series of treatment given over a pre-planned time span. If you do not follow this plan, then you will not receive the desired results.

If we did not insist that you meet all your appointments, we would be doing you a disservice and it would be indicative that we did not care. We do not want to do you a disservice and we do care about you and the success of your program here. Therefore, we have a few simple rules that we insist you follow:

1. Meet all your appointments. Arrange the activities in your life so that this can occur.
2. If you are unable to make it in due to an emergency, please call us and let us know so we can reschedule your appointment.
3. With the exceptions of unexpected emergencies, we request that you notify us at least 48 hours in advance as to any appointment changes.
4. **All cancelled or missed appointments must be rescheduled and made up within one week.**
5. **All Patient Appointments without a 24 hour notification will be charged a $50.00 service charge.**

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

Patient's Name: _____

Signature: **_____**

Staff Witness: **_____**

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PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ DOB: _____

I acknowledge that I have reviewed the Notice of Privacy Practices of Brookhaven Dental Associates
(Please initial one of the following options and sign below.)

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

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

My email address is: _____@_____

_____ 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.

Please initial below:

_____ I acknowledge that it is the policy of Brookhaven 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

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Dental Insurance Coverage

Patient Name_____

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 it is a guarantee of payment. The patient will be responsible for any balance not covered by their insurance. 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.

I understand that I am responsible for payment for whatever my insurance does not cover or pay in full.

_____ _____
Signature Date