Dental/Medical Health History

Confidential

Today's Date_____

Patient Name_____Birthdate_____

Last First MI

DENTAL HISTORY

Reason for Today's Visit_____ Former Dentist_____

Date of last Dental Care_____ Date of last Dental X-Rays_____

Were you referred by a current patient?_____ If so, who, so we may thank them: _____

Check if you are having problems with any of the following:

- ☐ Bad Breath
- ☐ Bleeding Gums
- ☐ Clicking or Popping Jaw
- ☐ Food Collection Between Teeth
- ☐ Grinding Teeth
- ☐ Loose teeth/Broken Fillings
- ☐ Periodontal Treatment
- ☐ Sores or Growths in Mouth
- ☐ Sensitivity to Hot
- ☐ Sensitivity to Cold
- ☐ Sensitivity to Sweets
- ☐ Sensitivity to Biting

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

MEDICAL HISTORY

Have you had any serious illnesses/operations?_____ If yes, describe_____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check if you have or have had any of the following:

☐ Anemia	☐ Cortisone Treatments	☐ Herpes Simplex	☐ Scarlet Fever
☐ Arthritis/Rheumatism	☐ Cough, Persistent	☐ High Blood Pressure	☐ Sickle Cell Anemia
☐ Artificial Heart Valves	☐ Diabetes	☐ HIV/AIDS	☐ Shortness of Breath
☐Artificial Joints	☐ Epilepsy	☐ Jaw Pain	☐ Skin Rash
☐ Asthma	☐ Fainting	☐ Kidney Disease	☐ Stroke
☐ Back Problems	☐ Glaucoma	☐ Liver Disease	☐ Swelling of Feet/Ankles
☐ Blood Disease	☐ Headaches	☐ Mitral Valve Prolapse	☐ Thyroid Problems
☐ Cancer	☐ Heart Murmur	☐ Pacemaker	☐ Tobacco Habit
☐ Chemical Dependency	☐ Heart Disease	☐ Radiation Therapy	☐ Tonsillitis
☐ Chemotherapy	☐ Hemophilia	☐ Respiratory Disease	☐ Tuberculosis
☐ Circulatory Problems	☐ Hepatitis	☐ Rheumatic Fever	☐ Ulcer

MEDICATIONS

List medications you are currently taking: _____

_____

_____

_____

ALLERGIES

- ☐ Aspirin
- ☐ Barbiturates (Sleeping Pills)
- ☐ Codeine
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Latex
- ☐ Other _____

SIGNATURE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if there are any changes to my medical history.

_____ Date _____

Signature of Patient, Parent, Guardian or Personal Representative

PATIENT INFORMATION

Address: _____
Street Apartment #

_____
City State Zip Code

Phone (Cell) _____Accept Text Messages? _____ (Home) _____

Email Address_____

Employer Name/Occupation _____

RESPONSIBLE PARTY INFORMATION

Name: _____

Social Security #:_____Birth Date: _____

Phone (Cell): _____ (Home): _____ (Work): _____

Address: _____
Street Apartment #

_____
City State Zip Code

INSURANCE INFORMATION

Name of Insured: _____
Last First MI

Insured's Birth Date: _____ ID #:_____ Group #: _____

Insured's Employer Name: _____

Patient's Relationship to Insured: □ Self □ Spouse □ Child □ Other _____

Insurance Plan Name: _____

CONSENT FOR SERVICES

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care, and financial responsibility on the part of each patient must be determined before treatment. Payment is expected as services are rendered unless prior financial arrangements have been made. ***If you have insurance, we will gladly file your claim, but we require that you pay your estimated portion when services are rendered.*** All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who have dental insurance should understand that all dental services furnished are charged directly to the patient, and that he or she is personally responsible for payment of dental services. ***The estimated amount due is based on information provided by the insurance company, and is only an ESTIMATE.*** This office will prepare the patient's insurance forms and assist in making collections from insurance companies, and will credit any such collections to the patient's account. However, this dental office does not render services on the assumption that our charges will be paid by the insurance company.

I understand that the treatment plan fee estimate for my dental care will only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, at my request, by the Doctor, I agree to pay the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered. 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, and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. I understand that forms of payment accepted by this office are cash, check, Visa, MasterCard, and CareCredit after approval. I also acknowledge that for any checks I may write that are returned to this office for insufficient funds, a $30.00 returned check fee will be charged. I further acknowledge that a 24 hour cancellation notice is required if I am unable to keep my appointment, and that if I fail to give notice, my account is subject to a $30.00 charge.

I grant my permission to you or your assignee to telephone me to discuss matters related to this form.

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

_____ _____
Signature of patient, parent or guardian Date

Chris Strickland, DMD, LLC
1582 Mars Hill Road, Suite B
Watkinsville, GA 30677

Patient Financial Agreement

We are committed to providing you with the best dental care possible, and have established our financial policies to achieve that goal. In order to provide optimal dental care, payment is expected at the time of service. We trust that you understand and appreciate the need for a clear policy regarding your account. Please read the financial information and sign at the bottom. If you have any questions, please feel free to ask our staff.

In order to keep your focus on your healthcare needs, we are happy to file your insurance as a *courtesy*, and accept assignment of your insurance benefits on your behalf once your coverage is verified. Full payment of services is expected until we verify your specific coverage. Based on your coverage and deductible, some out of pocket expenses should be expected. We require that your portion of the visit be paid at the time of service.

We offer this *courtesy* with these understandings:

- We recommend comprehensive dental care for you, regardless of your dental benefits.
- Your contract is between you and your insurance company. You are responsible for any amount not covered or paid by your insurance. This includes deductibles, co-payments, denials, downgrade of services, and any and all reasons for non-payment from your insurance provider.
- Our office cannot guarantee payment by your insurance company. You are responsible for all charges, regardless of ***estimated*** insurance coverage. We will make every attempt to verify your policy and what it covers. However, if your insurance claim is denied, you will be responsible for payment.
- In the event that you should receive payment directly from your insurance company, you are expected to inform our office and send the check to our office.
- Any account that is over 60 days past due will receive written notification that your account will be referred to a collection agency or legal action may be taken in order to receive full payment for services performed on you or any dependants.

Returned Check and Appointment Cancellation/No-Show Policy

- There is a $30.00 charge for all returned checks.
- We reserve the right to charge your account $30.00 for appointment no-shows and cancellations without at least 24 hours notification.

Payment Options

Payment is due at the time of treatment. We accept cash, checks, and Visa/MasterCard. We understand that dental treatment can be costly, so we offer a payment plan called CareCredit. CareCredit is a third party financial provider that, once approved, allows you to start treatment today and spread your payments over time. Applying for CareCredit only takes a few minutes, and there is no fee to apply. Please ask out front office staff if you are interested in applying for CareCredit or would like more information.

My signature below verifies that I have thoroughly read, understand, and agree to the above Patient Financial Agreement.

_____ _____

Signature of Patient/Responsible Party Date

Chris Strickland, DMD, LLC
1582 Mars Hill Road, Suite B
Watkinsville, GA 30677

Privacy Practice Notice

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully. The privacy of your medical information is important to us.

Our Obligations: We are required, by law, to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal obligations, and your rights concerning your health information. We must follow the privacy practices that are described in this notice.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided that such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all the health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available to you when you first receive service from us after the date the revised notice becomes effective or upon request.

You may request a copy of our notice at anytime. For more information about our privacy practices, or for additional copies of this notice, please contact us at 1582 Mars Hill Rd., Suite B, Watkinsville, GA 30677

Uses and Disclosures of Health Information

We use and disclose health information about you for our treatment, payment, and healthcare operations. For example:

- Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.
- Payment: We may use of disclose your health information to your health insurer to obtain payments for services we provide to you.
- Persons Involved in Care: We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative, or another person responsible for your care to the extent necessary to help with your health care or with payment of your health care, if you agree that we may do so. We may also advise these persons of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information that is directly relevant to the person's involvement in your health care. We will also use our professional judgment and our experience with common practices to make reasonable inferences for your best interest in allowing a person to pick up prescriptions, x-rays, or other similar forms of health information.
- Disclosure Permitted or Required by Law: We are permitted, and in some cases required, by law to make certain disclosures of health information without your consent. We may disclose your health information, if appropriate, to the following entities under the follow circumstances:
    - To any individual when ordered by a court or other legal processes to do so
    - To law enforcement officials when necessary for law enforcement purposes and required by law
    - To a coroner or medical examiner when necessary to enable them to perform their duties.

- Appointment Reminders: We may disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters), or information about treatment alternatives or other health related benefits and services that may be of interest to you.
- Marketing Health-Related Services: We will not use your health information for marketing communications without your written consent.
- Your Authorization: Other uses and disclosures of your health information will be made if you give us written authorization to do so. If you give us authorization, you may revoke it at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

Patient Rights

You have certain rights regarding your health information. These rights include:

- The right to obtain a paper copy of this notice
- The right to inspect and copy your health information
- The right to request amendments to your health information that your believe to be inaccurate
- The right to request restrictions on our permitted uses and disclosures of your information (although we are not legally obligated to honor this request)
- The right to request that communications regarding your health information be sent by alternative means or at alternative locations

Questions and Complaints

If you want more information about our privacy practices, or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or wish to exercise any of your rights described herein, please contact us using the information below. You may also submit a written complaint to the US Dept of Health and Human Services. We will provide you with the address to file your complaint upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the US Dept of Health and Human Services.

Contact Information:
1582 Mars Hill Road, Suite B
Watkinsville, GA 30677
706-769-9779

Chris Strickland, DMD, LLC
1582 Mars Hill Road, Suite B
Watkinsville, GA 30677

Acknowledgement of Receipt of Notice of Privacy Practices

You May Refuse to Sign this Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify)

_____

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