PATIENT INFORMATION

Name: _____ / _____ / _____ / _____
(Last) (First) (MI) (Preferred Name)

Age: _____ Gender: O Male O Female Birth Date: ____/____/____

Address: _____ City/State/Zip: _____

Home Phone #: _____ Cell: _____ Social Security #: _____

Email: _____

Marital Status: O Married O Single O Divorced O Widow O Widower O Domestic Partner

Employer Name: _____ Occupation: _____

Emergency Contact: _____ / _____ / _____
(First & Last Name) (Relation) (Phone Number)

Who may we thank for sending you to our office? _____

What is the reason for your appointment? _____

SPOUSE OR RESPONSIBLE PARTY INFORMATION

The following is for: O Patient's spouse O Person responsible for payment

First Name: _____ Last Name: _____

O Male O Female O Married O Single O Child O Other: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ Cell: _____ Work: _____ Best time to call: _____

Address: _____ / _____
(Street) (Apt. #:)

City: _____ State: _____ Zip: _____

Employer Name: _____ Occupation: _____

INSURANCE INFORMATION

Name of insured: _____ / _____ / _____ Is insured a patient? O Yes O No
(Last) (First) (MI)

Insured's Birth Date: ____/____/____ Social Security #: _____ ID #: _____

Insurance Plan Name: _____ Group #: _____

Insured's Employer Name: _____

Patient's relationship to insured: O Self O Spouse O Child O Other: _____

ASSIGNMENT OF INSURANCE BENEFITS AND RELEASE OF INFORMATION

I, the undersigned, certify that I (or my dependents) have dental insurance coverage with _____
(Name of Insurance Company)

And assign directly to Compass Dental LLC all benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance whether manual or electronic.

Responsible Party Signature _____ ***Date:*** _____

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive.

Do you have, or have you had, any of the following? (Check all that apply)

- ☐ Aids / HIV Positive
- ☐ Alzheimer's Disease
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis / Gout
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Breathing Problem
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Cold Sores / Fever Blisters
- ☐ Congenital Heart Disorder
- ☐ Cortisone Medicine
- ☐ Convulsions
- ☐ Diabetes
  - Most Recent HbA1c: _____
  - Date: _____
- ☐ Drug Addiction
- ☐ Easily Winded
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Fainting spells / Dizziness
- ☐ Frequent Cough
- ☐ Frequent Diarrhea
- ☐ Frequent Headaches
- ☐ Glaucoma
- ☐ Heart Attack / Failure
- ☐ Heart Murmur
- ☐ Heart Pacemaker
- ☐ Heart Trouble
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Hives or Rash
- ☐ Hypoglycemia
- ☐ Irregular Heartbeat
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Mitral Valve Prolapse
- ☐ Psychiatric Care
- ☐ Radiation Therapy
- ☐ Recent Weight Loss
- ☐ Renal Dialysis
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Seasonal Allergies
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus issues
- ☐ Stomach/ Intestinal Disease
- ☐ Stroke
- ☐ Swelling of Limbs
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Tumors or Growths
- ☐ Ulcers
- ☐ Venereal Disease

Women: are you... (circle those that apply)

Pregnant/ Trying to get pregnant? **Yes / No** Taking birth control? **Yes / No** Nursing? **Yes / No**

Are you allergic to any of the following? (check those that apply)

O Aspirin O Penicillin O Codeine O Acrylic O Metal O Latex O Local Anesthetics O Other

If yes, please explain: _____

Are you under a physician's care now?..... **Yes** **No**

* If yes, please explain:_____

Name of Physician: _____ Phone: _____

Have you 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**

*If yes, please explain:_____

Do you take, or have you taken, Bisphosphonates (medication for bone health)? .....**Yes** **No**

Do you use controlled substances?..... **Yes** **No**

Do you use tobacco?..... **Yes** **No**

Are you taking any medications, pills, or drugs? ..... **Yes** **No**

*If yes, please list: _____

_____

Have you ever had any serious illness not listed above?..... **Yes** **No**

*If yes, please explain: _____

Additional Comments: _____

_____

Dental Health Information

Are you having any discomfort at this time? Explain: _____

Have you ever had any serious complications associated with previous dental procedures? **Yes or No**

If Yes, Explain:_____

Does dental treatment make you nervous? (Circle) **No Slightly Moderately Extremely**

Have you ever been treated for periodontal disease (gum disease, pyorrhea, or trench mouth)? **Yes or No**

*If so, when?_____

How often do you brush?_____

What texture is your brush? (Circle) **Soft Medium Hard**

Do you have, or have you ever had any of the following? (Please check all that apply):

- ☐ Bleeding, sore gums
- ☐ Unpleasant taste/bad breath
- ☐ Burning tongue/lips
- ☐ Frequent blisters, lips or mouth
- ☐ Loose teeth
- ☐ Sensitivity to heat
- ☐ Sensitivity to cold
- ☐ Sensitivity to sweets
- ☐ Sensitivity to biting
- ☐ Shifting in bite
- ☐ Clenching/grinding; O Day O Night
- ☐ Swelling/lumps in mouth
- ☐ Biting of cheeks/lips
- ☐ Clicking/popping jaw
- ☐ Difficulty opening or closing jaw
- ☐ Food impaction

Are you happy with your smile and the appearance of your teeth in general (Color, Shape, Spaces)? **Yes or No**

*If "No", why not? _____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in my medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN **Date**

_____

SIGNATURE OF DENTIST **Date**

NOTES:

Cancelled and Broken Appointment Policy

Patients who fail to keep their scheduled appointments without adequate notice do cause problems for both the office, as well as other patients. We are better able to schedule you promptly and in your desired time frame if we know sufficiently in advance that you need to reschedule an appointment.

We strive to schedule patients one at a time to ensure the personal attention that you deserve. We make every effort possible to remind all patients of their scheduled appointments. Please understand that this is a courtesy. DO NOT DEPEND ON THIS. If we are unable to reach you, your appointment card will serve as your confirmation of the appointment and implies your obligation to be present.

In an effort to establish daily schedules that are efficient as well as considerate of your time and ours, we have adopted the following policy regarding broken and late cancelled appointments:

1. A late cancellation is defined as any scheduled appointment that a patient cancels without giving at least 48 hours advanced notice.
2. A broken appointment is any appointment which a patient fails to keep or arrives late.
3. Two late cancellations may result in a charge to the patient and/or legal guardian, not covered by an insurance plan.
4. One broken appointment will NOT incur a charge, however the second one and each one after will incur a fifty-dollar charge for hygiene and/or one hundred per hour for Dr. Fana's time.
5. Multiple late cancellations and/or broken appointments may result in your ineligibility for future care in our office and may require a non-refundable deposit when making an appointment.

Insurance is not responsible and will not pay for broken appointments

We realize that circumstances sometimes arise at short notice which may result in the necessity to cancel an appointment. When such circumstances occur, we will exercise discretion in the decision to charge a fee. It is our sincere desire to be considerate of your time, and as we make every effort to do so, we hope that our patients will also be considerate of our desire to predictably serve our patients with the time available to us.

Thank you for your consideration and cooperation.

Name of patient (print):_____

Signature of patient or guardian:_____ **Date:**_____

OUR OFFICE AND FINANCIAL POLICIES

Thank you for choosing Compass Dental, LLC as your dental health provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. If you have any questions, please feel free to ask any staff member for more information.

APPOINTMENTS

Your appointments are scheduled to respect your time. We reserve a significant amount of time and reserve a specific room for your care and make every effort to see you at the appointed time. We appreciate your promptness and consideration in not changing your reserved time. However, if you must change an appointment, a **48- hour** notice is expected. A fee will be applied for missed appointments or arriving more than 15 minutes late without notice. Arrangements must be made in advance if a minor (under age 18) is to be seen without an adult present. (Initial) _____ ⇦

INSURANCE

As a courtesy to you, we accept assignment of insurance benefits from most insurance companies. However, ***we do require you to pay your deductible and/or "estimated patient portion" at the time of service***. The balance is your responsibility whether your insurance pays or not. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Patients who carry dental insurance should remember that all dental services performed are charged directly to the patient and not the insurance company. If you have dental insurance, you must provide us with your dental insurance card and a claim form if needed. We must be able to verify coverage before we can accept assignment of benefits. If requested, a dental pre-estimate can be submitted to your insurance company for review. This will allow you to know the estimated amount that the insurance company will pay. However, this office cannot render services on the assumption that our charges will be paid by an insurance company. Patient or responsible party needs to pay in full for claims not paid after 45 days.

I understand that I am responsible for reading and understanding my dental insurance benefits. I am also responsible for notifying this office of any insurance plan or policy changes. (Initial) _____ ⇦

USUAL AND CUSTOMARY RATES

Please be aware that some of our services may be "non-covered", subject to an insurance company's arbitrary determination of usual and customary rates or have time limitations imposed by the insurance company. Our fees reflect what is usual and customary for our area, as well as the quality of treatment that you receive. The adult accompanying a minor is responsible for full payment.

I understand that I am responsible for any balance left unpaid by my insurance company. (Initial) _____ ⇦

PAYMENT OPTIONS AND ACCOUNT INFORMATION

In order to maintain our fees at a reasonable level, we do not send monthly statements. If a balance is over 30 days, a billing fee will be charged at the rate of 1.5% per month of the total balance, or $7.00, whichever is greater. In the event we receive a returned check for insufficient funds or a closed account, there will be a $35.00 fee charged to your account. If any delinquent account is turned over to a third-party collection agency for non-payment, there will be a collection fee of 30% added to the bill. This is pursuant to Georgia Statutory Law "O.C.G.A. -13-1.11"

PHOTOGRAPHY RELEASE

I am giving permission for Compass Dental, LLC to use any intra-oral, pre-op or post-op photos taken of my oral cavity for patient education and advertising. I understand that the pictures will be of the mouth and teeth only and that no facial photos will be used. (Initial) _____ ⇦

- ❖ PAYMENT IN FULL IS DUE AT TIME OF SERVICE
- ❖ WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, DISCOVER, & AMERICAN EXPRESS
- ❖ WE ALSO OFFER AN EXTENDED PAYMENT PLAN THROUGH CARE CREDIT (upon approval)
  If you wish to utilize this option, please ask the front desk for an application.

THANK YOU FOR UNDERSTANDING OUR GUIDELINES. PLEASE LET US KNOW IF YOU'VE ANY QUESTIONS OR CONCERNS

I have read, understand, and agree to the above office and financial policies.

_____

Signature of patient or responsible party *Date*

Staff _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Purpose of consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our notice provides a description of your treatment, payment activities, healthcare operations, the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. We encourage you to read it carefully and completely before signing this Consent.
We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation. Please understand that revocation of this Consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Emailing X-rays: In providing the best treatment for our patient, it might be necessary for us to email x-rays to other specialists or dentists. This allows other offices to have a better diagnostic tool available to them and to have access for quicker service.

Allowing for Discussion of Information: If you would like us to discuss your personal health information with another individual, please select with whom and what information we may discuss.

_____ Spouse _____ Family Member _____ Friend _____ Other

Please provide us with their name(s): _____

_____

Information to be disclosed: (please check all that apply)

- Appointment dates and times
- Treatment plans and referrals
- Financial and billing information
- Any other pertinent dental health information related to treatment at this office

I , _____ , have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I do hereby grant permission for Compass Dental, LLC to disclose my personal health information to carry out treatment, payment activities, and health care operations. This permission will remain in effect unless written cancellation has been provided.

_____ _____
Patient Signature Date

Staff_____

COMPASS DENTAL. LLC

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.

_____
Please print name

_____
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:

- ☐ The individual refused to sign.
- ☐ Communications barriers prohibited obtaining acknowledgement.
- ☐ An emergency prevented us from obtaining acknowledgement.
- ☐ Other (Please Specify)

_____

_____

_____