PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

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

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

PHARM NUMBER

CELL PH or BEEP#

MEDS

MEDS

MEDS

MEDS

MEDS

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

David C Pettey, DMD

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

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. Thank you for answering the following questions.

Are you under a physician's care now?	○ Yes ○ No	If yes
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes
Are you taking any medications, pills, or drugs?	○ Yes ○ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes
Are you on a special diet?	○ Yes ○ No	
Do you use tobacco?	○ Yes ○ No	
Do you use controlled substances?	○ Yes ○ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	○ Yes ○ No	Cortisone Medicine	○ Yes ○ No	Hemophilia	○ Yes ○ No	Radiation Treatments	○ Yes ○ No
Alzheimer's Disease	○ Yes ○ No	Diabetes	○ Yes ○ No	Hepatitis A	○ Yes ○ No	Recent Weight Loss	○ Yes ○ No
Anaphylaxis	○ Yes ○ No	Drug Addiction	○ Yes ○ No	Hepatitis B or C	○ Yes ○ No	Renal Dialysis	○ Yes ○ No
Anemia	○ Yes ○ No	Easily Winded	○ Yes ○ No	Herpes	○ Yes ○ No	Rheumatic Fever	○ Yes ○ No
Angina	○ Yes ○ No	Emphysema	○ Yes ○ No	High Blood Pressure	○ Yes ○ No	Rheumatism	○ Yes ○ No
Arthritis/Gout	○ Yes ○ No	Epilepsy or Seizures	○ Yes ○ No	High Cholesterol	○ Yes ○ No	Scarlet Fever	○ Yes ○ No
Artificial Heart Valve	○ Yes ○ No	Excessive Bleeding	○ Yes ○ No	Hives or Rash	○ Yes ○ No	Shingles	○ Yes ○ No
Artificial Joint	○ Yes ○ No	Excessive Thirst	○ Yes ○ No	Hypoglycemia	○ Yes ○ No	Sickle Cell Disease	○ Yes ○ No
Asthma	○ Yes ○ No	Fainting Spells/Dizziness	○ Yes ○ No	Irregular Heartbeat	○ Yes ○ No	Sinus Trouble	○ Yes ○ No
Blood Disease	○ Yes ○ No	Frequent Cough	○ Yes ○ No	Kidney Problems	○ Yes ○ No	Spina Bifida	○ Yes ○ No
Blood Transfusion	○ Yes ○ No	Frequent Diarrhea	○ Yes ○ No	Leukemia	○ Yes ○ No	Stomach/Intestinal Disease	○ Yes ○ No
Breathing Problems	○ Yes ○ No	Frequent Headaches	○ Yes ○ No	Liver Disease	○ Yes ○ No	Stroke	○ Yes ○ No
Bruise Easily	○ Yes ○ No	Genital Herpes	○ Yes ○ No	Low Blood Pressure	○ Yes ○ No	Swelling of Limbs	○ Yes ○ No
Cancer	○ Yes ○ No	Glaucoma	○ Yes ○ No	Lung Disease	○ Yes ○ No	Thyroid Disease	○ Yes ○ No
Chemotherapy	○ Yes ○ No	Hay Fever	○ Yes ○ No	Mitral Valve Prolapse	○ Yes ○ No	Tonsillitis	○ Yes ○ No
Chest Pains	○ Yes ○ No	Heart Attack/Failure	○ Yes ○ No	Osteoporosis	○ Yes ○ No	Tuberculosis	○ Yes ○ No
Cold Sores/Fever Blisters	○ Yes ○ No	Heart Murmur	○ Yes ○ No	Pain in Jaw Joints	○ Yes ○ No	Tumors or Growths	○ Yes ○ No
Congenital Heart Disorder	○ Yes ○ No	Heart Pacemaker	○ Yes ○ No	Parathyroid Disease	○ Yes ○ No	Ulcers	○ Yes ○ No
Convulsions	○ Yes ○ No	Heart Trouble/Disease	○ Yes ○ No	Psychiatric Care	○ Yes ○ No	Venereal Disease	○ Yes ○ No
						Yellow Jaundice	○ Yes ○ No

Have you ever had any serious illness not listed above? ○ Yes ○ No If yes

Comments:

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 medical status.

Signature of Patient, Parent or Guardian:

X Date:_____

Pettey Dental of Bartlett
Informed Consent for Dental Procedures

To our patients, you have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment. Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to the treatment, you are acknowledging your willingness to accept know risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dentist with accurate information before, during, and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow advice of your dentist, you may increase the chances of a poor outcome.

Please read the following items below and sign at the bottom of the form.

1. Treatment to be provided

I understand that during my course of treatment that the following care may be provided: Examination, Preventive Services, Diagnosis, Restorative, Prosthodontics, Oral Surgery, Endodontics, and Orthodontics.

2. Drugs and Medications

I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).

3. Changes in Treatment Plan

I understand start during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. The most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/ all changes and additions as necessary.

4. Treatment of Minors

In the case of divorced or separated parents, it is your responsibility to have a financial arrangement made according to the divorce decree before treatment begins. Patients 18 years of age or younger, must be accompanied by a parent or HIPAA assigned person to exercise the terms of this agreement. A signed permission letter can be kept on file if necessary.

We are committed to providing you with optimal dental treatment and strive to establish a lasting relationship with you. Thank you for your confidence in us.

I have read and understand all of the above information.

Date:_____ Print Name:_____

Patient Signature:_____

Print Name _____ Date: _____

To help us anticipate your individual needs and expectations at your dental visit, please take a brief moment to answer a few questions.
Thank You!

Please check any of the following problems that apply to you:

____ Sensitivity (hot cold, sweet)

____ Tooth pain or discomfort when chewing

____ Headaches, earaches neck pain

____ Jaw joint pain

____ Teeth or fillings breaking

____ Grinding or clenching teeth

____ Bleeding, swollen or irritated gums

____ Loose, tipped or shifting teeth

____ Bad breath or bad taste in your mouth

Do you have or have you had any of the following:

____ Dentures

____ Partial Dentures

____ Braces

____ Periodontal (gum) treatments

Are you interested in whiter teeth?

____ Yes ___ No ____ I would like more information

Please Circle :

Do you smoke or use chewing tobacco:

How much _____

How long _____

How often do you drink soda, coffee, tea?
Please circle:

AM PM Sip throughout the day

If you could change your smile, you would

____ Make it brighter

_____ Make it straighter

_____ Close spaces

_____ Replace black metal fillings with tooth colored fillings

_____ Repair chipped teeth

_____ Replace missing teeth

_____ Replace old crowns that don't match

_____ Have a smile makeover

How important is your dental health to you?
(circle) 1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health
(circle) 1 2 3 4 5 6 7 8 9 10

Have you ever had any unusual reactions or complications to medications or anesthesia?
Yes or No Please explain

_____

_____

Do you have any specific fears or concerns regarding dentistry? Please Circle:

Discomfort Injections Time Considerations

Financing Other _____

What is the most important thing to you about your dental visit?

_____

_____

_____

Pettey Dental of Bartlett

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:

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

_____

_____

_____

PETTEY DENTAL OF BARTLETT

FINANCIAL AGREEMENT

Thank you for selecting Pettey Dental of Bartlett as your dental provider. We are honored by your choice and we are committed to providing you with the highest quality healthcare. We ask that you provide us with the most correct and updated information about your insurance. You will be responsible for any changes incurred if the information provided is not correct or our office is not provided with your current or updated information.

Your dental benefits are based upon a contract made between you and your insurance company. If you have any questions regarding your dental benefits, **please contact your employer or dental insurance directly.** Dental benefit plans will never pay for completion of your dental care. It is only meant to assist you.

We estimate your portion based on the most up to date information we have, but it is only an estimate. If you would like to know your exact insurance benefit, we will be happy to file a "pretreatment authorization" with your insurance company prior to treatment. This does not GUARANTEE payment and will delay treatment, but gives you a more accurate figure you may require. This can also change due to deductible information or changes to your policy. **We bill your insurance as a courtesy. You are responsible for what insurance does not pay.** If insurance does not pay within 90 days, we reserve the right to request payment in full for services from you and let you collect the insurance funds that are due you. This is rare, but it is important that you recognize that the insurance you have is a legal contract between you and your insurance company. Our office is not and cannot be a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.

We require payment in full for your portion at the time services are rendered. We accept Mastercard, Visa, Discover, American Express, Cash and Checks. If you are in need of an extended finance option, we also work with CareCredit, which offers 6 month or 12 month "deferred interest" options.

For cases that involve the laboratory, we require that you pay 1/2 of your portion at the first appointment, and the remainder of the balance on the day of completion. We reserve the right to reschedule your appointment if you are unable to pay your balance on the day of completion unless prior arrangements have been made.

A specific amount of time is reserved for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, **we require at least 24 hour notice to avoid broken appointment fees.** After 2 rescheduled appointments, a deposit may be required to reserve your future appointments.
Patients may also incur and are responsible for the payment of additional charges. These other charges could include charges for returned checks and any cost associated with collection of patient balances.

We welcome you to our office and look forward to helping you get the healthy, beautiful smile you've always wanted.

I understand that I am financially responsible for all charges incurred at this office.

_____ _____

Printed Name Date Signature (parent if minor) Date