TIME 10:46 AM DATE 2/2/2022

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

Credit Card

EXP DATE

Type of card

Ins card copied

Employee Name

Ins. Effective Date:

Date ins was verifie

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:

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, c

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:_____

Marietta Smiles Family & Cosmetic Dentistry

557 South Marietta Parkway SE
Marietta, GA 30060
(770) 422-6521

Patient authorization for use and disclosure of protected health information

_____ _____
Last Name First Name Date of Birth

_____
Street Address City

_____ _____
State Zip Primary Contact Number

I authorize Marietta Smiles Family & Cosmetic Dentistry to disclose Protected Health Information to the following persons:

- Spouse:_____
  Name Phone Number
- Child(ren):_____
  Name Phone Number

  _____
  Name Phone Number
- Other: _____
  Name Phone Number

Information to be disclosed

- All Dental Information
- All Billing/Account Information

Authorization Statement: I understand that Protected Health Information (PHI) used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal or State Law. I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my revocation to Marietta Smiles Family & Cosmetic Dentistry. I understand that the revocation will not apply to information that has already been used or disclosed in response to this authorization. I understand that Marietta Smiles cannot require me to sign this authorization as a condition of treatment unless the provision of health care by Marietta Smiles is solely for the purpose of creating PHI disclosure to a third party legally authorized to receive such information. I understand I will be given a copy of this authorization.

_____ _____
Print Patient Name or Name of Legal Guardian Signature of Patient or Legal Guardian

_____
Indicate relationship to patient (required)

557 South Marietta Parkway SE
Marietta, GA 30060

Financial and Insurance Agreement

Our goal is to help remove financial barriers so patients can receive the quality dental treatment they need and desire. Your clear understanding of our financial policies is important to our professionals relationship. Please ask if you have any questions about our fees, financial policies or your responsibility after insurance.

Dental Benefits: Please remember that your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy to you, our office provides certain services, including a pre-treatment estimate which we send to the insurance company per your request. Due to the volume of stipulations associated with most insurance policies, it is difficult for us to have knowledge of every aspect of your policy. It is the patients responsibility to contact their insurance provider and inquire as to what their policy entails. If you have any questions regarding pre-treatments, fees or dental benefits we will be more than happy to help to minimize any confusion on your behalf.

Please be aware all treatment plans presented are **estimates** and services provided may or may not be covered by your benefits. Any balance would then become the patients responsibility,

Payment Options

Full payment is due at the time of services being rendered. If dental benefits apply, estimated patient co-payments and deductibles are due that the time of service, unless other arrangements have previously been made. We accept payments made with **cash, check, MasterCard, Visa, Discover** and **American Express.** If you have any questions in regards to what payment options are available to you, please let us know and we will be delighted to assist you.

Financing Options:
1. Care Credit
2. In House Monthly Payments (if you qualify)

Unpaid balances over 90 days old will be subject to monthly interest of 1.5% (APR 18%). If payment is delinquent, the patient will be responsible for payment of collection, attorney's fees and venue for litigation filed by either party.

Name:_____ Date:_____

Signature:_____ Date:_____

Marietta Smiles
Dental History

Last Name_____ First Name_____

Address _____

City _____ State_____ Zip_____

1. Date of last dental visit?_____/_____/_____ Date of last dental x-rays?_____/_____/_____

2. Reason for last visit?_____

3. Do you have any concerns about previous dental care or this dental

visit?_____

4. On a scale of 1 to 10 (10 being the highest) how important is it for you to keep your teeth for

the rest of your life? _____

5. Are you happy with your smile? If no, please
explain_____

6. Do your gums bleed? Yes No 7. Are your teeth loose? Yes No

8. Have you ever been told that you have bad breath? Yes No

9. Are your teeth sensitive to (circle all that apply) Sweets Cold Heat Pressure

10. Do you like the color of your teeth? Yes No

11. Do you feel your teeth starting to get longer? Yes No

12. Do you get food stuck between your teeth easily? Yes No

13. Do you ever experience tooth pain that is relieved by biting down on the affected area? Yes No

14. What would you change about the condition of your mouth? _____

I understand the need for these questions to be answered truthfully. To the best of my knowledge, the answers I have given are accurate. I also understand that it is very important to report any changes or updates in my medical status. I give permission to obtain from my physician any additional information regarding my medical history needed to provide me with the best treatment possible.

Patient Signature_____ Date_____

If you have completed this form for another person, please print your name and sign below along with your relationship to the patient.

Print Name_____ Relationship_____

Signature_____ Date_____