Vinings Family Dentistry

Demographic Information

LAST NAME: ______________________FIRST ___________________M.I.________

ADDRESS: ____APT# __________

CITY: ________________________ STATE: ________________ZIP: _____________

BIRTHDATE: ______/______/______ SOCIAL SECURITY ______/_______/_______

HOME PHONE: _____________________E-MAIL: ____________________________

MARITAL STATUS (M / S) SPOUSE'S NAME: _______________________________

WHO REFERRED YOU? ____

INSURANCE INFORMATION:

EMPLOYED BY: ____

INSURANCE COMPANY NAME AND ADDRESS: __________________________

____

INSURANCE COMPANY'S PHONE #: ______________________________________

GROUP POLICY NUMBER: ____

EMPLOYEE ID: ____

REALTIONSHIP TO PATIENT: ____

SUBSCRIBER'S BIRTHDATE: ___________________ SSN: ___________________

For our records the person with the dental insurance must also be the person responsible for the account. Please enter the insurance subscriber's information in FULL if you wish to assign benefits to our office.

Vinings Family Dentistry

MEDICAL HEALTH QUESTOIONAIRE

Please circle the appropriate response. Since a complete physical examination is not a part of our oral examination it is important that you inform the doctor of present medical conditions, and all the medications you are taking.

Yes No Are you under the care of a physician? ___________

Yes No Do you have a serious or chronic illness? ________

Yes No Do you have serious or chronic injuries? ________

Yes No Have you had hospital admissions? ______________

Yes No Operations? _____________

Yes No Blood transfusion? _________

Cardiovascular

Yes No Angina Pectoris?

Yes No Myocardial Infarction?

Yes No Congenital Heart Defect?

Yes No Rheumatic Fever?

Yes No Rheumatic Heart Disease?

Yes No Heart Murmur?

Yes No Hypertension?

Yes No Stroke?

Respiratory

Yes No Tuberculosis?

Yes No Emphysema?

Yes No Asthma?

Yes No Shortness of breath?

Yes No Edema?

Musculoskeletal

Yes No Arthritis?

Yes No Bone disorders? __________

Yes No Muscle Disorders? ________

Genitourinary

Yes No Kidney problems? _________

Yes No Venereal disease? _________

Endocrine

Yes No Diabetes? ________________

Yes No Adrenal disorders?

Yes No Thyroid disorders?

Yes No Parathyroid disorders?

Yes No Are you taking steroids?

Hematopoietic

Yes No Anemia?

Yes No Bleeding disorders?

Yes No Anticoagulants? _________

Yes No Leukemia?

Neurologic

Yes No Paralysis? ______________

Yes No Epilepsy?

Yes No Convulsions?

Yes No Psychiatric treatment**?**

Yes No Fainting spells?

Yes No Tranquilizes or Mood Elevating Medications?

Gastrointestinal

Yes No Ulcers?

Yes No Bleeding?

Yes No Hepatitis? ______________

Yes No Jaundice?

Yes No Cirrhosis?

Yes No Immune deficiency?

General

Yes No Present Medications? _______
____

Yes No Allergies? ________________
____

Yes No Illicit drugs? ______________

Yes No Alcohol? _________________

Yes No Tobacco? ________________

Women

Yes No Past pregnancy?

Yes No Current pregnancy?

Yes No Are you certain?

Yes No Breast Feeding?

ANY OTHER CONDITIONS? ______
____

Vinings Family Dentistry

Dental Health Questionnaire

Date of your last teeth cleaning appointment: ___________________________________

Yes No Do you have a complaint today? Please explain: _________________________

____

Yes No Are you satisfied with the appearance of your teeth?
Yes No Would you like to have whiter teeth?
Yes No Do you brush more than once a day?
Yes No Do you use dental floss?
Yes No Are your teeth stained?
Yes No Does calculus (tartar) form rapidly?
Yes No Do you usually have your teeth cleaned twice a year?
Yes No Do you frequently consume food or beverages between meals?
Yes No Are your gums shrinking away from your teeth?
Yes No Do your teeth seem to be shifting in position?
Yes No Do you notice a popping, clicking, or soreness of your jaws?
Yes No Do you have teeth that seem to be loose?
Yes No Do your gums bleed when you brush or floss?
Yes No Do you clench or grind your teeth?
Yes No Have you ever had an injury to your jaw or your face?
Yes No Were teeth extracted because of decay?
Yes No Were teeth extracted due to periodontal disease?
Yes No Does food frequently wedge between your teeth?
Yes No Have you had braces?
Yes No Are you having dental pain?
Yes No Are your teeth sensitive to hot, cold, or sweets? (Please circle)
Yes No Do you think you have decayed teeth?
Yes No Do you have difficulty chewing food?
Yes No Are your gums frequently sore or tender?
Yes No Do you have missing teeth?
Yes No Do you have "wisdom" teeth?
Yes No Would you like your missing teeth replaced?
Yes No Will you require Nitrous Oxide for today's appointment?
Yes No Have you been treated for periodontal disease?

I, the undersigned understand, and agree that all the information on these forms is true and correct. I give my informed consent for treatment. This chart, and any diagnostic films, or casts are the property of Dr. Guy F. McMaster. Any charges incurred are my sole responsibility.

Signature ____________________________________ Date ________________________
Patient or Guardian

Signature ____________________________________ Date ________________________
Treating Doctor

Vinings Family Dentistry

Dental Anxiety Questionnaire

Please answer the following as completely as possible. Your comfort is very important to us. Remember: ***WE CATER TO COWARDS!***

Please scale your responses from 1 to 10. (One being completely comfortable, and Ten being completely uncomfortable.)

Anticipating your appointment . . . . __________

Waiting your turn to see the dentist . . . . __________

Waiting your turn to see the hygienist . . . . __________

Sitting in the dental chair . . . . __________

Having your teeth filled . . . . __________

Having your teeth cleaned . . . . __________

The sounds of the dental instruments . . . . __________

OTHER, PLEASE EXPLAIN:

____

____

Our office staff will meet your comfort requirements through techniques from simple TLC (tender loving care) to pharmacological sedation. A request for any of the following is strictly a personal preference, and every attempt will be made to comply with your wishes.

Please check any that apply:

____ Don’t tell me anything; just do what you have to.

____ Inform me of anything that may cause discomfort so that it needs not be anticipated.

____ Music through headphones helps to distract me and drown out the noises during treatment.

____ Nitrous oxide (laughing gas) has helped me in the past, and I would like to have it during treatment.

____ I have had terrible experiences with the dentist in the recent, past, or as a child and would like to have some form of sedative medicine to help me through my treatment.

**Other, please explain:

____

____

____

Notes:

____

____

____

____

____

____

Vinings Family Dentistry

Office Payment Policy

Insurance:

Please be aware that your insurance company is only one of thousands. Every insurance company has their own **USUAL, CUSTOMARY, AND REASONABLE (UCR)** fees. The calculation of which will not be divulged to us. Therefore; you are financially responsible for your policy's exclusions and peculiarities. We are a preferred provider for several dental benefit companies and are bound to their fee schedule, however, the policies and exclusions in these plans may limit reimbursement. Your acceptance of treatment is an agreement to adhere to the reimbursement constraints of the delivered service and not the alternate benefit. Our office staff will make every reasonable effort to assist with your reimbursement for covered services. **It is our office policy to pursue your insurances benefit for 60 days at no cost to you.** Thereafter, the unpaid "insurance" balance will be transferred to the "patient" balance where compounded interest will accrue at **1.5%** per month, or **$2.00** per monthly billing period **(whichever is greater).** Balances over 90 days will be placed with our collections agent. I agree to pay any fees incurred by Dr. McMaster for the recovery of any funds owed. All fees quoted will be honored for a three-month period from the delivery of a treatment plan.

Co-payment:

An estimate of your co-payment is due and payable at the time of the initiation of your treatment!

I agree to pay using:

CASH: _____ CHECK: ______ CREDIT CARD: ______

Our Office Hours are by Appointment Only:

Our office strives to respect your time, and does the extra things required to be one time. We will call to confirm your appointment the day before you are scheduled. If you use voicemail or an answering machine, our message will be your confirmation. A fee will be applied that will be equal to the cost of your visit for a late cancellation/missed appointment. We require 24 hours notice. We reserve the right to refuse further appointments and treat you on a "space available" basis.

Senior Citizen's Discount:

Our office offers a 10% discount to seniors 65 years of age and over.

Printed Name: ____ **Date**: _____________

Signature: ____ **Date** ______________

(Responsible party)

ACKNOWLEDGEMENT
OF
RECIEPT OF NOTICE OF PRIVACY PRACTICES

Vinings Family Dentistry
Guy F. McMaster, D.M.D.
2931 Paces Ferry Rd
Suite 10
Atlanta, GA. 30339
(770) 432-8516

My signature confirms that I have been informed of my rights to privacy regarding my protected health information under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information is used to:

***Provide and coordinate my treatment among a number of healthcare providers who may be involved in that treatment directly and indirectly.**
***Obtain payment from third-party payers for my health care services.**
***Conduct normal health care operations such as quality assessment and improvement activities.**

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may use this office at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree you are bound to abide by such restrictions.

All x-rays, records and models are the property of Vinings Family Dentistry. A signed record release will be required to obtain copies.

Patient name: ____ Date: ________________

Address: ____

Phone #: _________________________Signature: ______________________________

Relationship to Patient: ____________________ Other Persons authorized to access my

information: ____

For office use only:
We were unable to obtain the patients written acknowledgment of our Notice of Privacy Practices due to:
(refusal to sign, communication barriers, emergency situation, Other):
____