ALPHARETTA OFFICE
3450 Old Milton Pkwy # 110
Alpharetta, GA 30005
Ph: (678) 562-1555, Fax: (678) 562-1556
Email: frontdesk@acefamilydental.com

NORCROSS OFFICE
3985, Steve Reynolds Blvd,
Suite K101, Norcross, GA 30093
Ph: (770) 806-1255, Fax: (770) 806-1254
Email: norcross@acefamilydental.com

LILBURN OFFICE
3993, Lawrenceville Hwy,
#100, Lilburn, GA 30047
Ph: (770) 279-2020, Fax: (770) 279-1222
Email: frontdesk@theaffordabledental.com

AFFORDABLE DENTAL NEW PATIENT FORM

PATIENT DETAILS

Name : _____ (Last Name) _____ (First Name) _____ (Middle Name) _____ (Title)

Preferred Name : _____ ○ Male ○ Female

Address : _____ City : _____ State : _____ Zip : _____

SSN : _____ Date of Birth : _____

Home Phone : _____ Work Phone : _____

Cell Phone : _____ Email Address : _____

Employer : _____ Occupation : _____

Marital Status : ○ Domestic Partner ○ Single ○ Married ○ Divorced ○ Widowed ○ Separated

How did you hear about our office? _____

NOTE: We will contact you by Email and/or by Phone for appointment confirmation.

INSURANCE - Primary

Subscriber Name : _____ Relationship to Patient : _____ Subscriber DOB: _____

Subscriber SSN / ID : _____ Subscriber Employer : _____

Insurance Co. Name : _____

Insurance Co. Address : _____

Insurance Co. Phone : _____ Group Number : _____

INSURANCE - Secondary

Subscriber Name : _____ Relationship to Patient : _____ Subscriber DOB: _____

Subscriber SSN / ID : _____ Subscriber Employer : _____

Insurance Co. Name : _____

Insurance Co. Address : _____

Insurance Co. Phone : _____ Group Number : _____

ASSIGNMENT & RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Affordable Dental Care all insurance 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 Dentist to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature :

Relationship : _____ Date : _____

CONSENT

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

Patient / Guardian Signature : _____

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Patient Name : _____ Date of Birth : _____

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. Thank you for answering the following questions.

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

Women:	Are you Pregnant / Trying to get pregnant? ○ Yes ○ No	Taking oral contraceptives? ○ Yes ○ No	Nursing? ○ Yes ○ No

Are you allergic to any of the following?

○ Aspirin ○ Penicillin ○ Codeine ○ Local Anesthetics ○ Acrylic ○ Metal ○ Latex ○ Sulfa drugs

○ Others - If yes, please explain _____

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

○ AIDS / HIV Positive	○ Cortisone Medicine	○ Hemophilia	○ Radiation Treatments
○ Alzheimer's Disease	○ Diabetes	○ Hepatitis A	○ Recent Weight Loss
○ Anaphylaxis	○ Drug Addiction	○ Hepatitis B or C	○ Renal Dialysis
○ Anemia	○ Easily Winded	○ Herpes	○ Rheumatic Fever
○ Angina	○ Emphysema	○ High Blood Pressure	○ Rheumatism
○ Arthritis/Gout	○ Epilepsy or Seizures	○ High Cholesterol	○ Scarlet Fever
○ Artificial Heart Valve	○ Excessive Bleeding	○ Hives or Rash	○ Shingles
○ Artificial Joint	○ Excessive Thirst	○ Hypoglycemia	○ Sickle Cell Disease
○ Asthma	○ Fainting Spells/Dizziness	○ Irregular Heartbeat	○ Sinus Trouble
○ Blood Disease	○ Frequent Cough	○ Kidney Problems	○ Spina Bifida
○ Blood Transfusion	○ Frequent Diarrhea	○ Leukemia	○ Stomach/Intestinal Disease
○ Breathing Problem	○ Frequent Headaches	○ Liver Disease	○ Stroke
○ Bruise Easily	○ Genital Herpes	○ Low Blood Pressure	○ Swelling of Limbs
○ Cancer	○ Glaucoma	○ Lung Disease	○ Thyroid Disease
○ Chemotherapy	○ Hay Fever	○ Mitral Valve Prolapse	○ Tonsilitis
○ Chest Pains	○ Heart Attack / Failure	○ Osteoporosis	○ Tuberculosis
○ Cold Sores / Fever Blisters	○ Heart Murmur	○ Pain in Jaw Joints	○ Tumors or Growths
○ Congenital Heart Disorder	○ Heart Pacemaker	○ Parathyroid Disease	○ Ulcers
○ Convulsions	○ Heart Trouble / Disease	○ Psychiatric Care	○ Veneral Disease
			○ Yellow Jaundice

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

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 _____ Date: _____

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Patient Name : _____ Date of Birth : _____

DENTAL HISTORY

How may we help you today? _____

Your current dental health is:	○ Good	○ Fair	○ Poor
Do you require antibiotics before dental treatment?		○ Yes	○ No
Are you currently in pain		○ Yes	○ No
Have you ever had gum treatment?		○ Yes	○ No
Do you now or have you had any pain/discomfort in your jaw joint? (TMJ)		○ Yes	○ No
Are you under stress? (New job, Moving, Relationships)		○ Yes	○ No
Do you like your smile?		○ Yes	○ No
Is there anything you would like to change about your smile?		○ Yes	○ No
Are you happy with the color of your teeth?		○ Yes	○ No
Do your gums bleed?		○ Yes	○ No
How many times a do you:	Floss / Week? _____	Brush / Day? _____	
Have you lost any teeth?		○ Yes	○ No
Have you ever had a serious/difficult problem with any previous dental work?		○ Yes	○ No
Have you ever had any unfavorable dental experiences?		○ Yes	○ No

When was your last dental cleaning? _____

When was your last dental visit? _____

Why did you leave your previous dentist? _____

How can we accommodate you better during your dental visit? _____

Here at Affordable Dental Care, we offer a wide variety of services to enhance and keep your smile healthy and beautiful. Please select any services below you would like our friendly staff to discuss with you during your visit.

☐ In House Teeth Whitening	☐ Veneers / Lumineers	☐ Invisalign
☐ Six Month Smiles Cosmetic Braces	☐ Smile Makeover	☐ Bonding
☐ Sealants	☐ Crown and Bridge	☐ Implant / Implant Crowns
☐ Partials / Dentures	☐ Night / Sport Guards	☐ Snap-On Smile

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Patient Name : _____ Date of Birth : _____

FINANCIAL AGREEMENT

- For my convenience, this office may release my information to my insurance company and receive payment directly from them.
- I understand that I am responsible for my estimated portion of the treatment fees at the time that treatment is delivered.
- I understand that my dental insurance benefits are one form of payment that I am providing to this dental practice and that payment for the total cost of services delivered to me is ultimately my responsibility. This practice will make efforts to help me secure optimal reimbursement from my insurance plan. However, if the insurance carrier does not pay as expected, I am ultimately responsible for all fees charged.
- I understand that, due to the complexity of dental diagnosis, treatment plans sometimes change. I will be responsible for payment for the care that is actually delivered to me.
- In the case of returned checks or any other reversal of payment methods that I have provided to the practice, my account will be subject to a **$30** processing fee.
- If I allow my account to become severely delinquent in payments, causing the practice to enlist the assistance of a collections agency, I agree to pay all related fees and court costs.
- Accounts not paid within **90 days** are subject to a **1.5%** monthly finance charge.
- Any unpaid insurance balance is assumed to be patient financial responsibility.

Signature : _____ Date : _____

NOTICE OF PRIVACY POLICIES

I have had full opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that I am giving my permission to your use and disclosure of my protected health information in order to carry out treatment, payment activities and healthcare operations. I also understand that I have the right to revoke permission.

Signature : _____ Date : _____

MISSED APPOINTMENTS

I understand that this practice requires at least **48 hours** advance notice to cancel or reschedule my appointment. I also understand that, in the case that I miss an appointment, providing no or late (failing to inform the office at least **48 hours** in advance) cancellation, my account will be subject to a **$25** charge.

Signature : _____ Date : _____

CONSENT OF SERVICES

I understand that the information that I have given is correct to the best of my knowledge. I hereby authorize the Dentist or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize the Dentist to perform all recommended treatment mutually agreed upon and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications. I agree to be responsible for payment of all services rendered to me or my dependents. I understand payment is due at the time of service.

Signature : _____ Date : _____

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COVID-19 PANDEMIC - PATIENT DISCLOSURES

This patient disclosure form seeks information from you that we must consider before making treatment decisions in the circumstance of the COVID-19 virus.

A weak or compromised immune system (including, but not limited to, conditions like diabetes, asthma, COPD, cancer treatment, radiation, chemotherapy, and any prior or current disease or medical condition), can put you at greater risk for contracting COVID-19. Please disclose to us any condition that compromises your immune system and understand that we may ask you to consider rescheduling treatment after discussing any such conditions with us.

It is also important that you disclose to this office any indication of having been exposed to COVID-19, or whether you have experienced any signs or symptoms associated with the COVID-19 virus.

I fully understand and acknowledge the above information, risks and cautions regarding a compromised immune system and have disclosed to my provider any conditions in my health history which may result in a compromised immune system.

	Yes	No
Do you have a fever or above normal temperature?	☐	☐
Have you experienced shortness of breath or had trouble breathing?	☐	☐
Do you have a dry cough?	☐	☐
Do you have a runny nose?	☐	☐
Have you recently lost or had a reduction in your sense of smell?	☐	☐
Do you have a sore throat?	☐	☐
Have you been in contact with someone who has tested positive for COVID-19?	☐	☐
Have you tested positive for COVID-19?	☐	☐
Have you been tested for COVID-19 and are awaiting results?	☐	☐
Have you traveled outside the United States by air or cruise ship in the past 14 days?	☐	☐
Have you traveled within the United States by air, bus or train within the past 14 days?	☐	☐

By signing this document, I acknowledge that the answers I have provided above are true and accurate.

Signature: _____ Date: _____

Patient Name: _____