



West Cobb Dental Designs

770-428-5959

PATIENT INFORMATION

Date: ____/____/____

Date of Birth: ____/____/____

Patient Name: _____

Nickname: _____

Address: _____

Social Security # ____/____/____

City State Zip

Home # _____

Cell # _____

Employer: _____

Wk # _____

Employer Address: _____

Other# _____

Email _____

City State Zip

Occupation: _____

Spouse/Parent (if dependant name of responsible party)

Name: _____

Social Security # ____/____/____

Address _____

Date of Birth: ____/____/____

Home # _____

City State Zip

Occupation: _____

Employer: _____

Wk # _____

Employer Address _____

Cell # _____

Email: _____

City State Zip

Insurance Information (For Patients with dental insurance)

Primary Employee Name: _____ Employee Date of Birth ____/____/____

Employer: _____ # years employed__ Policy # : _____

Name of Insurance Co. _____ Social Security # ____/____/____

Group Number: _____ Insured's Address if different from above _____

Secondary Employee Name: _____ Employee Date of Birth ____/____/____

Employer: _____ # years employed__ Policy # : _____

Name of Insurance Co. _____ Social Security umber ____/____/____

Group Number: _____ Insured's address if different from above _____

Person to contact in case of emergency: _____ Phone: _____

Relationship: _____ Address: _____

Whom may we thank for referring you to our office? _____

DENTAL HISTORY

Name _____ Date of Birth ____/____/____

1: Purpose of initial visit _____

Comments

2: Are you aware of a problem? _____

3: How long since your last dental visit? _____

4: What was done at that time? _____

5: Previous dentist name _____

Address _____

Phone number _____

6: When was the last time your teeth were cleaned? _____

Circle the Appropriate Answer

7: Have you made regular visits? Yes No

How often? _____

8: Were dental x-rays taken? Yes No

9: Have you lost any teeth Yes No

Why? _____

10: Have they been replaced Yes No

11: How have they been replaced?

Fixed bridge _____ age of bridge _____

Removable bridge _____ age of removable bridge _____

Denture _____ age of denture _____

12: Are you happy with the replacement Yes No

13: Would you like to know about permanent replacements Yes No

14: Have you ever had any problems or complications with previous dental care? Yes No

15: do you clench or grind your teeth? Yes No

16: Does your jaw click or pop? Yes No

17: Have you experienced any pain or soreness in the muscles of your face or around your ear? Yes No

18: Do you have frequent headaches, neck or shoulder aches Yes No

19: Does food get caught between your teeth Yes No

20: Are any of your teeth sensitive to Hot ____-Cold ____

Sweet ____ Pressure ____

21: Do your gums bleed or hurt Yes No

When? _____

22: How often do you brush your teeth? _____ When? _____

23: Do you use Dental Floss Yes No

24: Are any of your teeth loose tipped or shifted? Yes No

25: Are you happy with the appearance of your teeth? Yes No

Do you have any discolored teeth that bother you? Yes No

26: How do you feel about your teeth in general _____

27: Do you feel your breath is offensive at times? Yes No

28: Have you ever had gum treatment or surgery? Yes No

What _____

Where _____ When _____

29: Have you had orthodontic work? Yes No

30: Have you had any unpleasant dental experiences? Yes No

Explain _____

I certify that the above information is complete and accurate

Patient's Signature _____ Date _____

Dentist Signature _____ Date _____

Comments

Medical History

Name _____ Date of Birth ____/____/____

Circle the Appropriate Answer

1:Physicans name _____ Phone umber _____
Address _____ City and State _____ Zip _____

2: Are you under a physician care Yes No
Since when _____ Why _____

3: When was your last complete physical exam? _____

4: Are you taking any medication? Yes No

5: Do you routinely take health related substances? Yes No

6: Are you allergic to any medications or substances? Yes No

7: Do you have any other allergies? Yes No

8: Do you have any problems with Penicillin, antibiotics,
anesthetics or other medications? Yes No

9: Are you sensitive to any metals or latex? Yes No

10: Are you pregnant or suspect that you may be? Yes No

11: Do you use any birth control medications? Yes No

12: Have you ever been treated for or been told you might have a
Heart disease? Yes No

13: Do you have a pacemaker or an artificial heart valve? yes No

14: Have you ever had rheumatic fever? Yes No

15: Are you aware of any heart murmurs? Yes No

16: Do you have high or low blood pressure Yes No

17: Have you ever had a serious illness or major surgery? Yes No
Explain _____

18: Have you ever had radiation treatment chemo treatment for tumor?
growth or other conditions? Yes No

19: Do you have inflammatory diseases, such as arthritis Yes No

20: Do you have any artificial joints/prosthesis? Yes No

21: Do you have any blood disorders such as anemia, leukemia? Yes No

22: Have you ever bled excessively after being cut or injured? Yes No

23: Do you have any stomach problems? Yes No

24: Do you have kidney problems? Yes No

25: Do you have any liver problems? Yes No

26: Are you diabetic? Yes No

27: Do you have asthma? Yes No

28: Do you have epilepsy or seizure disorder? Yes No

29: Do you or have you had venereal disease? Yes No

30: Have you tested HIV positive? Yes No

31: Do you have AIDS? Yes No

32: Have you had or do you test positive for hepatitis? Yes No

33: Do you or have you had T. B.? Yes No

34: Do you smoke, chew use snuff or any other forms of tobacco? Yes No

35: Do you consume alcoholic beverages? Yes No

36: Do you habitually use controlled substances? Yes No

37: Have you had psychiatric treatment? Yes No

38: Do you have any disease conditions or problem not listed? Yes No
Explain _____

39: Is there anything else we should know about your health that we have not covered in this form? _____

40: Would you like to speak to the Doctor privately about any problem? Yes No

I certify that the above information is complete and accurate

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Comments

Payment Alternatives

Payment Alternatives: Cash Credit Card Check

5% Courtesy Discount for \$1000 or above with a cash or check payment

If you have dental insurance, please read below message

Extended payments with Citi Bank or Care Credit

I hereby authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with the dental care of the patient above, and further authorize and consent that the doctor chooses and employs such assistance as he deems fit. I also understand that previous to treatment the doctor and or his staff will give a full explanation of the procedure(s) involved. I agree to pay for all services rendered by this office. If any payment is not made and considered in default, then patient or responsible party is responsible for any and all collections attorney's fees. There will be a \$25.00 charge for any returned check due to insufficient funds. I understand interest of 18% per annum (1.5% monthly) may be charged on account over 30 days delinquent. I further understand and give permission to access my credit for the intent of extending payments.

I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM:

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE Dentist of the Group Insurance Benefits otherwise payable to me.

NAME _____ DATE ____/____/____

Message for those with Dental Insurance

Dental insurance is playing a larger role in helping people obtain dental treatment. Since we feel strongly that our patients deserve the best dental care we can provide, and in an effort to maintain a high quality of dentistry, we would like to share some facts about dental insurance with you.

I consider our relationship with you to be of primary importance and will always make our recommendations to you based on what we believe is the very best treatment for you regardless of your insurance coverage. As the patient, it is your responsibility to deal with your insurance company and your employer. We will assist in any way possible to maximize your dental insurance benefits but to reemphasize; I have no relationship or responsibility to your insurance company.

Fact 1:: Dental Insurance is not meant to be a “PAY ALL”

Fact 2: Many plans tell their insured that they will be covered up to 80-100%. In spite of what you're told, we've found many plans cover 40-50% of an average fee. Some plans pay more...some pay less. The amount your plan pays is determined by the contribution you and your employer make to your dental plan. The smaller the contribution paid into the plan for “insurance”, the less you'll receive. It is your responsibility to advise us of your insurance coverage and restrictions.

Fact 3: It has been the experience of many dentist that some insurance companies tell their customers that “fees are above the usual and customary fees” rather than saying to them that “our benefits are low”. Remember you get back only what you and your employer put into your insurance coverage less the profits of the insurance company. In dealing with over 1000 dental insurance plans, most plans do cover our fees.

Fact 4: Each plan utilized in our office has different percentages, deductibles, maximums, procedures covered, and varying fees that the plan will allow. We will do our very best to make a close a calculation as possible of what your insurance plan will cover. However, as we cannot estimate precisely, there may be variances for which the patient is individually responsible.

Fact 5: Many routine dental services are NOT covered by insurance carriers. We make our recommendations based on your needs and not on what your insurance may or may not cover.

Fact 6: Dental insurance companies have the legal right to only pay for the least costly treatment option. This does not mean that this is the best treatment option, only the least costly. The dental association does not agree or endorse this right. This means that even though we have estimated what your insurance will pay, even after treatment is complete, they may downgrade the treatment codes and pay a lesser amount. Examples include: 1. Composite fillings downgraded to silver mercury fillings. 2. Porcelain crowns downgraded to all metal crowns .3. Fixed bridges downgraded to removable partial dentures. The patient then becomes responsible for any amounts not covered by the above estimate or downgraded treatment

Please do not hesitate to ask us any questions about our office protocol. We want you to be comfortable in dealing with these matters and we urge you to consult us if you have any questions regarding our service or fees. We will fill out and file insurance forms at no charge. We will do all we can to assure you of your maximum benefits.

If you have any questions regarding your insurance, please contact your insurance carrier regarding the specifics and details of the plan they are operating on your behalf.

