125 Southern Junction Blvd Suite 701 Pooler, GA 31322-2216
Phone: (912) 330-4545 Fax: (888) 629-3621
www.townelakedentalgroup.com
officemanager@townelakedentalgroup.com

Patient Information

Chart #. _____
FOR OFFICE USE ONLY

Patient Name: _____ _____ _____ _____
Last First MI Preferred Name

Title: _____ Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ SS#: _____ Prev. Visit: _____

Email Address: _____ Best time to call: _____

Phone: _____ _____ _____ _____ _____
Home Work Ext Mobile Other

Address: _____

_____ _____ _____
City State Zip Code

Referral Information

Name of person, office, or other source referring you to our practice:

_____

Employment Information

The following is for: ◯ the patient ◯ the person responsible for payment

Employer Name: _____ Phone: _____

Address: _____

_____ _____ _____
City State Zip Code

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Medical & Dental History Form

Patient Name: _____ _____ _____ _____
Last First MI Preferred Name

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well-being.

Would you consider yourself to be in fairly good health?

◯ Yes ◯ No

Within the past year, have there been any changes in your general health?

◯ Yes ◯ No

Your Primary Care Physician's name, address, and phone number:

What is the date (or approximate date) of your last medical exam?

Please mark any of the following to indicate YES in response to the question:

☐ Have you ever had complications following dental treatment?
☐ Are you currently under the care of a physician due to a specific condition?
☐ Have you been hospitalized within the last 5 years due to surgery or illness?
☐ Are you currently taking any prescription or non-prescription medications?
☐ Do you use tobacco (smoking or chewing)?
☐ Do you require the use of corrective lenses (contacts or glasses)?
☐ Do you have any other conditions, diseases, etc., not listed above that we should be aware of?

If any of the previous questions are marked, please explain:

Are you taking or scheduled to begin taking either of the medications, Fosamax, or Actonel for osteoporosis or Paget's disease?

◯ Yes ◯ No

Where you treated or are you presently scheduled to begin treatment with intravenous bisphosphonates for bone pain, hypercalcemia, or skeletal complication resulting from Paget's disease, multiple myeloma, or metastatic cancer?

Yes No

◯ ◯

WOMEN ONLY: Are you pregnant?

◯ Yes ◯ No

If Yes, when is the due date? _____

Please, indicate if you have any of the following:

☐ Abnormal Bleeding	☐ Allergy - Codeine	☐ Allergy – Food	☐ Allergy - Latex
☐ Allergy – Other	☐ Allergy – Penicillin	☐ Allergy – Sulfa	☐ Anemia
☐ Arthritis	☐ Artificial Joints	☐ Aspirin Therapy	☐ Asthma
☐ Autoimmune Disease	☐ Blood Disease	☐ Cancer	☐ Congenital Defects
☐ Coumadin Therapy	☐ Diabetes	☐ Dizziness	☐ Epilepsy
☐ Fainting	☐ Glaucoma	☐ Head Injuries	☐ Heart Disease
☐ Heart Murmur	☐ Hepatitis	☐ High Blood Pressure	☐ HIV/AIDS
☐ Jaundice	☐ Kidney Disease	☐ Liver Disease	☐ Mental Disorders
☐ Migraines	☐ Mitral Valve Prolapse	☐ Nervous Disorders	☐ Osteoporosis
☐ Other	☐ Pacemaker	☐ Pre-Med AMOX	☐ Pre-Med OTHER
☐ Radiation Treatment	☐ Respiratory Problems	☐ Rheumatic Fever	☐ Rheumatism
☐ Sinus Problems	☐ Sleep Disorder	☐ STD's	☐ Stomach Problems
☐ Stroke	☐ Tuberculosis	☐ Tumors	☐ Ulcers

Do you have any other health issues or allergies?

What is the reason for your dental visit today?

When was your last visit to the dentist (if to a different office)?

What was done on your last dental visit (if to a different office)?

Prior Dentist's name, address, and phone number:

How frequently do you brush your teeth?

◯ 3 (+) a day ◯ Twice a day ◯ Once a day ◯ Weekly ◯ Seldom

How frequently do you floss your teeth?

◯ 1 (+) a day ◯ 2 – 6 weekly ◯ 1 – 6 monthly ◯ Seldom ◯ Never

Please mark any of the following to indicate YES in response to the question:

☐ Do your gums bleed when you brush or floss?

☐ Do your teeth experience sensitivity to cold or hot temperatures?

☐ Are any of your teeth currently causing you pain?

☐ Do you grind your teeth (either consciously or during sleep)?

☐ Are any of your teeth loose, or are you concerned about any teeth loosening?

☐ Do you currently have any dental implants, dentures or partials?

If any of the previous questions are marked, please explain:

If you could change anything about your mouth, teeth, or smile, what would it be?

Authorization

I hereby certify that I have read and understand the previous information and that is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependents(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Relationship to Patient:

Signature:

Date:

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Practice Financial Policy and Release of Information

Patient Responsibility

All Professional services rendered are charged to the patient and are due at the time of service. As a courtesy, this office will file your claim with your insurance carrier. Insurance carriers typically do not cover all dental costs. Some pay fixed allowances for each procedure and office visit, while other pays only a percentage of the costs. It is the patient's responsibility to understand their insurance coverage. When you receive a statement from our office, you are required to pay the balance due upon receipt of the statement. If for some reason you do not agree with the balance due amount, you are to contact our billing representative at the number noted on the statement.

I understand that I am financially responsible to Towne Lake Dental Group, LLC for all treatment rendered at this facility.

Assignment of Benefits

I hereby assign and authorize my insurance benefits to be paid directly to Towne Lake Dental Group, LLC.

Authorization to Release Information

The signature below provides authorization for this office to furnish and/or release any information necessary to insurance carriers, or other dental benefit payor representatives in order to process dental care claims incurred at this office. This authorization also serves as permission to obtain a copy of your complete medical/ dental record from any other dental or medical facility. A copy of this authorization may be used in place of the original in obtaining the medical/dental records.

Appointment Policy

The nature of our practice is to provide high quality care that requires at times a longer appointment for each of our patient visits. It is our policy that **24 hours notice** must be given if you are forced to cancel an appointment. After 2 broken appointments with no notice, we will place your file in an inactive status and special arrangements must be made to reactivate it.

Relationship to Patient:

Signature: Date:

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Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan, and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.

Obtain payment from third-party payers.

Conduct normal healthcare operation such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

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

Patient Name:

Relationship to Patient:

Signature: Date: