Horizon Dental of Norcross
PATIENT INFORMATION

Welcome to our office! To assist us in serving you, please complete the following confidential form. The information provided is important to your dental health.

Patient's name ____________________ Preferred name ____________ Birth date__________

If minor, parents names ____________________ Home phone __________ Work phone __________

Mailing address ____________________ City ____________ State ______ Zip ________

Employer ____________________ E-Mail ____________________

Spouse's name ____________________ Spouse's employer ____________________ ❑ Unmarried

Whom may we thank for referring you to our office? ____________________ ❑ Phonebook

BILLING, CREDIT, AND INSURANCE INFORMATION: ❑ Not covered by dental insurance

Your Social Security number: ____________ Dental Insurance Co.__________ Group number________

Covered by spouse's insurance? ❑ yes ❑ no

Spouse's dental insurance company ____________ Group number ____________

Spouse's birthday ____________ Social Security number ____________

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?
(Please check any that apply)

- ❑ Cancer or tumor
- ❑ Heart ailment or angina
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Artificial joint or valve
- ❑ High or low blood pressure
- ❑ Pacemaker
- ❑ Tuberculosis or other lung problems
- ❑ Kidney disease
- ❑ Hepatitis or other liver disease
- ❑ Alcoholism
- ❑ Blood transfusion
- ❑ Diabetes
- ❑ Neurologic condition
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Emotional condition
- ❑ Arthritis
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Migraine headaches or frequent headaches
- ❑ Anemia or blood disorders
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Hayfever or sinus trouble
- ❑ Allergies or hives
- ❑ Asthma

Do you smoke or use chewing tobacco? ❑ yes ❑ no

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Latex materials
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics ("Novocain")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other:____________________

Are you taking any of the following?

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners)
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Insulin, Orinase, or other diabetes drug
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medicine
- ❑ Other:____________________

Women:

- ❑ May be pregnant
  Expected delivery date: __________
- ❑ Taking hormones or contraceptives

Name of your physician:____________________

Do you have any disease, condition, or problem not listed above?____________________

Please add anything else you would like us to know about:____________________

Signature of patient (or parent) ____________________ Date ____________

Horizon Dental of Norcross

Financial Policy

Thank you for chooing us as your dental care provider.

In an effort to keep dental costs down, while maintaining a high level of professional care, we have established this financial policy for your benefit. In order to operate our office as efficiently as possible, we will schedule each appointment with your specific needs in mind. Therefore, if you are more than fifteen minutes lates, we may have to reschedule your appointment. If you are unable to keep your scheduled appointment: **We require a 48 business hour cancellation notice to avoid a broken appointment fee of $50.00.** We will make every effort to provide a courtesy reminder by post card and/or phone call.

All returned checks will incur a $45.00 fee for processing. Account balances over 90 days are subject to collections.

Payment is expected in full at the time of serivce, and for your ease and convenience, we offer the following types of payment arrangements.

2 Equal Payments: For major multi appointment treatment. One-half is due at the beginning of treatment and the balance is due at treatment completion.

Care Credit is available at 0% interest with 6 to 12 months to pay for your treatment. You may apply at carecredit.com or in the office with our IPad. Care Credit is a credit card. If you use this form of payment it does not absolve you from your fee for service responsibility to the practice. In the event that your account is charged back your fees are due immediately in order to not receive theft of services charge.

Prepayment courtesy: For treatment over $600.00, a 5% immediate pre-payment courtesy will be applied if treatment paid in full at the time of scheduling or first appointment.

DENTAL INSURANCE

IT IS YOUR RESPONSIBILITY TO KNOW YOUR INSURANCE BENEFITS.

By definition, dental insurance is a contract between the contracted individual and the insurance carrier. Therefore, all patients are responsible for all dental fees regardless of insurance company. Our doctor cares for his patients not based on insurance but on over all dental health, preventive and restorative needs. We do provide an additional service for our insure patients by submitting their claims free of charge directly to their carrier under the following guidelines:

If insurance payment is paid directly to our office the patient is required to pay any co-payments at the time of service. The co-payments are always an estimate. **Insurance never guarantees payment to the provider**.

If the insurance company sends payment to the patient the full payment is due at the time of service.Patients using insurance, please be advised that our office files claims as a courtesy to you, not a requirement. In the event that your insurance company has not paid claims within 60 days of the date filed, any unpaid charges become the responsibility of the patient as does the follow up with the insurance company.

I understand and agree to the above dental practice policy.

____ _______________________

(Patient/Guardian Signature) (Date)

HIPAA PRIVACY FORM 2

Acknowledgement of Receipt of Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement*

I, ______________________________, have received a copy of this office's Notice of Privacy Practices.

____
Please Print Name

____
Signature

____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign

Communications barriers prohibited obtaining the acknowledgement

An emergency situation prevented us from obtaining acknowledgement

Other (Please Specify)

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