

PATIENT REGISTRATION

ID: _____ Chart ID: _____

First Name: _____ Last Name: _____ Middle Initial: _____

Patient Is: Policy Holder Responsible Party Preferred Name: _____

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

Responsible Party is also a Policy Holder for Patient Primary Insurance Policy Holder Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City: _____ State / Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: Male Female Marital Status: Married Single Divorced Separated Widowed

Birth Date: _____ Age: _____ Soc Sec: _____ Drivers Lic: _____

E-mail: _____ I would like to receive correspondences via e-mail.

Section 2

Section 3

Employment Status: Full Time Part Time Retired

Student Status: Full Time Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg: _____

Referred By _____
Previous Dentist _____
Emergency Contact _____
Emergency Contact # _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Rem. Benefits: _____ Rem. Deduct: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Rem. Benefits: _____ Rem. Deduct: _____

Patient Name:

Birth Date:

Date Created:

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

Have you ever been hospitalized or had a major operation? Yes No If yes

Have you ever had a serious head or neck injury? Yes No If yes

Are you taking any medications, pills, or drugs? Yes No If yes

Do you take, or have you taken, Phen-Fen or Redux? Yes No If yes

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No If yes

Are you on a special diet? Yes No

Do you use tobacco? Yes No

Women: Are you...

Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Do you need to Pre-Medicate? Yes No

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic
 Metal Latex Sulfa Drugs Local Anesthetics

Do you use controlled substances? Yes No If yes

Other? If yes

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

AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No	Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No	Diabetes <input type="radio"/> Yes <input type="radio"/> No
Hepatitis A <input type="radio"/> Yes <input type="radio"/> No	Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No	Drug Addiction <input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No
Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No	Anemia <input type="radio"/> Yes <input type="radio"/> No	Herpes <input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No
Angina <input type="radio"/> Yes <input type="radio"/> No	Emphysema <input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No
Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No	High Cholesterol <input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No	Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No
Hives or Rash <input type="radio"/> Yes <input type="radio"/> No	Shingles <input type="radio"/> Yes <input type="radio"/> No	Artificial Joint <input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No
Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No	Asthma <input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No
Kidney Problems <input type="radio"/> Yes <input type="radio"/> No	Spina Bifida <input type="radio"/> Yes <input type="radio"/> No	Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No	Leukemia <input type="radio"/> Yes <input type="radio"/> No
Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No	Breathing Problems <input type="radio"/> Yes <input type="radio"/> No	Liver Disease <input type="radio"/> Yes <input type="radio"/> No	Stroke <input type="radio"/> Yes <input type="radio"/> No
Genital Herpes <input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Cancer <input type="radio"/> Yes <input type="radio"/> No	Glaucoma <input type="radio"/> Yes <input type="radio"/> No
Lung Disease <input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No	Chemotherapy <input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No
Chest Pains <input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No	Osteoporosis <input type="radio"/> Yes <input type="radio"/> No	Tuberculosis <input type="radio"/> Yes <input type="radio"/> No
Heart Murmur <input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No	Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No
Ulcers <input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No	Venereal Disease <input type="radio"/> Yes <input type="radio"/> No

Have you ever had any serious illness not listed Yes No If yes

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:

X

Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

PEACH VALLEY DENTAL CO.
3040 Briarcliff Rd. NE
Atlanta, GA 30329

Acknowledgement

I, _____, hereby acknowledge that I have received and reviewed a copy of Peach Valley Dental Co's *HIPAA Notice of Privacy Practices*.

I understand that Peach Valley Dental's *HIPAA Notice of Privacy Practices* may change periodically and that I am entitled to receive a copy of Peach Valley Dental's revised *HIPAA Notice of Privacy Practices* upon request.

I understand that, if I have questions about Peach Valley Dental's *HIPAA Notice of Privacy Practices*, I may contact Thaddaus Dawson.

I understand that it is my right to refuse to sign this Acknowledgement should I so choose, and that Peach Valley Dental's will not refuse treatment to me if I refuse to sign this Acknowledgement.

I further understand that I may contact the Secretary of the U.S. Department of Health and Human Services should I have concerns regarding Peach Valley Dental's privacy policies and procedures. For information on how to contact the U.S. Department of Health and Human Services, please ask Thaddaus Dawson noted above, for assistance.

Patient Signature

Date

Signature of Personal Representative

Print Name of Personal Representative

Relationship of Personal Representative to Patient

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

PEACH VALLEY DENTAL CO.
3040 BRIARCLIFF RD. NE
ATLANTA GA. 30329

PLEASE PRINT CLEARLY

Patient Name _____ Today's Date _____
Address _____ Date of Birth _____
City, State ZIP _____ Email _____
Phone _____ Fax _____

Patient Authorization

I, _____, hereby authorize **PEACH VALLEY DENTAL CO.** to release, use and/or disclose my protected health information as directed below.

Health Information

This Authorization pertains to the following types of protected health information about me:

- All dental records received or created by **PEACH VALLEY DENTAL CO.**
- Dental report(s) (please specify) _____
- Dental image(s) (please specify) _____
- All dental records relating to (specify injury or condition) _____
- Other (please describe) _____

Release Information

Please release my health information to:

Organization _____ Phone _____
Contact _____ Email _____
Address _____ Fax _____
City, State ZIP _____ Handling Notes _____

I understand that, per my voluntary request, this Authorization permits **PEACH VALLEY DENTAL CO.** to release, use or disclose my protected health information for purposes other than payment, treatment, or healthcare operations as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its corresponding regulations. I further understand that I may revoke this Authorization at any time by providing written notification to **PEACH VALLEY DENTAL CO.** Revocation of this Authorization will be effective on the date notice is received and processed by **PEACH VALLEY DENTAL CO.** except to the extent that action has already been taken in reliance upon this Authorization.

Authorization Expiration

This Authorization will expire one (1) year from the date that I sign it, unless I indicate an alternative expiration date below:

Enter Alternative Expiration Date: _____, 20____

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

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3040 Briarcliff Rd. NE
Atlanta, GA 30329

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Patient Signature

Date

Signature of Personal Representative

Print Name of Personal Representative

Relationship of Personal Representative to Patient

PATIENT DENTAL HISTORY

PATIENT'S NAME _____ DATE OF BIRTH _____

REASON FOR THIS VISIT _____

WHEN WAS YOUR LAST DENTAL VISIT _____ WHAT WAS DONE THEN _____

HOW OFTEN DID YOU VISIT THE DENTIST BEFORE THEN _____

PREVIOUS DENTIST (NAME AND LOCATION) _____

HAVE YOU HAD A COMPLETE SERIES OF DENTAL FILMS (X-RAYS) TAKEN- WHEN & WHERE _____

HOW OFTEN DO YOU BRUSH YOUR TEETH _____ HOW OFTEN DO YOU FLOSS YOUR TEETH _____

IS YOUR DRINKING WATER FLUORIDATED YES NO

YES	NO	YES	NO		
Do your gums bleed while brushing or flossing.....	<input type="checkbox"/>	<input type="checkbox"/>	Do you bite your lips or cheeks frequently.....	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to hot or cold liquids/foods.....	<input type="checkbox"/>	<input type="checkbox"/>	Have you noticed any loosening of your teeth.....	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to sweet or sour liquids/foods.....	<input type="checkbox"/>	<input type="checkbox"/>	Does food tend to become caught between your teeth.....	<input type="checkbox"/>	<input type="checkbox"/>
Do any of your teeth feel painful.....	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had periodontal treatment (gums).....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any sores or lumps in or near your mouth.....	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever worn a bite plate or other appliance.....	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any head, neck, or jaw injuries.....	<input type="checkbox"/>	<input type="checkbox"/>	Have you had any difficult extractions in the past.....	<input type="checkbox"/>	<input type="checkbox"/>
Have you experienced any of the following problems			Have you ever had any prolonged bleeding following Extractions.....	<input type="checkbox"/>	<input type="checkbox"/>
Clicking in your jaw.....	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear dentures or partials.....	<input type="checkbox"/>	<input type="checkbox"/>
Pain (joint, ear, side of face).....	<input type="checkbox"/>	<input type="checkbox"/>	If yes, give the date they were placed	_____	
Difficulty in opening or closing your jaw.....	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever received oral hygiene instructions regarding the care of your teeth and gums.....	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in chewing.....	<input type="checkbox"/>	<input type="checkbox"/>			
Do you have frequent headaches.....	<input type="checkbox"/>	<input type="checkbox"/>			
Do you clench or grind your teeth.....	<input type="checkbox"/>	<input type="checkbox"/>			

IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, WHAT WOULD YOU CHANGE?

AUTHORIZATION AND RELEASE

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION TO THE BEST OF MY KNOWLEDGE. THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I AUTHORIZE THE DENTIST TO RELEASE ANY INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME OR MY CHILD DURING THE PERIOD OF SUCH DENTAL CARE TO THIRD PARTY PAYORS AND/OR HEALTH PRACTITIONERS. I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DENTIST OR DENTAL GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

_____ SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR	_____ DATE
_____ DOCTOR'S SIGNATURE	_____ DATE
DOCTOR'S COMMENTS _____	



3040 Briarcliff Rd NE, Suite A, Atlanta, GA 30329 404-254-5196

Here at Peach Valley Dental, we take pride in the personalized care that we give to our patients. We schedule our appointments with one goal in mind: provide the best dental care possible. In order to achieve that goal, we need to have the proper amount of time to focus on you and your dental health.

We will charge a broken appointment fee of \$50.00 if you fail to show for the appointment, whether the appointment is confirmed or not. A charge of \$100.00 will be assessed for any procedure scheduled for two or more hours. If you cannot keep your appointment, we REQUIRE a 24 hour notice. **Please keep in mind that our office is only open from 8am-12pm on Fridays, if you leave a message after the office closes to cancel an appointment on Monday, a broken appointment fee will be charged.** We send reminders via phone message, text and e-mail as early as one week prior to the appointment and as late as one hour before the appointment. Our phone call, text and e-mail system ONLY ACCEPTS CONFIRMATIONS. If you need to change your appointment, you must call the office directly.

Because we want to give each patient our undivided attention, patients are asked to arrive on time. Should you arrive 20 minutes or more after your scheduled time, we reserve the right to reschedule the appointment and a broken appointment fee will be assessed.

Please note that insurance coverage is only an estimate. Guarantor is responsible for all treatment not covered by insurance.

Patient/Guardian Signature _____

Print Name _____

Date _____