Oakwood Family Dental
3885 Mundy Mill Rd, Suite 116
Oakwood, GA 30566
Phone: (470) 577 - 9777
Fax: (470) 208 - 2390

Khushbu Mody, DDS

Today's Date _____

Name _____ Name I like to be called_____

Mailing Address_____ City _____ Zip_____

Physical Address _____ City _____ Zip_____

Birthdate_____ Marital Status_____ SSN_____E-mail_____

Home # ( ) _____ Work # ( ) _____ Ext._____ Cell # ( ) _____

Occupation _____ Employer _____

Spouse's Or Parent's Name _____ Birthdate _____ SSN _____

Spouse's or Parent's Occupation _____ Spouse's or Parent's Employer _____

Contact Phone Number ( ) _____

PERSON RESPONSIBLE FOR ACCOUNT

❑ Check if same as above: proceed to next section

Name_____ SSN or ID number_____

Address_____City_____ Zip_____

Relationship to Patient_____ Birthdate_____

Work Phone ( ) _____

DENTAL INSURANCE

Employee Name_____ Birthdate _____

Insurance Company_____ Customer Service Number _____

Employer_____ Group ID# _____

GETTING TO KNOW YOU

Please list the members of your family that are patients in our office: Names: _____

_____

How did you hear about our office? ❑ Facebook ❑ Website ❑ Post Card / Mailer ❑ Sign ❑ Google

❑ Other_____ ❑ Friend/Family_____

Person to contact in case of emergency (not living with you)

Name _____ Phone ( ) _____

Address _____ City_____ State_____ Zip_____

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available.
If you have any questions please do not hesitate to ask us.

Patient Name: _____

Date of Birth: _____

MEDICAL HISTORY

Do you have a personal physician? Y N

Are you currently under a physician's care? Y N

Physician's Name:_____

Physician's Phone #: _____

YOUR CURRENT PHYSICAL HEALTH IS:

GOOD FAIR POOR

Do you smoke or use tobacco in any form? Y N

Do you have any implants, valves, rods or pins? Y N

Have you ever had any of the following diseases or medical problems?

(Please answer all that apply)

Y	N	Alcohol/Drug Abuse	Y	N	HIV/AIDS
Y	N	Anemia	Y	N	Kidney Problems
Y	N	Arthritis	Y	N	Liver Disease
Y	N	Artificial Joints/Valves	Y	N	High/Low Blood Pressure
Y	N	Asthma/COPD	Y	N	Lung Disease
Y	N	Bleeding problem/Anemia	Y	N	Mitral Valve Prolepses
Y	N	Blood Transfusion	Y	N	Osteoporosis
Y	N	Cancer	Y	N	Pacemaker/Heart Surgery
Y	N	Congenital Heart Defect	Y	N	Pneumonia
Y	N	Diabetes	Y	N	Psychiatric Problems
Y	N	Difficulty Breathing	Y	N	Radiation /Chemo
Y	N	Emphysema	Y	N	Rheumatic Fever
Y	N	Fainting/Dizzy Spells	Y	N	Seizures/Epilepsy
Y	N	Migraines	Y	N	Sickle Cell Trait/Disease
Y	N	Heart Attack	Y	N	Sinus Problems
Y	N	Heart Murmur	Y	N	Stroke
Y	N	Herpes/shingles	Y	N	Thyroid
Y	N	Hepatitis A B C	Y	N	Ulcers/Stomach

ARE YOU USING ANY OF THE FOLLOWING?

Antibiotics	Y	N
Anticoagulants (Blood Thinners)	Y	N
Aspirin or drugs such as Motrin, Aleve, Ibuprofen?	Y	N
High Blood Pressure medications?	Y	N
Steroids (Cortisone, Prednisone, etc.)?	Y	N
Insulin or Oral Anti-Diabetic drugs?	Y	N
Chemotherapy?	Y	N
Are you taking or have you ever taken Bisphosphonate for Osteoporosis. Multiple myeloma or other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa)?	Y	N
Have you ever been advised not to take a medication?	Y	N

Please list any and all medications taken, including Prescription medications, diet drugs, over-the-counter Medications, herbal or holistic remedies, Vitamins or minerals: _____

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MEDICAL HISTORY (continued)

Are you Allergic to any of the following? (Please Circle)

Aspirin	Codeine	Penicillin/Amoxicillin	
Tetracycline	Jewelry	Metals	
Chemicals	Local Anesthetics	Latex	Other_____

FOR WOMEN: Are you taking birth control pills? Y N

It is important that you understand the antibiotics and some other medications may interfere with the effectiveness of oral contraceptives. Please consult with your physician.

Are you pregnant? Y N Week#: _____

Are you nursing? Y N

DENTAL HISTORY

What is the primary reason for your visit today?

_____

Are you currently in pain? Y N

Do you require antibiotics before dental treatment? Y N

Your current dental history is: GOOD FAIR POOR

When was the last time you had a complete dental evaluation? _____

Have you ever had a serious/difficult problem associated with? _____

Any previous dental work? Y N | Brush 1 2 3 Times/Daily

Do you floss regularly? Y N | Floss 1 2 3 Times/Daily

Have you ever been informed or treated for the following?

Y	N	Bleeding Gums	Y	N	Mobility of Teeth
Y	N	Bad Taste / Odor	Y	N	Oral Cancer / Biopsy
Y	N	Cold Sores / Ulcers	Y	N	Osseous Surgery
Y	N	Deep Cleanings / Scaling	Y	N	Jaw Clicking / Popping
Y	N	Gum / Periodontal Disease	Y	N	Toothbrush Abrasion
Y	N	Hot / Cold Sensitivity	Y	N	Clenching / Grinding

I understand the importance of a truthful and complete health history to assist my dentist in providing best care possible. I have had the opportunity to discuss my health history with my dentist.

PATIENT'S (or PARENT'S) SIGNATURE: _____

Date: _____

Dentist's Signature: _____

ACKNOWLDGEMENT OF RECIEPT OF

Notice of privacy Practices

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

1) 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.
2) Obtain payment from third-party payers.
3) conduct normal health care operation such as quality assessments and physicians certifications.

I have received, read, and understood 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 changes it's Notices of Privacy Practices from time to time and that I may contact this organization at any time at this address to obtain a current copy of the Notice of Privacy Practices.

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

Patient Name (print):_____ Relationship to Patient:_____

Signature:_____ Date:_____

Information Authorization Form

We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, unless you specifically instruct us to do otherwise.

Please list anyone you specifically *do* want us to share your information with below:

Name: _____ Relationship: _____ Phone:_____

Name: _____ Relationship: _____ Phone:_____

(Examples: Husband, Wife, Insurance Company, etc…)

By signing below you *are* allowing us to share personal information with the above listed people (if any changes in this information you will need to fill out a new form in person).

Signature: _____ Date: _____

WORK AUTHORIZATION & FINANCIAL POLICY

The undersigned hereby authorizes Doctor to take x-rays. study models, photographs or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient dental needs. I also authorize Doctor to perform any and all forms treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies certain risk. I understand that responsibility of payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time of services rendered unless financial arrangements have been made.

Patient (Parent) Signature:

Date: _____

Dentist Signature: _____

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Our staff is committed to providing you with the very best possible care! With your assistance and understanding we can share a mutual respect that will lead to a long lasting relationship. In order to achieve this goal, we would like to make you aware of our payment policies. We make every effort to explain your treatment needs and costs to you up front so that we can avoid any misunderstandings. If you have any questions, please do not hesitate to ask. We are here to serve you.

MISSED OR BROKEN APPOINTMENTS

We strive to see all of our patients on time. Each appointment that is scheduled for you is a time that has been specifically reserved just for you. If you need to change your appointment kindly give us a 3 day notice so that your appointment time can be filled.

ANYONE MISSING OR CANCELLING AN APPOINTMENT WITH LESS THAN A 48 HOUR NOTICE WILL BE SUBJECT TO A $25 CHARGE PER HOUR SCHEDULED.

Exceptions may be considered in the event of illness or if the appointment time can be filled. If broken appointments become a chronic problem, we reserve the right to dismiss you from the office.

PATIENT FINANCIAL POLICY

1. Payment is due at the time services are rendered unless payment arrangements have been approved by our staff. We accept cash, MasterCard, Visa, American Express and Discover. Emergency visits for all new patients must be paid in full unless dental insurance can be verified.

2. Balances older than 30 days will be subject to interest charges of 1.5% per month. In the event that payment is not made for services after a reasonable period of time, our attorney will be advised and formal action to collect will be initiated. You will be responsible for any attorney's fees and/or collection expenses.

3. Our staff will estimate your co-pay for each visit and this amount will be due at the time of service.

ALL CHARGES ARE YOUR RESPONSIBILITY AND MUST BE PAID WITHIN 45 DAYS FROM THE DATE SERVICES ARE RENDERED; REGARDLESS OF INSURANCE.

4. I authorize and direct payments of the dental benefits directly to Oakwood Family Dental LLC and consent to disclosure of my protected dental health information to carry out payment of benefits.

I have read, understood and accept the terms stated above. I have been given a copy of this document.

Signature _____ **Date** _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Print Name: _____

Signature: _____

Date: _____

YOU MAY REFUSE TO SIGN THIS PRIVACY

FOR OFFICE USE ONLY

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

*Individual refused to sign acknowledgement form:*_____
*Communication barriers prohibited obtaining acknowledgement:*_____
*Emergency situation prevented us from obtaining acknowledgement*_____

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DENTAL TREATMENT CONSENT FORM

Doctor's Name: _____ Patient's Name:_____

Please read and initial the items checked below and read and sign at the bottom of form.

1. X-RAYS (Initials_____)

2. DRUGS AND MEDICATIONS
I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). (Initials_____)

3. CHANGES IN TREATMENT PLAN _____
I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary. (Initials_____)

4. REMOVAL OF TEETH #'s_____
Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (Paresthesia) that can last for an indefinite period of time (days or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility. (Initials_____)

5. CROWNS, BRIDGES, ONLAYS, INLAYS #'s_____
I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size and color) will be before cementation. (Initials_____)

6. DENTURES, COMPLETE OR PARTIAL
I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing these appliances have been explained to me, including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new dentures (including shape, fit, size, placement, and color) will be the "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee. (Initials_____)

7. ENDODONTIC TREATMENT (ROOT CANAL) #'s_____
I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extend through the root, which does not necessarily affect the success of the treatment, I understand that occasionally additional surgical procedures may be necessary following root canal treatment (Apicoectomy). (Initials_____)

8. PERIODONTAL LOSS (TISSUE & BONE)
I understand I have infection in my gums that cannot be taken care of with a "regular" cleaning. I understand that a deeper cleaning is necessary in order to get my infection under control. I also understand that I will need maintenance cleanings every 3 or 4 months as recommended by my hygienist/doctor depending on my progress as well as how well I do my homecare. All my questions have been answered regarding my gum treatment. (Initials_____)

9. FILLINGS TEETH #'s_____
I understand that care must be exercised in chewing on fillings especially during the first 24 hours to avoid breakage. I understand that a more expensive filling that initially diagnosed may be required due to additional decay. I understand that significant sensitivity is a common after effect of a newly placed filing. Initials(_____)

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Signature of Patient_____ **Date**_____

Signature of Parent/Guardian if patient is a minor_____ **Date**_____