Chatsworth Family Dentistry

General Dentistry

Welcome

CHILD'S REGISTRATION

Date:_____

To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us. We will be happy to help you.

NOTE (MINORS): The parent or legal guardian must complete this form for a minor, provide consent for dental treatment and accompany the child during EACH dental visit. If the parent or guardian consented to treatment in advance, an authorized individual name on Page 3 may bring the child. ***Treatment will NOT be provided for unattended children (anyone under the age of 18).***

Name _____ Home Phone_____ Cell#_____

Address _____ City_____ State _____ Zip_____

Social Security #:_____ Birth Date:_____ Age:_____

Mother's/Guardian's Name:_____ Mother's SS#_____

Mother's/Guardian's Employer _____ Work Phone _____

Father's/Guardian's Name:_____ Father's SS#_____

Father's/Guardian's Employer _____ Work Phone _____

Person to Contact in Case of Emergency _____Phone: _____

Whom May We Thank for Referring You? _____

RESPONSIBLE PARTY

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address_____ Home Phone _____

Employer_____ Work Phone _____

Is this Person Currently a Patient with our Office? ☐ Yes ☐ No

Are You Currently Covered by Georgia Medicaid?* ☐ Yes ☐ No Medicaid # _____

(If Yes, we require verification of coverage at each appointment.) Amerigroup #_____

INSURANCE INFORMATION

Name of Insured _____ Relationship to Patient _____

Birth Date _____ Social Security # _____

Employer_____ Work Phone _____

Insurance Company*_____ Ins. Phone #:_____

Group#_____ Subscriber ID #_____

DO YOU HAVE ADDITIONAL DENTAL INSURANCE? ☐ Yes ☐ No If Yes, Complete the following section:

Name of Insured _____ Relationship to Patient _____

Birth Date _____ Social Security # _____

Employer_____ Work Phone _____

2nd Insurance Company*_____ Phone #:_____

2nd Group#_____ 2nd Subscriber ID #_____

**** Please provide insurance card(s) and driver license(s) for copy.***

— Over Please —

PATIENT MEDICAL HISTORY

Physician_____ Office Phone _____ Date of Last Exam_____

	YES	NO
1. Are you under medical treatment now?	❍	❍
2. Have you ever been hospitalized for any surgical operation or serious illness?	❍	❍
3. Are you taking any medications?	❍	❍
Including non-prescription medicine	❍	❍
If yes, what medication(s) are you taking? — **SEE BELOW** —		
4. Do you use tobacco	❍	❍
5. Do you use alcohol, cocaine or other drugs?	❍	❍
6. Are you allergic to or have you had any reactions to the following:		
(1) Local Anesthetic (eg. novocaine)	❍	❍
(2) Penicillin or other Antibiotics	❍	❍
(3) Sulfa Drugs	❍	❍
(4) Latex	❍	❍
(5) Metals	❍	❍
(6) Sedatives	❍	❍
(7) Iodine	❍	❍
(8) Aspirin	❍	❍
(9) Codeine	❍	❍
(10) Other (please list)_____	❍	❍
7. Do you have or have you had any of the following?		
(1) High Blood Pressure	❍	❍
(2) Swollen Ankles	❍	❍
(3) Fainting/Seizures	❍	❍
(4) Asthma/Hayfever	❍	❍
(5) Low Blood Pressure	❍	❍
(6) Epilepsy/Convulsions	❍	❍
(7) Leukemia	❍	❍
(8) Diabetes TYPE 1____ or TYPE 2____	❍	❍
(9) Kidney Disease	❍	❍
(10) AIDS or HIV infection	❍	❍

	YES	NO
(11) Thyroid Problem	❍	❍
(12) Heart Disease (please list)_____	❍	❍
(13) Cardiac Pacemaker	❍	❍
(14) Angina	❍	❍
(15) Anemia	❍	❍
(16) Emphysema	❍	❍
(17) Cancer	❍	❍
(18) Arthritis	❍	❍
(19) Joint Replacement, Implants, Pins, Plates or Screws	❍	❍
Date Placed:_____		
(20) Hepatitis or Jaundice	❍	❍
(21) Sexually Transmitted Disease	❍	❍
(22) Stomach Troubles/Ulcers	❍	❍
(23) Stroke (Date:_____)	❍	❍
(24) Tuberculosis	❍	❍
(25) Radiation/Chemo Therapy	❍	❍
Date of last treatment:_____		
(26) Glaucoma	❍	❍
(27) Liver Disease	❍	❍
(28) Respiratory Problems (please list)_____	❍	❍
(29) Prostrate Problems	❍	❍
(30) Hepatitis	❍	❍
(31) Osteoporosis ***(List Meds below)***	❍	❍
— FOR WOMEN ONLY —		
(31) a) Are you pregnant or think you may be pregnant?	❍	❍
OBGYN_____		
b) Are you Nursing?	❍	❍

Medications ***(List ANY medications taken, including aspirin)***:_____

_____

Reason for present visit (chief complaint) _____

_____

What are your primary concerns for your Dental Health? ***(Circle as many as applicable)***

Pain Avoidance • Appearance • Losing Teeth • Gum or Periodontal Disease • Cavities • Oral Cancer • Cleaning
Wasting or Exceeding Dental Insurance Limits • Your General Health • Routine Checkup Other _____

Acknowledgement of Receipt of Notice of Privacy Policies
Your Privacy Is Important to Us

I received a copy of the Notice of Privacy Practices of Chatsworth Family Dentistry, PC. I hereby authorize, as indicated by my signature below, Chatsworth Family Dentistry, PC to use and to disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent form.

I also have received a copy of Our Policy Regarding Dental Insurance. I have read the policy and understand that any insurance estimate given to me is just that, an estimate. I understand and agree that I am fully responsible for any dental treatment I receive regardless of coverage provided.

_____ Print Name

Signature of Parent or GuardianX _____ Date _____

Please check your preferred means of communication:

You may contact me at my:

☐ Home telephone #_____ ☐ Mobile telephone # _____

☐ Work telephone #_____ ☐ Email_____

☐ Other _____

Please list authorized persons with whom we may discuss your child's Protected Health Information (PHI) and who may bring them to appiontments other than parents. Please notify us if you desire to remove a name from this list in the future.

1. _____ Date ____/____/_____ Relationship: _____ ☐ PHI ☐ Appt.

2. _____ Date ____/____/_____ Relationship: _____ ☐ PHI ☐ Appt.

3. _____ Date ____/____/_____ Relationship: _____ ☐ PHI ☐ Appt.

PATIENT CONSENT

Clinical

1. I authorize Chatsworth Family Dentistry, PC, hereinafter referred to as Practice, to perform all recommended treatment.
2. I have answered all the questions truthfully and accurately. I understand that providing incorrect information can be dangerous to my health.
3. I authorize the Practice to take radiographs, study models, photos, and other diagnostic aids or materials (collectively, "Diagnostic Material") as needed to make a thorough diagnosis. I authorize that such Diagnostic Material may be released to third-party payors and/or other health professionals.
4. I authorize the use of anesthetics, sedatives, and other medication, as needed, and am fully aware that using anesthetic agents involves certain risks, including but not limited to redness and swelling of tissues, pain, itching, vomiting, dizziness, miscarriage, cardiac arrest, drowsiness, and/or lack of coordination.

Financial

1. I am responsible for payment for all services rendered on my behalf or my dependents. I understand that insurance is filed on my behalf but is a contract between me and the insurance company and I'm ultimately responsible for all services rendered on my behalf. I understand that payment is due when services are rendered. I am aware that a $5.00 rebilling fee will be automatically tabulated into my account each month if my balance is 60 days old or older. Should my account become delinquent, I will be responsible for all additional collection costs, including reasonable attorney fees. This fee will be added by Chatsworth Family Dentistry, PC to cover collection expenses. I understand and agree to any fees that may be added to assist in collection my past due account.
2. I am aware that to hold down operating costs, a minimum of 24 hours notice of cancellation is required. I understand that if I have had multiple broken appointments, I may be required to place a $25 deposit to hold my appointment time.

Insurance

1. I authorize the Practice to release to staff, hospitals, health care service plans, insurance companies, self-insurers or their representatives, any and all information, records, and other Diagnostic Material about my medical history, services rendered, or recommended treatment.
2. I authorize the Practice to submit claims for payment for services rendered or pre-authorizations necessary to my insurance company, on my behalf and in my name listed as "signature on file" and assign to the Practice the insurance benefits providing assignment is accepted. I am responsible for payment regardless of coverage provided.

I have read this Patient Consent and agree to all terms and conditions herein.

Patient's Name: _____ Date: _____

Patient's Address: _____

If patient requires a legal guardian, please provide the parental or legal guardian's consent:

Signature: _____Relationship: _____ Date: _____

Chatsworth Family Dentistry, PC
Dental Financial Policy

Thank you for choosing our office for your dental needs. We realize that every person's financial situation is different. For this reason, we have worked hard to provide a variety of payment options to help you receive the dental care you need and deserve that allows you to enjoy a healthy, beautiful smile with respect to your budget. Dental Treatment is an excellent investment in an individual's medical and psychological care. We are always available to answer your questions or assist you in a any way we can.

To maintain the practice operations and prevent potential misunderstandings, we ask patients to accept and adhere to financial arrangements regarding their dental treatment. Payments are expected at the time services are rendered. We accept cash, checks, ATM cards, Visa, MasterCard, Discover and American Express.

Initial ONE choice:

_____ 1. Full Pay Cash Discount: We offer a 10% accounting courtesy for treatments ($500 or more) that are paid in full (cash or check) at the time of service. Patients are then required to file their own insurance and payment will go directly to you the patient.

_____ 2. Insurance Co-Payment: I will pay my insurance co-pay portion at each appointment for the services rendered on the date of treatment.

_____ 3. Major Service 2-Payment Option: We offer two-payment option for Crown, Bridge and Denture treatment. We ask that you pay one-half of your co-payment at the first appointment and the second half at the seat date appointment.

_____ 4. Credit Card Payment Option: We allow (with a signed agreement form), a credit card payment option for treatments $500 and over, this allows you to make three equal installments by credit card. One-third payment is due at the first appointment, on-third is due thirty (30) days later, and the remaining one-third is due sixty (60) days from the initial appointment. Our office personnel will charge theses payments to your credit card on the due dates. It is your responsibility to notify us if you credit card is cancelled and you will be charged a $35.00 fee if your credit card is refused.

_____ 5. Third Party Financing: By arrangement with Care Credit, we offer our patients, upon approval, an interest-free 6 month term loan with no down payments, no annual fee, and no prepayment penalty. (Treatment must be $100 for this option) Longer payment options are available with interest. (Please ask for an application).

_____6. HSA/Flex Card: I will pay my responsibility using my HSA/Flex Card.

*Please initial the statement that you have read and understand:

_____ ***Return Check Fee:*** *We charge $35.00 for returned checks.*

_____

Patient, Parent or Guardian Signature Date

_____

Please print signed name