Exceptional Dentistry at John's Creek

Health. Confidence. Beauty. Success.

Name _____ **Date** _____

Address _____

_____

Date of Birth _____ **Marital Status** _____

Social Security #_____ **Cell #** _____

Home Phone # _____ **Work Phone #** _____

Email Address _____

Dental Insurance Information:

Insurance Policy Holder _____

Name of Employer _____

Group Name _____ **Group #** _____

Policy Holder SS # _____ **ID#** _____

Policy Holder Date of Birth _____

Nearest Relative not living with you:

Address _____

_____

Phone # _____

Who may we contact in case of an emergency?

Name _____ **Phone #** _____

How did you hear about us? _____

What is the reason for your visit today?

_____

_____

_____

How important is it to keep your teeth for the rest of your life?

1. **Very Important**
2. **Somewhat Important**
3. **Not Important**

How important is it for you not to have emergencies with your teeth?

1. **Very Important**
2. **Somewhat Important**
3. **Not Important**

What obstacles (if any) typically prevent you from obtaining optimal dental care and treatment?

1. **Time Constraints**
2. **Cost of Treatment**
3. **Fear of Dental Treatment. If so describe:**

   _____

4. **Other:**

   _____

   _____

If there were anything you could do to change or improve the appearance of your teeth/smile, what might that be:

_____

_____

Would you like Dr. Connell to discuss that with you? _____

HEALTH HISTORY

Name _____ Date _____

Date of last health care exam: _____ What was this exam for? _____

Have you been hospitalized in the last 5 years? (Please circle) No Yes

If yes, reason: _____

Are you currently receiving care? No Yes If yes, nature of care: _____

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. _____
2. _____
3. _____
4. _____

For the following questions circle yes or no. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.

Anemia or Blood Disorder?	No	Yes	Hepatitis, Any Form	No	Yes
Arthritis, Rheumatism or other inflammatory disease?	No	Yes	Joint Replacement? When placed?	No	Yes
Asthma	No	Yes	Kidney Disease	No	Yes
Abnormal Bleeding from a cut?	No	Yes	Liver Disease (including Jaundice)	No	Yes
Cancer or Tumor?	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Diabetes	No	Yes	Psychosis	No	Yes
Emphysema or other Respiratory/Lung Illnesses	No	Yes	Previous Biopsies	No	Yes
Epilepsy	No	Yes	Radiation or Chemotherapy Treatment	No	Yes
Fainting or Dizzy Spells	No	Yes	Rheumatic Fever	No	Yes
Glaucoma	No	Yes	Slow-Healing Mouth Sores	No	Yes
Abnormal Heart or Previous Bacterial Endocarditis	No	Yes	Unintentional Weight Loss/Gain	No	Yes
Heart Valve (artificial) or Heart Transplant	No	Yes	H.I.V. Infection/AIDS or ARC	No	Yes
Heart Disease, Heart Attack, Heart Surgery	No	Yes	Venereal Disease	No	Yes
Heart Murmur (mitral valve prolapse)	No	Yes	Other Conditions	No	Yes
Heart Stent? When placed?	No	Yes	Recurrent Illnesses	No	Yes

Are you taking any of these medications?

Pre-medication before dental treatment?	No	Yes	Tagamet® (cimetidine) or Prilosec® (omeprazole)?	No	Yes
Antacids?	No	Yes	Cardizem® (diltiazem) or Calan, Isoptin® (Verapamil)?	No	Yes
Dilantin® or Tegretol®	No	Yes	Serzone® (nefazodone)	No	Yes
Barbiturates (any)	No	Yes	Diflucan® (fluconazole) or Sporonox® (itraconazole)	No	Yes
St. John's Wort or Kava-Kava?	No	Yes	Biaxin® (clarithromycin)	No	Yes
Have you been treated with Bisphosphonate drugs (Fosamax®, Aredia®, Zometa®, Actonel®, Boniva®)? If so, when did the treatment begin? When did the treatment end?				No	Yes
Have you ever taken any prescription drugs such as fen-phen for weight loss?				No	Yes
Do you consume grapefruit juice, grapefruits or grapefruit extract?				No	Yes

Please list any medications you are currently taking:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

Please list any dietary or herbal supplements you are taking, and for what purpose:

7. _____ 8. _____
9. _____ 10. _____
11. _____ 12. _____

Women: Are you pregnant? No Yes
If no, are you planning a pregnancy in the near future? No Yes
Are you a nursing mother? No Yes

Are you taking birth control pills? No Yes

Abnormal Blood Pressure? (Please circle) No Yes

Have you ever received a diagnosis of "high blood pressure"?

What is your normal blood pressure? S /D Today: _____/_____

Are you allergic or have you had a reaction to:

a. Local anesthetics ..... No Yes
b. Penicillin or other antibiotics ..... No Yes
c. Aspirin, Ibuprofen or Tylenol ..... No Yes
d. Codeine, Valium or other sedatives..... No Yes
e. Latex or Metals
f. Other (please specify) _____

Tobacco, Alcohol, Drugs

Do you use tobacco? If yes, circle type: smoke chew How much per day? For how long?	No	Yes
Do you want to quit using tobacco?	No	Yes
Do you consume alcohol? If yes, approximately how many alcoholic beverages per week?	No	Yes
Do you use any mood altering drugs other than those previously listed?	No	Yes

DOCTOR'S USE ONLY

Comments on patient interview concerning medical history:

_____

_____

Significant findings from questionnaire or oral interview:

_____

_____

Dental management considerations:

_____

_____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health and medication.

_____	_____	_____
Patient (Print Name)	*Patient Signature*	*Date*
_____	_____	_____
Doctor (Print Name)	*Doctor Signature*	*Date*

EXCEPTIONAL DENTISTRY
at JOHN'S CREEK

Consent for Purposes of Treatment, Payment & Healthcare Operations (3/06)

In this document, "I" and "my" refer to the patient,
And "dental office" refers to Exceptional Dentistry.

I consent to the use or disclosure of my protected health information by dental for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of dentistry. I understand that analysis, diagnosis or treatment of me by the doctor may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Dentistry is not required to agree to the restrictions that I may request. However, if the doctor agrees to a restriction that I request, the restriction is binding on the doctor.
I have the right to revoke this consent, in writing, at any time, except to the extent that the doctor has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of Dentistry and understand that I have a right that Notice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Dentistry. The Notice of Privacy Practices for Dentistry is also posted in the waiting room at 3895 John's Creek Pkwy Suite A. This Notice of Privacy Practices also describes my rights and duties of the dentist with respect to my protected health information.

Dentistry reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Exceptional Dentistry and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative Printed Name of Patient

Exceptional Dentistry at John's Creek

Exceptional Smiles Through Exceptional Dentistry

CONSENT FOR TREATMENT

I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of

Name of Patient _____

Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

I give consent to the doctor's designated staff's use and disclosure of an oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18%APR) may be added to my account. If required, I also understand a check of my credit history may be made.

_____ _____

Patient(guardian) signature Date

Exceptional Dentistry at Johns Creek

Cancellation Policy

Exceptional Dentistry has established a new policy for cancellations and/or no show appointments. We require a 48 hours notice to cancel or reschedule your appointment. Your appointment was reserved specifically for you so we may focus on your oral health concerns or treatment. By notifying us in advance of the change, our staff will have enough time to contact another patient that has been waiting to be seen. We understand there are illnesses and true emergencies that occur and will try to accommodate those unique circumstances.

If you are running late for your appointment, please give our staff a courtesy phone call informing us of your status for time of arrival. Depending on the day of our schedule and the set procedures for your specific appointment, we may ask you to reschedule. This is common courtesy to our patients that have appointments following yours.

A fee will be charged to your account on the day of cancellation and/or no show appointments if under 48 hour notice. For an appointment scheduled with our hygienist [redacted], there will be a fee of $35.00. If you are scheduled with Dr. Connell for treatment, a fee of $100.00 will apply to your account.

Exceptional Dentistry reserves time in our schedules for your specific needs in advance, so that we may accommodate your busy schedule. We ask that you give us the same courtesy and consideration when needing to change or move your appointment.

Thank you very much for understanding and respecting our policies and entrusting your oral health to Exceptional Dentistry.

_____ _____

Signature of Patient or Responsible Party Date

To schedule an appointment after two cancelled/failed appointments, will require a deposit of fees listed above for the Doctor/Hygienist