

Dear patient,

Please allow me to welcome you into our family of patients. My staff and I are delighted that you have chosen us to care for your dental needs. We strive to provide our patients with the highest quality dental care in a gentle and pleasant manner and to emphasize prevention of dental problems. Your initial visit in our office will include a comprehensive examination and all necessary x-rays and cancer screening.

We realize that you are an individual with unique preferences; therefore we will strive to tailor our approach to your needs. If you have special needs or concerns please advise us – your input is appreciated and essential for us to serve you properly. We will also provide you with a variety of financing options from which you may choose.

We are proud of our highly trained staff, each of which is carefully chosen for his or her ability to serve you in a gentle way. We appreciate the value of your time and except for emergencies in our day, you can expect us to be on time for you. We expect the same courtesy from you.

Please complete the enclosed information and kindly bring it with you for your first visit. Should you have any questions, please do not hesitate to call. All of us are looking forward to meeting you at your first visit.

Sincerely,

Karl Burgess, DDS

WELCOME TO THE OFFICE OF DR. KARL BURGESS

Today's Date _____ Last Name _____ First Name _____ MI ____ Soc Sec# _____

Date of Birth _____ Male Female Minor Single Married Divorced Widowed Separated

Home Address _____ City _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Preferred Number to call to confirm appointments Home Work Cell

E-Mail address _____ Referred By _____

Would you like Email or text message reminders for your appointments? Email Text Both

Employer _____ Occupation _____ College student (where?) _____

Spouse Name _____ Soc Sec# _____ Work Phone _____

Person Responsible for Account _____ Relationship to Patient _____

Address _____ City _____ Zip _____ Home Phone _____

Employer _____ Work Phone _____ Is this Person a Patient in our office? Yes No

Are there any other family members that are patients in this office? _____

Emergency Contact Name and Number _____

To reduce our administrative costs and keep our fees to you as low as possible, we ask that you pay your **estimated** copayment at the time you receive treatment. Please indicate below the method of payment you intend to use to pay for your dental treatment, including your copayment. Cash or check VISA, MasterCard, or Discover Extended Payment Options CareCredit

Payment is due at the time services are rendered. Accounts over 45 days are subject to a re-billing fee.

Insurance Information: Policy Holder's Last Name _____ First Name _____ MI _____

Soc Sec# _____ Birthdate _____ Relationship to Patient _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Dental Insurance Company _____ Group# _____ Phone# _____

AUTHORIZATION AND RELEASE: 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. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of patient (or parent if minor)

---TURN PAGE OVER---

DENTAL HISTORY

Name of Previous Dentist and Location _____ Date of Last Exam _____

		Yes	No			Yes	No
1. Do your gums bleed while brushing/flossing?	<input type="checkbox"/>		<input type="checkbox"/>	8. Do you have frequent headaches?	<input type="checkbox"/>		<input type="checkbox"/>
2. Are your teeth sensitive to hot/cold?	<input type="checkbox"/>		<input type="checkbox"/>	9. Do you clench or grind your teeth?	<input type="checkbox"/>		<input type="checkbox"/>
3. Are your teeth sensitive to sweet/sour?	<input type="checkbox"/>		<input type="checkbox"/>	10. Do you bite your lips or cheeks frequently?	<input type="checkbox"/>		<input type="checkbox"/>
4. Do you feel pain in any of your teeth?	<input type="checkbox"/>		<input type="checkbox"/>	11. Have you ever had any difficult extractions in the past?	<input type="checkbox"/>		<input type="checkbox"/>
5. Any sores or lumps in your mouth?	<input type="checkbox"/>		<input type="checkbox"/>	12. Have you ever had any prolonged bleeding following extractions?	<input type="checkbox"/>		<input type="checkbox"/>
6. Have you had any head, neck or jaw injuries?	<input type="checkbox"/>		<input type="checkbox"/>	13. Have you ever worn braces?	<input type="checkbox"/>		<input type="checkbox"/>
7. Have you ever experienced any of the following Problems in your jaw?				14. Do you wear dentures or partials? If yes, date of placement _____	<input type="checkbox"/>		<input type="checkbox"/>
Clicking	<input type="checkbox"/>		<input type="checkbox"/>	15. Have you received oral hygiene instructions regarding care of your teeth or gums?	<input type="checkbox"/>		<input type="checkbox"/>
Pain (joint, ear, side of face)	<input type="checkbox"/>		<input type="checkbox"/>	16. DO YOU LIKE YOUR SMILE?	<input type="checkbox"/>		<input type="checkbox"/>
Difficulty in opening or closing	<input type="checkbox"/>		<input type="checkbox"/>				
Difficulty in chewing	<input type="checkbox"/>		<input type="checkbox"/>				

MEDICAL HISTORY

		Yes	No			Yes	No
1. Are you under medical treatment now?	<input type="checkbox"/>		<input type="checkbox"/>	8. Are you allergic to or have you had any reactions to the following?			
2. Have you been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain _____	<input type="checkbox"/>		<input type="checkbox"/>	Local Anesthetics (e.g. Novocaine)	<input type="checkbox"/>		<input type="checkbox"/>
3. Are you taking any medications including non-prescription medicine? If yes, Please List: _____	<input type="checkbox"/>		<input type="checkbox"/>	Penicillin or any other Antibiotics	<input type="checkbox"/>		<input type="checkbox"/>
4. Are you a recovering addict?	<input type="checkbox"/>		<input type="checkbox"/>	Sulfa Drugs	<input type="checkbox"/>		<input type="checkbox"/>
5. Have you ever taken Phen-Fen/Redux?	<input type="checkbox"/>		<input type="checkbox"/>	Barbiturates	<input type="checkbox"/>		<input type="checkbox"/>
6. Do you use tobacco?	<input type="checkbox"/>		<input type="checkbox"/>	Sedatives	<input type="checkbox"/>		<input type="checkbox"/>
7. Are you wearing contact lenses?	<input type="checkbox"/>		<input type="checkbox"/>	Iodine	<input type="checkbox"/>		<input type="checkbox"/>
				Aspirin	<input type="checkbox"/>		<input type="checkbox"/>
				Any Metals (e.g. nickel, mercury, etc.)	<input type="checkbox"/>		<input type="checkbox"/>
10. Do you have any of the following?				Latex Rubber	<input type="checkbox"/>		<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>		<input type="checkbox"/>	Other (please list) _____	<input type="checkbox"/>		<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>		<input type="checkbox"/>	9. Women Only:			
Rheumatic Fever	<input type="checkbox"/>		<input type="checkbox"/>	(a) Are you or think you may be pregnant?	<input type="checkbox"/>		<input type="checkbox"/>
Swollen Ankles	<input type="checkbox"/>		<input type="checkbox"/>	(b) Are you nursing?	<input type="checkbox"/>		<input type="checkbox"/>
Fainting/Seizures	<input type="checkbox"/>		<input type="checkbox"/>	(c) Are you taking oral contraceptives?	<input type="checkbox"/>		<input type="checkbox"/>
Asthma	<input type="checkbox"/>		<input type="checkbox"/>				
Low Blood Pressure	<input type="checkbox"/>		<input type="checkbox"/>	Chest Pains	<input type="checkbox"/>		<input type="checkbox"/>
Epilepsy/Convulsions	<input type="checkbox"/>		<input type="checkbox"/>	Easily Winded	<input type="checkbox"/>		<input type="checkbox"/>
Leukemia	<input type="checkbox"/>		<input type="checkbox"/>	Stroke	<input type="checkbox"/>		<input type="checkbox"/>
Diabetes	<input type="checkbox"/>		<input type="checkbox"/>	Hay Fever/Allergies	<input type="checkbox"/>		<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>		<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>		<input type="checkbox"/>
AIDS or HIV Infection	<input type="checkbox"/>		<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>		<input type="checkbox"/>
Thyroid Problem	<input type="checkbox"/>		<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>		<input type="checkbox"/>
				Recent Weight Loss	<input type="checkbox"/>		<input type="checkbox"/>
				Liver Disease	<input type="checkbox"/>		<input type="checkbox"/>
				Heart Trouble	<input type="checkbox"/>		<input type="checkbox"/>
				Respiratory Problems	<input type="checkbox"/>		<input type="checkbox"/>
				Mitral Valve Prolapse	<input type="checkbox"/>		<input type="checkbox"/>
				Other _____	<input type="checkbox"/>		<input type="checkbox"/>

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.

X _____ Date: _____
Signature of patient (or parent if minor)

Karl Burgess, D.D.S., P.C.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: Patient Giving Consent

Name: _____ Telephone: _____

Address: _____

Social Security#: _____ E-mail: _____

Section B: To the Patient – Please read the following statements carefully

Purpose of Consent: By signing this form, you consent to our use and disclosure of your protected health information to carry out treatment, discuss treatment and/or care in a specialist office, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice Of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice of Privacy Practices is posted at the front desk. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Office Manager/Privacy Officer
Telephone: 770-879-1200 Fax#: 770-413-1821
Address: 2415 West Park Place Blvd., Stone Mountain, Georgia, 30087

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Print Name

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ **Date:** _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Revocation of Consent

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that Dr. Burgess may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

PATIENT MISSED APPOINTMENT AGREEMENT

Trying to accommodate every patient's individual needs and work schedules can be difficult, but we always try to do our best. We work very hard to stay on schedule so that our patients will not spend time in our reception area waiting for an appointment.

A scheduled appointment is a commitment of time between you and our practice. We ask when you schedule an appointment that you make every effort to keep that commitment. We have reserved that time *just for you*. When appointments are missed or cancelled, that time is permanently lost.

It is our **policy** for you to give us 48 hours' notice if you need to change an appointment, and for you to call and speak directly with a staff member as our answering machine does not accept changes or cancellations.

We understand that personal emergencies sometimes occur, and we always take that into consideration when receiving a last minute cancellation. We also ask for you to call us back to confirm your appointment or your appointment may be double booked.

Because missed appointments increase the cost of healthcare for everyone, after two missed appointments in which 48 hours' notice has not been given, you may be required to pay a deposit before we reserve your next appointment. The deposit fee will then be applied to any treatment rendered, or forfeited if your reserved appointment is missed or cancelled without giving us the required 48 hours' notice. We appreciate your understanding in this matter.

Patient Signature

Date