Smile Now Dental Clinic

REGISTRATION FORM

Driver's License#:

Today's Date: [Date]			PCP: [PCP]		
PATIENT INFORMATION					
Patient's last name: First:		Middle: [Initial]		Marital status:	
Is this your legal name? ○ Yes ○ No	If not, what is your legal name?	Former name:	Birth date:	Age:	Sex: ○ M ○ F
Address:		City:	State:		Zip:
Social Security no.:		Home phone no.:		Cell phone no.:	
Occupation:		Employer:		Employer phone no.:	
Email Address:					
Chose clinic because/referred to clinic by (Please choose one option): ○		[Doctor's name]			
○		[Choose an item]			

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Smile Now Dental Clinic or insurance company to release any information required to process my claims

Patient/Guardian signature_____ Date _____

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:

How would you wish we communicate with you: ☐ Text ☐ Email ☐ Phone Number

Email Address:

Phone Number

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HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Patient Name:_____
(First name) (Middle intial) (Last name)

Have you traveled outside Augusta in the last 30 days? If yes, Where? And When? Yes____ No____
Explain:_____

Are you now under the care of a physician? Yes___ No___ Physician name: _____
Phone: (____) _____-_____

List any medical problems that other doctors have diagnosed, and any unusual medical problems:

- _____
- _____
- _____
- _____

List all medications your are currently taking:

- _____
- _____
- _____
- _____

Are you currently taking ANY blood thinners? Yes___ NO_____

Latex Allergy: (Please check the appropriate response to this question)
Yes____ No____

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia or Zometa) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? Yes___ No___ Date treatment begin: _____

Do you have any artificial joints or joint replacements (ie: Knee, hip, etc..) Yes_____ No_____

Description:_____

ALLERGIES TO MEDICATIONS	
NAME THE DRUG	REACTION YOU HAD

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YES	NO	DK		YES	NO	DK		YES	NO	DK	
☐	☐	☐	Artificial (prosthetic) heart valve	☐	☐	☐	Mitral Valve prolapse	☐	☐	☐	Bronchitis
☐	☐	☐	Previous infective endocarditis	☐	☐	☐	Pacemaker	☐	☐	☐	Emphysema
☐	☐	☐	Damaged heart valves in transplanted heart	☐	☐	☐	Rheumatic Fever	☐	☐	☐	Sinus Trouble
☐	☐	☐	Congenital Heart disease (CHD)	☐	☐	☐	Rheumatic Heart disease	☐	☐	☐	Tuberculosis
☐	☐	☐	Cardiovascular disease	☐	☐	☐	Abnormal bleeding	☐	☐	☐	Cancer/Chemotherapy/Radiation Treatment
☐	☐	☐	Angina	☐	☐	☐	Anemia	☐	☐	☐	Chest pain upon exertion
☐	☐	☐	Arteriosclerosis	☐	☐	☐	Blood transfusion Date:	☐	☐	☐	Chronic pain
☐	☐	☐	Congestive heart failure	☐	☐	☐	Hemophilia	☐	☐	☐	Diabetes Type I or II
☐	☐	☐	Damaged heart valve	☐	☐	☐	AIDS of HIV infection	☐	☐	☐	Eating disorder
☐	☐	☐	Heart attack	☐	☐	☐	Arthritis	☐	☐	☐	Malnutrition
☐	☐	☐	Heart murmur	☐	☐	☐	Autoimmune Disease	☐	☐	☐	Gastrointestinal Disease
☐	☐	☐	Low Blood Pressure	☐	☐	☐	Rheumatiod Arthrits	☐	☐	☐	G.E. Reflux/persistent heartburn
☐	☐	☐	High Blood Pressure	☐	☐	☐	Systemic lupus erythematosus	☐	☐	☐	Ulcers
☐	☐	☐	Other congenital heart defects	☐	☐	☐	Asthma	☐	☐	☐	Thyroid problems
☐	☐	☐	Stroke	☐	☐	☐	Glaucoma	☐	☐	☐	Hepatitis, jaundice or liver disease
☐	☐	☐	Epilepsy	☐	☐	☐	Fainting spells or seizures	☐	☐	☐	Neurological disorders SPECIFY:
☐	☐	☐	Sleep disorder	☐	☐	☐	Mental health disorders SPECIFY:	☐	☐	☐	Recurrent infections Type:
☐	☐	☐	Kidney problems	☐	☐	☐	Night sweats	☐	☐	☐	Osteoporosis
☐	☐	☐	Persistent swollen glands in neck	☐	☐	☐	Severe Headaches/migraines	☐	☐	☐	Severe or rapid weight loss
☐	☐	☐	Sexually transmitted disease	☐	☐	☐	Excessive urination	☐	☐	☐	Pregnant Due date: Nursing: Y N

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

_____

Patient Name (Print)

_____Date:_____

Signature of Patient/Legal Guardian:

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DENTAL HISTORY

Please Circle the appropriate response next to each question below: Yes (Y), No (N), Don't Know (?) If yes please explain.

1. **What is the reason for your dental visit?** _____
2. **Have you ever had any problems following dental treatment?** Y N ? _____
3. **Have you ever had a bad or unusual reaction to local anesthetic?** Y N ? _____
4. **Have you ever had a severe injury to your face, teeth or jaws?** Y N ? _____
5. **Have you ever had surgery in your mouth or on your lips?** Y N ? _____
6. **Have you ever had periodontal treatment to your gums?** Y N ? _____
7. **Have you ever had orthodontic treatment?** Y N ? _____
8. **Have you ever had extraction (pulling) of any teeth?** Y N ? _____
9. **Have you ever had endodontics (root canals) on any teeth?** Y N ? _____
10. **Have you had any missing teeth replaced by a removable denture, fixed bridge or an implant?** Y N ? _____
11. **Have you ever worn a bite splint/nightguard?** Y N ? _____
12. **Have you had a recent toothache?** Y N ? _____
13. **Are your teeth sensitive to hot, cold or pressure?** Y N ? _____
14. **Do you have bleeding gums?** Y N ? _____
15. **Do you have trouble chewing?** Y N ? _____
16. **Do you clench or grind your teeth?** Y N ? _____
17. **Do you have difficulty opening your mouth as wide as you would like?** Y N ? _____
18. **Do your jaw joints or muscles hurt?** Y N ? _____
19. **Does your jaw click, pop or lock when you chew?** Y N ? _____
20. **Do you experience a dry mouth?** Y N ? _____
21. **Do you have sores in or around your mouth?** Y N ? _____
22. **Please circle the amount of sugar in your diet.** **small moderate high**
23. **When was the last time your teeth were cleaned at a dental office?** _____
24. **How often do you brush?** _____
25. **How often do you use dental floss?** _____
26. **Are you satisfied with the appearance of your teeth?** Y N ?
    If No, Why not? _____
27. **Do you have any questions, concerns, or additional information you would like us to know before we treat you?**
    _____
28. **How do you feel about going to the dentist (please circle)** **Scared Apprehensive No problem**
29. **Do you use any tobacco products including smokeless tobacco?** Y N ?

Patient's/Guardian Signature: _____ **Date:** _____

Dentist's Signature: _____ **Date:** _____

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Insurance Form

Our office gladly files insurance for all patients. Please provide us with proper dental insurance information to verify ***ESTIMATED*** *benefits, annual maximums, and deductibles. We ask that any questions you have regarding your particular plan be directed to your employer or by contacting your insurance company.* ***ALL ESTIMATED NON-COVERED AMOUNTS ARE EXPECTED AT THE TIME SERVICES ARE RENDERED****. We will follow up on outstanding (unpaid) claims; however it is the insured's responsibility to contact the insurance company if a claim has been filed and no benefits received after* ***60*** *days at which point the balance becomes your responsibility. If you are not able to provide our office with complete insurance information we will not be able to file your insurance and will ask that payment be paid in full. Your insurance company should NOT dictate the treatment that Dr. Jacqueline OJimba has proposed to you. Thank you!*

Primary Dental Insurance

Patient name: _____D.O.B:_____

Cardholder Name: _____ D.O.B:_____ Cardholder's SS#:_____

(AS IT APPEARS ON THE INSURANCE CARD)

Phone: _____Employer: _____ Employer Phone#_____

Cardholder's address: _____City:_____ST._____Zip_____

(IF DIFFERENT FROM PATIENT)

Insurance Company Name: _____ Group#: _____

ID#: _____ Phone#: _____

Secondary Insurance

Cardholder Name: _____D.O.B:_____ Cardholder's SS#:_____

(AS IT APPEARS ON THE INSURANCE CARD)

Phone: _____Employer: _____Employer Phone#_____

Cardholder's address:

_____City:_____ST._____Zip_____

(IF DIFFERENT FROM PATIENT)

Insurance Company Name: _____ Group#: _____

ID#: _____ Phone#: _____

I authorize the release of any information relating to treatment. I understand that I am responsible for all accosts of dental treatment regardless of my dental coverage.

Patient Name: _____ Date: _____

Patient/Guardian (Print name):_____

Patient/Guardian Signature: _____

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Financial Policy

Here at Smile Now Dental Clinic our primary goal is not to allow the cost of treatment prevent you from benefiting from the quality care you need or desire. At our office we strive to maximize your insurance benefits and make any remiaining balance easily affordable.

The fees for our services are based on the quality of materials we use and time, effort and skill required in performing your needed treatment. We charge what is customary for our area. We will assist you with your benefit eligibility before treatment to help you calculate your costs and maximize your insurance. We will be sensitive to your financial circumstances and do everything we can to help you achieve good oral health. You are responsible for payment regardless of any insurance companies arbitrary determination of usual and customary rates.

Payment for treatment is due at the time services are rendered unless prior arrangements have been made. Checks that are returned to our office from your financial institution are subject to a $25.00 returned check fee. This fee covers the processing fees that are charged to our office.
We accept the following forms of payment: Cash, Visa, Mastercard, Discover, American Express and CareCredit. In addition, we offer CareCredit, a financing company offering a full range “No Interest” and Extended Payment Plans for treatment costing from $1 and up.

We understand that temporary financial situations may affect timely payment of your account. If such problems arise, we encourage you to contact us promptly for the assistance in the management of your account. In most instances financial misunderstandings can be managed with a phone call. Please feel free to contact our staff anytime to discuss any concerns you may have. **Thanks for understanding our Financial Policy.**

I understand that I, not my insurance company, am responsible for the entire account. I acknowledge that my insurance will have no bearing on the fee and that it is my full responsibility to pay my account. In the event that I do not pay, and go into default, I realize that after 60 days my account will be sent to a collection agency for collections. At that time, I will be obligated to pay 50% of the balance owed to cover the collection costs, in addition to my balance.

Rescheduling/Change in Appointment Policy

Our practice is dedicated to providing quality care. Our team spends extensive time preparing for your visit. Broken and missed appointments create scheduling problems for our team as well as for other patients. If you find that you must change your appointment, we require a 24 hour notice so we can make every effort to accommodate other patients. If proper notice is not received, a fee of $50.00 will be applied to your account and expected to be paid prior to scheduling a future appointment.

I have read and agree with the Financial Policy and the Cancellation Policy of Smile Now Dental Clinic.

Patient Name (Print name) _____ Date: _____

Patient/Guardian signature_____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Jacqueline Ojimba, D.M.D.

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my Protected Health Information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operation such as quality assurance and dental chart reviews.

We ask that you please read the current Notice of Privacy Practices of PHI located in the front office before signing this consent or you may request a copy from the receptionist. There may be periodic changes in the terms of this Notice. You may request a revised copy of the Privacy Notice from our Privacy Officer.

It is your right to request that our office restrict how PHI is used or disclosed to fulfill treatment, payment or health care operations. This practice is not required to agree to these restrictions, however, if the Practice agrees to your requested restrictions, the restrictions is binding on it.

Your information is protected under Federal Law and you have the right to revoke this consent, unless we have taken action in reliance on your authorization (determined by our Privacy Officer). By signing below, you recognize that the protected health information used or disclosed prior to this Consent may be subject to re-disclosure by the recipient and may longer be protected under the Federal Law.

Please list below name, relationship, and phone number of individuals that we may communicate with regarding this patients PHI (Protected Health Information).

	NAME	**Relationship**	**PHONE NUMBER**
1.	_____	_____	_____-_____-_____
2.	_____	_____	_____-_____-_____
3.	_____	_____	_____-_____-_____

***Patient*: _____*Patient/Guardian signature*:_____**

I have the authority to act for the patient because I am the patient's _____ and have read this Privacy Notice.

FOR OFFICE USE ONLY: We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

() Individual refused to sign

() Communication barriers prohibited obtaining the acknowledgement

() An emergency situation prevented us from obtaining acknowledgement

() Other (Please Specify)

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Smile Now Dental Clinic
104 N. Belair Road, Suite 102,
Evans, GA 30809.
Tel: 706.504.4903
Fax: 706.504.4907

Informed Consent for Dental Treatment

Clinical Examination:

Proposed treatment: The dentist or hygienist will evaluate your risk of developing tooth decay and other oral health problems, as well as check your face, neck and mouth for abnormalities. A dental exam might also include dental X-rays or other diagnostic procedures.

During a dental exam, the dentist or hygienist will likely discuss your diet and oral hygiene habits and might demonstrate proper brushing and flossing techniques**.**

X-rays:

Proposed treatment: taking of intra-oral and extra-oral radiographs. Benefits of treatment: taking x-rays enables us to view dental cavities, abnormalities, development and eruption of teeth. They are also necessary for proper diagnosis and evaluation purposes.

Alternatives of treatment: none; limited visual examination. Common risks: radiation exposure to soft and hard tissues. Consequences of not performing the treatment: missed diagnosis.

Cleaning:

Proposed treatment: involves thorough cleaning of teeth to help heal inflamed or infected gum tissue. It involves removal of soft plaque build-up and harder calculus deposits above and below the gum line. Benefits of treatment: healthy oral environment; also, reduction /elimination of bleeding, odor, and periodontal disease. Alternatives of treatment: referrals for periodontal (gum) surgery according to the severity of condition. Common risks: bleeding, soreness, swelling, infection of tissue, hot and cold sensitivity, stiff or sore jaw joint. Consequences of not performing the treatment: discontinued of interrupted treatment could result into further inflammation and infection of gum tissues, lead to more tooth decay, and deterioration of surrounding bone structure which could lead to tooth loss.

Patient Name: _____DATE:_____

PRINT NAME LEGIBLY

Patient/Guardian Signature: _____

Doctor's Signature: _____DATE:_____