CENTER FOR
ADVANCED DENTISTRY
USHMA PATEL, D.M.D.

REGISTRATION

PATIENT INFORMATION

Last Name	First	Middle	**M F** Sex	**S M D W CHILD** Marital Status	DOB

How would you like to be addressed? Email Address Social Security Number

Home Address- Street/City/State/Zip

Name of Employer Occupation Driver's License Number

Home Phone Number Cell Phone Number Business Phone Number

Best way to confirm your appointment: Email Text Call All None

Emergency Contact:_____ Telephone:_____

What are your hobbies or special interests?

How did you hear about Center For Advanced Dentistry?_____

Insurance Information- Insured Member

Last Name First Middle Relationship to Patient

Insured Date of Birth Social Security Number

Name of Employer Occupation Business Phone Number

Business Address- Street/City/State/Zip

Dental Insurance Company Group Number ID Number

Patient Signature **Date**

If patient was assisted with this form, print name of the person assisting.

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MEDICAL HISTORY **Patient Name:**_____

Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

General Health: Excellent ☐ Good ☐ Fair ☐ Poor ☐

Are you currently under the care of a physician? Yes ☐ No ☐ Date of Last Physical:_____
Name of physician:_____ Address:_____ Phone:_____

Do you smoke or use tobacco products? Yes No If yes, how much? _____
Are you pregnant or think you may be? Yes No If yes, expected delivery date:_____
Are you nursing? Yes No
Are you taking birth control pills? Yes No
Do you or have you used controlled substances? Yes No
Do you bruise easily? Yes No
Do you take any daily blood thinners (e.g. aspirin, Plavix, Coumadin)? Yes ☐ No ☐ If yes, please list below
Do you take anything for the treatment or prevention of osteoporosis (e.g. Fosamax)? Yes ☐ No ☐ If yes, please list below

Please list any medications you are taking now:

1) _____ Taken for _____ 4) _____ Taken for _____
2) _____ Taken for _____ 5) _____ Taken for _____
3) _____ Taken for _____ 6) _____ Taken for _____

Have you ever had (circle those that apply):

Abnormal blood pressure..... High Low No
AIDS or HIV.....Yes No
Allergies.....Yes No
Anemia.....Yes No
Arthritis .....Yes No
Asthma or Hay fever.....Yes No
Back Problems.....Yes No
Blood Transfusion.....Yes No
Cancer.....Yes No
Chemical dependency.....Yes No
Chemotherapy for any cancers...Yes No
Cold sores or Fever Blisters.....Yes No
Congenital heart lesions.....Yes No
Diabetes.....Yes No
Drastic weight loss.....Yes No
Eating disorders.....Yes No
Epilepsy or Seizures.....Yes No
Excessive urination and/or thirst.....Yes No
Fainting spells.....Yes No
Glaucoma.....Yes No
Heart disease.....Yes No
Heart murmur.....Yes No
Heart surgery.....Yes No
Hepatitis.....Yes No
Jaundice.....Yes No
Joint replacement or implant (pre-med.....Yes No
Kidney trouble.....Yes No
Lymph node enlargement/swollen glands.....Yes No
Mental health care.....Yes No
Mitral valve prolapse.....Yes No
Pacemaker.....Yes No
Persistent diarrhea.....Yes No
Prolonged bleeding.....Yes No
Rheumatic fever.....Yes No
Sexually transmitted disease.....Yes No
Sinus trouble.....Yes No
Stroke.....Yes No
Thyroid problems.....Yes No
Tuberculosis or lung disease.....Yes No
Ulcers.....Yes No
X-ray treatments for cancer.....Yes No

If you have entered "yes" please explain:_____

Are you allergic to had reactions to:

Local anesthetic like Novocaine..... Yes No
Penicillin or other antibiotics..... Yes No
Sulfa drugs..... Yes No
Barbiturates, sedatives, sleeping pills..... Yes No
Latex/Rubber..... Yes No
Aspirin..... Yes No
Any metal (gold, nickel, etc.)..... Yes No
Other (please list) _____

Patient Name:_____ **Date:**_____

Signature:_____

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Customized Treatment and Presentation Questionnaire

Patient Name:_____

1. If we were sitting here together a year from now, what needs to happen for you to consider our office an excellent choice for you? Examples might be: Being pain free, in great dental health, having whiter teeth, no more silver fillings, cost, etc.

_____

2. When the Dentist or Dental Team Member needs to present you with information about issues or potential issues that may be occurring in your mouth, do you typically:
   A. Prefer all of the facts and details of your condition. Why it occurred, how to prevent it from occurring again, etc? Want to see x-rays, photos of the condition, etc. Prefer a line item estimate of every cost involved with your treatment.
   B. Prefer some of the details but would rather have a thorough plan created to get your mouth back to good dental health with emphasis on cost and how many visits it will take to complete your treatment as well as how long each treatment appointment will last so we can fit it into your schedule.
   C. Prefer a summarized, bullet point version of the findings, highlighting the most important things but not getting too involved with the details or specifics of what needs to happen. You want bottom line emphasis on cost and time commitment needed to complete treatment.

3. When faced with dental work you need performed, do you prefer:
   A. To think about the pros and cons of the treatment recommended, analyze the data presented and the call our office when you are ready to have the work performed.
   B. To schedule the appointment today for a future date that better fits your timeline and schedule.
   C. Prefer to get the work done today if at all possible so you don't have to return for 2 or 3 more visits.

4. When the Dentist or Dental Team Member needs to talk to you about options to restore your dental health (such as crowns, dentures, implants, etc.), do you prefer:
   A. A simplified oral explanation and description of dental treatment needed.
   B. Both detailed oral and visual explanations which could include video animations demonstrating the procedure recommended and or photographs of the procedure or photos of other patients mouths who had similar treatment.
   C. Have physical models on hand to hold and feel to aid in visualizing the work needed to be performed.

Dental Health and Appearance Questionnaire

Reason for visit:_____ Approximate date of last dental visit:_____

What is your primary concern that you would like us to address first?_____

Has anything ever happened in previous experiences at the dentist that was reason not to return? Yes ☐ No ☐
If yes, please explain:_____

Please rate your smile from 1 to 10 (1= I hate my smile, 10= awesome): _____

If you had a magic wand, what, if anything, would you change about your smile? _____

Would you like to see what you would look like with a new and improved smile (at no additional charge)? Yes ☐ No ☐
If yes, check off all that apply:

☐ Lighten all front teeth showing	☐ Rebuild fracture(s)	☐ Straighten rotation	☐ Eliminate dark or stained fillings
☐ Lighten single tooth	☐ Lengthen	☐ Straighten angulation	☐ Reduce gum showing in smile
☐ Close spaces between teeth	☐ Shorten	☐ Eliminate crowding	☐ Repair uneven edges

Please add anything you feel is important:_____

_____

_____

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APPOINTMENT AGREEMENT

At Center For Advanced Dentistry, we understand that your time is very valuable. We are constantly striving to make your experience here more pleasant than any other place you have previously been. Trying to accommodate every patient's individual needs and work schedule can be challenging. We make every effort to stay on time so that our patients are not kept waiting unnecessarily.

Your appointment is a commitment of time between you and the doctor and/or hygienist. Since we do not double book, we ask that you make every effort to keep that commitment. We gladly provide a courtesy reminder via email, text, and call for your appointment.

If you find that you cannot keep your appointment, we do request a minimum of 2 business days notice so that we are able to offer that time to other patients with dental needs. If our office is not notified within the 2 business days, you will be subject to a late cancellation fee. A broken hygiene appointment will result in a $50 cancellation fee, and a broken doctor appointment will result in a $100 per scheduled hour cancellation fee.

By signing below, I agree to fulfill my obligation as a patient at Center For Advanced Dentistry and agree to the "broken appointment" fee should I not give proper notification.

_____

Signature of patient or responsible party **Date**

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FINANCIAL AGREEMENT

As a condition of the treatment performed by the providers of the office, financial arrangements must be made in advance for the full cost of proposed treatment. The practice's vitality depends upon payment for services as rendered and it is the responsibility of the patient or patient's parent/guardian to satisfy the costs incurred in dental care. Financial arrangements on the part of each individual must be determined prior to treatment completion.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are rendered. Additionally, a discount can be extended, at the doctor's discretion, for payments in full with cash or check. (Inquire for more details)

Individuals who carry dental insurance understand that all dental services furnished are charged directly to the patient and that said patient is personally responsible for payment of all dental services provided, regardless of dental insurance reimbursement. As a customer courtesy, this office will help prepare and submit patients' insurance forms as well as assist in making collections from insurance companies. We will credit any such collections to the appropriate account. However, this dental office cannot render services on the assumption that our charges will be paid in part or in full by an insurance company. (Please understand that the amount to be paid by your particular policy is pre-determined and agreed to by your employer and the insurance company. If you have any questions about the amount the plan will pay or the treatments your plan will cover, you should refer these questions to your employer). Additionally, there may be a deductible, a co-insurance factor, and a yearly maximum to be considered. Most policies cover what they consider a "usual and customary fee." However, the insurance company sets these fees, and they are not always the same as the fees that may be charged in this or any office. All these factors may combine to reduce the benefits you will ultimately receive. Our office will file your claim once services have been rendered. We will do our best to see that you receive your full benefits within the structure of your particular dental plan but any balance that remains on your account, whether your insurance company covered the procedure in question or not, is ultimately your responsibility to pay.

A service charged of 2% per month (24% per annum) on any unpaid balance will be charged on all accounts exceeding 60 days from date of service, unless previously written financial arrangements are agreed upon and satisfied. I understand that the fee estimate listed for any proposed dental care can only be extended for a period of six months from the date of diagnosis and/or examination. I further acknowledge that the proposed treatment plan can shift and/or change from the diagnosed treatment plan once treatment is begun due to unforeseen circumstances beyond the doctors' control.

In consideration for the professional services rendered to me by the doctor, at the provider's recommendation, or at my own request, I agree to pay the reasonable value of said services to said doctor, or his assignee, at the time said services are rendered, or within five (5) business days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be billed unless objected to, by me, in writing, within the time allotted for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition, and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to Center For Advanced Dentistry's financial coordinator to telephone me at home or at my place of business to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent or guardian	**Date**	**Relationship to patient**
Signature of guarantor of payment/responsible party	**Date**	**Relationship to patient**

Authorization to Receive Dental Records
Expires upon one time release

Patient Information

Name of Patient:_____ Date of Birth:_____

Address:_____

City, State, Zip:_____ Phone:_____

I authorize the practice below to release my dental records (please include phone # if known):

_____

_____

_____

Please forward/release my dental records to: FD@HITECHSMILES.COM

Center For Advanced Dentistry
6916 McGinnis Ferry Rd., Suite 500
Suwanee, GA 30024
Phone: 770-623-8750 Fax: 770-623-4765

Please describe the Protected Health Information that you would like released:

_____

_____

This authorization shall be in effect until the information has been forwarded as requested.

Patient Information
I understand that my treatment will not be conditioned on signing this authorization and that I have the right to refuse to sign this authorization. I understand that information disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to revoke this authorization by sending a written notification to the address below and that a revocation is not effective if the information has already been disclosed but will be effective going forward.

I understand that I have the right to inspect or copy the protected health information as described in this document. I can do this by written notification to Center For Advanced Dentistry, 6916 McGinnis Ferry Rd., Suite 500, Suwanee, GA 30024.

_____ **Date**_____

Signature of Patient or Personal Representative

_____

Description of Person Representative's Authority (attach necessary documentation)

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AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Patient:_____ Date of Birth:_____

Center for Advanced Dentistry is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Circle entity/person that you approve to Receive information.	**Circle description of information to be released to entity/person at left.**
Voice Mail (Home or Mobile)	Appointment Reminders
Email: _____ (Provide Email Address)	Appointment Reminders, X-Rays, Financial

Spouse: _____ (Provide Name and Phone Number)	Appointment Reminders Financial Treatment Plans
Parent: _____ (Provide Name and Phone Number)	Appointment Reminders Financial Treatment Plans
Other: _____ (Grandparents, Step-parents, Nanny) (Provide Name and Phone Number)	Appointment Reminders Financial Treatment Plans

Patient Information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

_____

Signature of Patient or Personal Representative Date

Acknowledgment of Receipt of Notice of Privacy Practices

Patient Name & Address: _____

_____

_____

_____

I have received a copy of the Notice of Privacy Practices for the above named practice.

_____ _____

Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

☐ An emergency existed & a signature was not possible at the time.

☐ The individual refused to sign.

☐ A copy was mailed with a request for a signature by return mail.

☐ Unable to communicate with the patient for the following reason: _____

☐ Other: _____

Prepared By: _____

Signature: _____

Date: _____