



REGISTRATION

PATIENT INFORMATION

Last Name	First	Middle	M F Sex	S M D W CHILD Marital Status	DOB
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How would you like to be addressed?	Email Address	Social Security Number
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Home Address- Street/City/State/Zip

Name of Employer	Occupation	Driver's License Number
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Home Phone Number	Cell Phone Number	Business Phone Number
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Best way to confirm your appointment: Email Text Call All None

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
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Insured Date of Birth	Social Security Number
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Name of Employer	Occupation	Business Phone Number
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Business Address- Street/City/State/Zip

Dental Insurance Company	Group Number	ID Number
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Patient Signature

Date

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



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		Heart murmur.....	Yes No
Allergies.....	Yes	No		Heart surgery.....	Yes No
Anemia.....	Yes	No		Hepatitis.....	Yes No
Arthritis	Yes	No		Jaundice.....	Yes No
Asthma or Hay fever.....	Yes	No		Joint replacement or implant (pre-med.....	Yes No
Back Problems.....	Yes	No		Kidney trouble.....	Yes No
Blood Transfusion.....	Yes	No		Lymph node enlargement/swollen glands.....	Yes No
Cancer.....	Yes	No		Mental health care.....	Yes No
Chemical dependency.....	Yes	No		Mitral valve prolapse.....	Yes No
Chemotherapy for any cancers...Yes	No			Pacemaker.....	Yes No
Cold sores or Fever Blisters.....	Yes	No		Persistent diarrhea.....	Yes No
Congenital heart lesions.....	Yes	No		Prolonged bleeding.....	Yes No
Diabetes.....	Yes	No		Rheumatic fever.....	Yes No
Drastic weight loss.....	Yes	No		Sexually transmitted disease.....	Yes No
Eating disorders.....	Yes	No		Sinus trouble.....	Yes No
Epilepsy or Seizures.....	Yes	No		Stroke.....	Yes No
Excessive urination and/or thirst.....	Yes	No		Thyroid problems.....	Yes No
Fainting spells.....	Yes	No		Tuberculosis or lung disease.....	Yes No
Glaucoma.....	Yes	No		Ulcers.....	Yes No
Heart disease.....	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	Latex/Rubber.....	Yes No
Penicillin or other antibiotics.....	Yes No	Aspirin.....	Yes No
Sulfa drugs.....	Yes No	Any metal (gold, nickel, etc.).....	Yes No
Barbiturates, sedatives, sleeping pills.....	Yes No	Other (please list) _____	

Patient Name: _____

Date: _____

Signature: _____



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:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Lighten all front teeth showing | <input type="checkbox"/> Rebuild fracture(s) | <input type="checkbox"/> Straighten rotation | <input type="checkbox"/> Eliminate dark or stained fillings |
| <input type="checkbox"/> Lighten single tooth | <input type="checkbox"/> Lengthen | <input type="checkbox"/> Straighten angulation | <input type="checkbox"/> Reduce gum showing in smile |
| <input type="checkbox"/> Close spaces between teeth | <input type="checkbox"/> Shorten | <input type="checkbox"/> Eliminate crowding | <input type="checkbox"/> Repair uneven edges |

Please add anything you feel is important: _____



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 will not wait unnecessarily.

Your appointment is a commitment of time between you and our office. We ask that you make every effort to keep that commitment. We do provide a courtesy reminder call one to two days prior to your appointment.

If you find that you cannot keep your appointment, we do require a minimum of 2 business days notice so that we are able to assist other patients with their dental needs. If our office is not notified within the 2 business days, you will be subject to a \$35 late 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



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.

Signature of Patient or Personal Representative **Date** _____

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



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

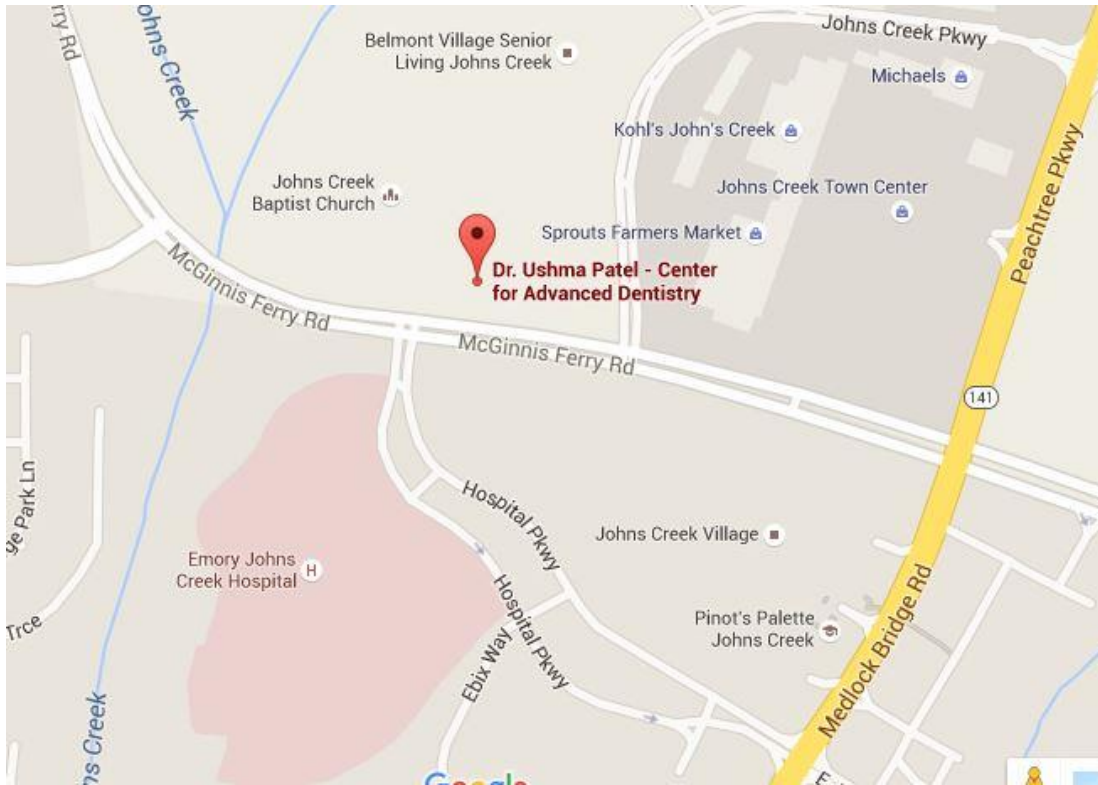
We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- 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: _____



6916 McGinnis Ferry Road, Suite 500, Suwanee, GA 30024



(Across from Emory Hospital, in the medical park with the 3 one-story buildings, that is next to the Johns Creek Baptist Church)