



*Thank you for trusting us with your dental care.
We promise to do our best to provide you with
the finest care available. If you have any
questions please do not hesitate to call us.*

Patient # _____
SS # _____
Date _____

PATIENT INFORMATION

Name _____ Birthdate _____ Home Phone (____) _____
Address _____ City _____ State _____ Zip _____
Sex ☐ M ☐ F ☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ Partnered for _____ years
E-mail _____ Cell Phone #1 (____) _____ Cell Phone #2 (____) _____
Employer/School _____ Employer/School Phone (____) _____
Employer/School Address _____ City _____ State _____ Zip _____
Spouse or Parent's Name _____ Employer _____ Work Phone (____) _____
Whom may we thank for referring you? _____
Person to contact in case of emergency _____ Phone (____) _____

RESPONSIBLE PARTY

Name of Person _____ Relation to Patient _____
Responsible for this Account _____ Home Phone (____) _____
Address _____ Birthdate _____ Bank _____
Driver's License # _____ Work Phone (____) _____
Employer _____
Currently a patient in our office? ☐ Yes ☐ No E-mail _____ Cell Phone (____) _____

INSURANCE INFORMATION

Name of Insured _____ Relation to Patient _____
Birthdate _____ Social Security # _____ Date Employed _____
Employer _____ Work Phone (____) _____
Employer Address _____ City _____ State _____ Zip _____
Insurance Company _____ Group # _____ Union or Local # _____
Address _____ City _____ State _____ Zip _____
How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit _____

ADDITIONAL INSURANCE

Name of Insured _____ Relation to Patient _____
Birthdate _____ Social Security # _____ Date Employed _____
Employer _____ Work Phone (____) _____
Employer Address _____ City _____ State _____ Zip _____
Insurance Company _____ Group # _____ Union or Local # _____
Address _____ City _____ State _____ Zip _____
How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit _____

- O V E R -

DENTAL HISTORY

Reason for today's visit _____ Date of last dental care _____
Former Dentist _____ Date of last dental X-rays _____
Address _____

Check (✓) if you have had problems with any of the following:

- | | | |
|--|---|---|
| ☐ Bad breath | ☐ Grinding teeth | ☐ Sensitivity to hot |
| ☐ Bleeding gums | ☐ Loose teeth or broken fillings | ☐ Sensitivity to sweets |
| ☐ Clicking or popping jaw | ☐ Periodontal treatment | ☐ Sensitivity when biting |
| ☐ Food collection between the teeth | ☐ Sensitivity to cold | ☐ Sores or growths in your mouth |

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Physician's Name _____ Date of last visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, describe _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates _____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (✓) if you have or have had any of the following:

- | | | | |
|--|---|--|---|
| ☐ Anemia | ☐ Congenital Heart Lesions | ☐ Hepatitis | ☐ Scarlet Fever |
| ☐ Arthritis, Rheumatism | ☐ Cortisone Treatments | ☐ Hernia Repair | ☐ Shortness of Breath |
| ☐ Artificial Heart Valves | ☐ Cough, Persistent | ☐ High Blood Pressure | ☐ Skin Rash |
| ☐ Artificial Joints, Pins, etc. | ☐ Cough up Blood | ☐ HIV/AIDS | ☐ Stroke |
| ☐ Asthma | ☐ Diabetes | ☐ Jaw Pain | ☐ Swelling of Feet or Ankles |
| ☐ Back Problems | ☐ Epilepsy | ☐ Kidney Disease | ☐ Thyroid Problems |
| ☐ Bleeding Abnormally | ☐ Fainting | ☐ Liver Disease | ☐ Tobacco Habit |
| ☐ Blood Disease | ☐ Glaucoma | ☐ Mitral Valve Prolapse | ☐ Tonsillitis |
| ☐ Cancer | ☐ Headaches | ☐ Pacemaker | ☐ Tuberculosis |
| ☐ Chemical Dependency | ☐ Heart Murmur | ☐ Radiation Treatment | ☐ Ulcer |
| ☐ Chemotherapy | ☐ Heart Problems | ☐ Respiratory Disease | ☐ Venereal Disease |
| ☐ Circulatory Problems | ☐ Hemophilia | ☐ Rheumatic Fever | |

List medications you are currently taking and the correlating diagnosis:

Allergies:

_____	_____
_____	_____
_____	_____

AUTHORIZATION AND RELEASE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to _____
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative _____	Date _____
Please print name of Patient, Parent, Guardian or Personal Representative _____	Relationship to Patient _____

Payment is due in full at time of treatment unless prior arrangements have been approved.

Evans Family Dental Associates

A. Todd Weaver, D.M.D.

P.O. Box 410
Evans, GA 30809
(706) 868-8145

OUR FINANCIAL POLICY

Thank you for choosing us as your dental care provider. We are committed to the best treatment possible. Please understand that payment of your account is considered part of your treatment. The following is a statement of our Financial Policy, which we require that you read and sign prior to any dental treatment.

REGARDING INSURANCE

We accept assignment of insurance benefits after verification of your dental plan. We cannot bill your insurance company unless you give us your insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. The balance is your responsibility whether your insurance company pays or not. Our office files your insurance as a courtesy. Ultimately it is your responsibility to follow up with it. Regarding insurance plans where we are a participating provider, all co-pays and deductibles are due on the date of service. We make every effort possible to attain payment from your insurance provider; however, any balance remaining after insurance is the patients responsibility. Outstanding balances should be paid in full within 60 days of 2 billing cycles unless other arrangements have been made. If your account is turned over for collection, you will additionally be responsible for any and all collection fees.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best dental treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

ADULT PATIENTS

Adult patients are responsible for their deductibles and co-payments at the time of service.

MINOR PATIENTS

The adult accompanying a minor is responsible for deductible and co-payment at time of service. Please do not leave your child here alone, when coming in for dental services. We ask that parents remain in our reception area during treatment.

MISSED APPOINTMENTS

Unless canceled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal visit. Please help us serve you better by keeping scheduled appointments.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns. I have read the Financial Policy; I understand and agree to the Financial Policy.

Patient or Responsible Party

DATE _____

Co-Responsible Party

DATE _____

Patient Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1966 (HIPAA), I have certain rights to privacy regarding my health information. 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 operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____