Buckhead Esthetic Dentistry

FINE ART DENTISTRY

Dr. Jolanda M. Warren
3098 Piedmont Road, Suite 100
Atlanta, GA, 30305

Patient Information

Name: _____ Preferred Name: _____ Date: _____

Phone Numbers: Home: _____ Work: _____ Cell: _____

Address: _____ City: _____ Zip Code: _____

E-Mail: _____ Employer: _____

Gender: Male _____ Female _____ Marital Status: Single _____ Married _____

Social Security Number: _____ Date of Birth: _____

Who may we thank for referring you to our practice? _____

Please list any family members that are current patients here: _____

Insurance Information

Insurance Carrier: _____ Phone Number: _____

Carrier Address: _____

Employer: _____ Group Number: _____

If insured different from patient:

Subscriber Name: _____ Date of Birth: _____

Social Security Number: _____ ID Number: _____

Patient relationship to insured: Spouse: _____ Child: _____ Other: _____

Photo Release

I hereby authorize Dr. Jolanda Warren to use any and all models, casts, photographs, radiographs of me and my treatment for the purpose of dental education. This includes, but is not limited to, case presentations to other dentists, lectures illustrating specific treatment modalities, case outcomes and examples to other patients. These may be used for educations and promotional purposes for Buckhead Esthetic Dentistry.

Patient/Legal Guardian Signature: _____ Date: _____

Printed Name: _____

Office Policies

Thank you for choosing our practice. Our goal is to provide excellent care and superior patient service. Our policies are intended to accomplish that goal in a cost-effective manner.

Your agreement to the following policies will help us serve you well.

Appointments:

Appointment times are reserved for you. So that we may assure you and other patients of uninterrupted treatment it is necessary for all patients to accept and adhere to a definite arrangement of appointment times and fees. As a courtesy, we make every effort to reach you to remind you of your appointment. However, we do expect that you will accept responsibility to provide us with **48 hours'** notice should the need to change or cancel your appointed time with us arise. Failure to do so will result in a $50.00 cancellation charge or the necessity to require a deposit or advanced payment to reserve future appointments. Please be aware that we are closed on Fridays and need notice before 5:00 PM Thursday to change Monday appointments. We value the time you take for your dental needs; therefore, we want to make sure you are seen in a timely and efficient manner. We also appreciate you respecting our time and our schedule we have reserved for you as well as for other patients.

Payments/Insurance:

- As a condition of your treatment by our office, payment is due in full at the time services are rendered.
- If you do not have insurance, or it cannot be verified, total payment for your visit is due at the time of service.
- We will file claims to your insurance carrier and accept payment directly from them. We must have your complete and current demographic and insurance information to do this. It is your responsibility to let us know about any changes in your insurance coverage and contact information. If we submit the information you provide us and the claim is denied due to incorrect/missing information, we will bill you for the full amount and you may file for reimbursement from your insurance company. Our Insurance coordinator wants to help you in every way with filing your insurance. Please help her do so in an efficient manner.
- Since insurance benefits are unique to each patient's insurance coverage, it is your responsibility to know your insurance benefits PRIOR to services being rendered. Many routine dental services are not covered by insurance. It is imperative that the patient understand that this office does not have access to all insurance company records. Most plans tell their insured that they will be covered "up to 80% or 100%", but do not specify the plan fee schedule allowance annual maximum, or any limitations such as pre-existing conditions. We are not responsible for unpaid amounts as a result of deductibles or denials from your insurance.
- You may receive a letter from your insurance company stating that our fees are higher than the usual and customary. An insurance company surveys a geographic area, finds the average fee, and then takes 90% of that fee and considers it customary. Included in the fee survey are discount clinics which will further bring down the average. Any dentist in private practice will have fees that are considered higher than average.

Treatment Plan Estimates:
Treatment plan estimates are just that. We will make every attempt to plan accurately, but unanticipated situations do arise and can affect previously planned treatment. Patients will be notified of applicable fees before services are rendered. A fee estimate is effective for 90 days.

Cosmetic and Elective Services:
Full payment is required at the time of service. Cosmetic and elective procedures may require a deposit or payment in full to hold the appointment. Please be aware that a missed appointment can result in loss of some or all of your deposit.

Fees:
Returned check fee: A $30 fee will be due for any check returned from the bank for non-payment.

Health Insurance Portability and Accountability ACT (HIPPA):
Patient copy available upon request.

Patient Permission:
I grant my permission to Dr. Jolanda M. Warren, DMD, PC, or her assignee, to telephone me at home or my place of employment to discuss matters related to this form.

I have read, understand, and agree to the office terms and financial policy as well as the $50.00 cancellation fee.
I acknowledge that I have read a copy of this office's Notice of Privacy Practices.
I authorize and request my insurance company to pay directly to the dentist otherwise payable to me.
I agree to be responsible for payment of all services rendered on my behalf or my dependents.
In consideration for the professional services rendered to me, or at my request, by Dr. Jolanda Warren, DMD, PC, I agree to pay the fee for said services to Dr. Jolanda M. Warren, DMD, PC (Buckhead Esthetic Dentistry) or her assignee at the time services are rendered. I understand that I am responsible for all charges for myself and my dependents whether or not covered by insurance

Signature of Patient/Responsible Party: _____

Print Name: _____ Date: _____

Emergency Contact:

Name: _____

Relationship to Patient: _____

Phone Number: _____

I give Dr. Warren permission to discuss my case and/or financial arrangements with the above contact person.

Signature: _____ Date: _____

Dental History

One of the goals in our office is to consistently understand and meet the needs of our patients. We are committed to making each visit an exceptional experience. The comfort and quality of care you receive here is one of our highest priorities. We are asking for the following information because we want to get to know you and serve you consistently each time we see you. Please answer the following questions to the best of your ability. We welcome you to our office and your new dental home.

What brought you in to see us today? _____

_____

Date of Last Dental Exam: _____ What was done? _____

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

Have you had problems with prior dental treatment? _____

What dental concerns do you have? _____

Are you in pain now? _____

Does *hot* temperature bother your teeth? _____ What area of the mouth? _____

Does *cold* temperature bother your teeth? _____ What area of the mouth? _____

Are any of your teeth sensitive to biting/chewing? _____

Do your gums bleed when you brush or floss? _____

How do you feel about the appearance of your teeth? _____

Would you change anything about their appearance or function? _____

Have you ever experienced any of the following? Please reply "Y" or "N" after each question and any remarks:

Grinding or clenching of your teeth? _____

Clicking or popping in front of your ears? _____

Tenderness or tightness in the muscles that work your jaw? _____

Pain in the jaw joints? _____ Right/Left side? _____ When did you first notice pain? _____

Locking of your jaw? _____ Frequency? _____

Frequent headaches? _____ When did these headaches start? _____

Difficulty chewing your food? _____

Do you feel your bite is off? _____

Have you been treated for TMJ, headaches or joint problems? _____

Have you had jaw problems following dental treatment in the past? _____

Problems associated with any previous dental work? _____

Problems with your bite or tooth sensitivity in the past? _____

Do you currently wear a nighttime appliance? _____

Have you been treated for periodontal or gum problems in the past? _____ If so:

Have you had Root Planing or a Deep Cleaning? _____ When: _____

Have you had Gum Surgery? _____ When: _____

Are you currently under the care of a Periodontist (Gum Specialist)? _____ Who? _____

Have you had Orthodontic (braces) treatment in the past or currently under treatment? _____

By whom? _____

If you have <u>not</u> had orthodontic treatment, was it ever recommended? Y / N

Have you bleached your teeth in the past? Y / N If yes, did you get the results you expected? _____

Are you considering bleaching your teeth now? Y / N

I am interested in learning more about: (Circle all that apply)

Cosmetic Dentistry
Facial Esthetics
Smile Enhancements/Improving Your Smile
Silver/Mercury Filling Removal
Improved Dental/Oral Health
Cosmetic Posterior Restorations
Smile Whitening
Improved Denture Stability
Ideal, Comprehensive Dentistry
Alternatives to Bridges or Partials
Straighter Teeth
Porcelain Veneers/Lumineers
Oral Cancer
Dental Implants
Sleep Apnea/Snoring
Dentures/Partials
Invisible Braces – Invisalign
Teeth Grinding and Wear / Bruxism / Fractured Teeth

Medical History

Patient Name: _____ Date of Birth: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	Y	N	If yes, please explain: _____
Have you ever been hospitalized or had a major operation in the last ***5 years***?	Y	N	If yes, please explain: _____
Have you ever had a serious head/neck injury?	Y	N	If yes, please explain: _____
Are you taking any medications, pills, or drugs?	Y	N	If yes, please explain: _____
Do you take, or have taken Phen-Fen or Redux?	Y	N	If yes, please explain: _____
Have you ever taken Fosamax, Boniva, Actonel or any medications containing bisphosphonates?	Y	N	If yes, please explain: _____
Are you on a special diet?	Y	N	If yes, please explain: _____
Do you use tobacco?	Y	N	If yes, type & frequency: _____
Do you used a controlled substance?	Y	N	If yes, please explain: _____

Women:

Are you pregnant/trying to get pregnant?	Y	N
Taking oral contraceptives?	Y	N
Nursing?	Y	N

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Y	N	Excessive Bleeding	Y	N	Lung Disease	Y	N
Alzheimer's Disease	Y	N	Excessive Thirst	Y	N	Mitral Valve Prolapse	Y	N
Anaphylaxis	Y	N	Fainting Spells/Dizziness	Y	N	Pain in Jaw Joints	Y	N
Anemia	Y	N	Frequent Cough	Y	N	Parathyroid Disease	Y	N
Angina	Y	N	Frequent Diarrhea	Y	N	Psychiatric Care	Y	N
Arthritis/Gout	Y	N	Frequent Headaches	Y	N	Radiation Treatments	Y	N
Artificial Heart Valve	Y	N	Genital Herpes	Y	N	Recent Weight Loss	Y	N
Artificial Joint	Y	N	Glaucoma	Y	N	Renal Dialysis	Y	N
Asthma	Y	N	Hay Fever	Y	N	Rheumatic Fever	Y	N
Blood Disease	Y	N	Heart Attack/Failure	Y	N	Rheumatism	Y	N
Blood Transfusion	Y	N	Heart Murmur	Y	N	Scarlet Fever	Y	N
Breathing Problem	Y	N	Heart Pacemaker	Y	N	Shingles	Y	N
Bruise Easily	Y	N	Heart Trouble/Disease	Y	N	Sickle Cell Disease	Y	N
Cancer	Y	N	Hemophilia	Y	N	Sinus Trouble	Y	N
Chemotherapy	Y	N	Hepatitis A/B/C	Y	N	Spina Bifida	Y	N
Chest Pains	Y	N	Herpes	Y	N	Stomach/Intestinal Disease	Y	N
Cold Sores/Fever Blisters	Y	N	High Blood Pressure	Y	N	Stroke	Y	N
Congenital Heart Disorder	Y	N	High Cholesterol	Y	N	Swelling of Limbs	Y	N
Convulsions	Y	N	Hives/Rash	Y	N	Thyroid Disease	Y	N
Cortisone Medication	Y	N	Hypoglycemia	Y	N	Tonsilitis	Y	N
Diabetes	Y	N	Irregular Heartbeat	Y	N	Tuberculosis	Y	N
Drug Addiction	Y	N	Kidney Problems	Y	N	Tumors/Growths	Y	N
Easily Winded	Y	N	Leukemia	Y	N	Ulcers	Y	N
Emphysema	Y	N	Liver Disease	Y	N	Venereal Disease	Y	N
Epilepsy/Seizures	Y	N	Low Blood Pressure	Y	N	Yellow Jaundice	Y	N

Have you ever had any serious illness(es) not listed above? Yes / No If yes, please explain: _____

_____

_____

Comments: _____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN _____ DATE _____