north atlanta
Family Dentistry

Date ..... / ..... / .....

Patient Information

Name..... SS #.....

Birthdate ...../...../..... Age..... Sex…M…/…F… Marital Status.....

Address.....

City..... State..... Zip Code.....

Home phone (.....) ..... E-mail.....

Cell phone (.....) ..... Work telephone (.....) .....

Employer.....

Pharmacy..... Pharmacy telephone (.....) .....

How did you hear about us?.....

Insurance Information

Primary Insurance..... Insurance Phone (.....) .....

Policy #..... Policy holder's name.....

Policy holder's SS#..... Relation to patient..... Birthdate ...../...../.....

Policy holder's Address.....

City..... State..... Zip Code.....

Cellphone (.....) ..... E-mail.....

Secondary Insurance..... Insurance Phone (.....) .....

Policy #..... Policy holder's name.....

Policy holder's SS#..... Relation to patient..... Birthdate ...../...../.....

Policy holder's Address.....

City..... State..... Zip Code.....

Cellphone (.....) ..... E-mail .....

Emergency Contact

Name..... Relationship..... Cell phone (.....) .....

Name..... Relationship..... Cell phone (.....) .....

Please be prepared to take care of fees at the time service is rendered unless previous arrangements have been made. To assist you, we accept Visa, Mastercard, Debit cards, and cash. We DO NOT accept personal checks. We also offer extended payment plans through Care Credit and Lending Club.

If you have dental insurance, we will accept assignment of benefits from your insurance carrier. However, it must be understood that you are responsible for any deductible and co-insurance payment at the time service is rendered AND for any portion not paid for by your insurance within 60 days.

***To the best of my knowledge, I have answered the preceeding questions correctly and should assignment of Dental Insurance benefits be used, I consent to those benefits being made payable to Sandra Vargas D.M.D, P.C.**

Signature responsible for the account: .....

Medical History

Physician's name..... Phone (.....) ..... Last visit……

Have there been any changes in your general health within the past year?.....**Y** **N**

If so, please explain…….....

Have you had any serious illness or operation?.....**Y** **N**

If so, please explain (include dates)…….....

Have you ever had any surgical prostheses? (joint replacement or implants)..**Y** **N**

Do you have or have you had any of the following conditions or diseases?

Rheumatic Fever……..……..**Y** **N**
Congenital Heart Defect……..**Y** **N**
Angina or Heart Attack……..……**Y** **N**
Heart Murmurs……..……**Y** **N**
Congestive Heart Failure……..……**Y** **N**
Heart Surgery or Pacemaker……..……**Y** **N**
High Blood Pressure……..……**Y** **N**
Low Blood Pressure……..……**Y** **N**
Stroke……..……**Y** **N**
Asthma or Bronchitis……..……**Y** **N**
Emphysema……..……..**Y** **N**
Hay Fever or Sinusitis……..…… **Y** **N**
Diabetes……..……**Y** **N**
Hyperthyroidism……..……**Y** **N**
Hypothyroidism……..……**Y** **N**
Anemia……..……**Y** **N**
Do you bleed excessively when cut.....**Y** **N**

Do you have an allergy or reaction to any of the following?

Latex Allergy……..……..……..**Y** **N**
Local Anesthetics……..……..**Y** **N**
Penicillin……..……**Y** **N**
Other Antibiotics……..……**Y** **N**
Codeine……..……**Y** **N**
Other Pain Medication……..……**Y** **N**
Aspirin……..……**Y** **N**
Barbiturates or Sedatives……..……**Y** **N**
Other Medicines……..……..……**Y** **N**

If so, which medicines?……..……..……..……
……..……..……
……..……

Kidney infections……..……..**Y** **N**
Kidney surgery……..……..**Y** **N**
Hepatitis……..……..**Y** **N**
HIV Positive……..……..**Y** **N**
Veneral Disease (within the last 10 yrs)……..**Y** **N**
Tuberculosis……..……..**Y** **N**
Frequent Fainting……..……..**Y** **N**
Liver Disease……..……**Y** **N**
Arthritis……..……..**Y** **N**
Ulcers……..……..……**Y** **N**
Glaucoma……..……..**Y** **N**
Cancer……..……..…… **Y** **N**
Radiation Therapy (for Cancer)……..…… **Y** **N**
Epilepsy……..……..**Y** **N**
Do you smoke……..……..**Y** **N**
Do you use any other form of tobacco……..…**Y** **N**

Women only, are you pregnant?.....**Y** **N**
If so, when are you due?……

Are you currently taking any of the following drugs or medications?

Antibiotics……..……..**Y** **N**
Blood Thinners……..……..**Y** **N**
Steroids or Cortisone……..……..……**Y** **N**
High Blood Pressure Medication……..……**Y** **N**
Tranquilizers……..……..**Y** **N**
Aspirin……..……..……**Y** **N**

Please list all medications you are currently taking
……..……
……..……
……..……
……..……

Dental History

Former dentist……..... Last dental visit..... Date of last full mouth x-rays.....

Do you have dentures or partial dentures?.....**Y** **N**
Do you have bridges or crowns?.....**Y** **N**
Have you ever worn braces?.....**Y** **N**
Have you ever had gum surgery?.....**Y** **N**

Have you ever had difficulty with any dental work or extractions?.....**Y** **N**
Have you ever had dental implant surgery?.....**Y** **N**

Do you need to be pre-medicated (take antibiotics) before your dental visits?.....**Y** **N**

Patient's Signature: ……..…. **Doctor's Signature:** ……

Rate Your Smile

An American Academy of Dentistry survey reveals that **92% of respondents say an attractive smile is an important social asset**, while 74% believe an unattractive smile can hurt a person's chances for career success. Whether your smile needs minor improvements or more extensive improvements, your dentist can help.

1. **Rate your smile on a scale of 1-10, with 10 being perfect:**
   1 2 3 4 5 6 7 8 9 10
   HELP! ---------- PERFECT!

2. **If you feel your smile is less than perfect, how does this affect you?**
__ I rarely smile.
__ I smile less than I would like.
__ I smile a lot even though my smile is less than perfect.
__ My imperfect smile hurts my self confidence.
__ My imperfect smile does not bother me.
__ Other, please explain: _____

3. **Are you ever worried what other people think about your smile?**
__ Yes, I always worry about what others think about my smile.
__ Yes, I sometimes worry about what others think about my smile.
__ Yes, but I rarely worry about what others think about my smile even though my smile could use improvement
__ No, I don't worry about it.

4. **How do you think that having a perfect smile would improve your life? (check all that apply)**
__ I would smile more often
__ I would feel better about myself
__ I would have more confidence with friends, family, and on the job
__ My oral health would improve and be easier to maintain
__ Other, please explain: _____

5. **What would you like to improve about your smile? (check all that apply)**
__ I would like whiter, brighter teeth.
__ I would like to get rid of gaps between teeth.
__ I would like to repair chipped or broken teeth.
__ I would like to replace missing teeth.
__ I would like to straighten my teeth
__ I would like to improve my oral health routine

6. **Do you ever have any tooth pain or discomfort? If yes, please explain?**
_____
_____
_____

North Atlanta
FAMILY DENTISTRY
Sandra L. Vargas, DMD
678-474-4917 Duluth
770-781-0888 Cumming

FINANCIAL POLICY

Dental treatment is an excellent investment in your medical and psychological well being. Financial considerations should not be an obstacle to obtaining healthcare. If your insurance company rejects a claim and refuses to pay for treatment, it is not a reflection of how important the treatment is to your health.

Please note our agreement is solely with you, NOT your insurance company. If your insurance company refuses to pay or pays less than estimated your are responsible to pay the remaining balance. You must remember that dental insurance is designed to offset the cost of your dental treatment. You are responsible for the cost of your treatment and any insurance reimbursement conflicts. Our staff will help you to the best of our ability to obtain your maximum benefits and provide estimates, but we strongly advise you, as our patient, to familiarize yourself with your dental coverage and your benefits. ***Ultimately, you are responsible for the understanding and awareness of the usage and availability, your benefits and provider network participation.***

We provide the following payment options, being sensitive to the fact that each patient has different needs in fulfilling his/her financial obligations: we accept Cash, Visa, MasterCard, Discover, and American Express. *Please note:* ***we do not accept personal checks.***

1. We offer extended payment plans through Care Credit and Lending Club.
2. Please note that payment is due at the time of service.
3. In Workman's Comp cases we will work directly with your employer and workman comp insurance provider.

To avoid increased fees to all patients, any account balance over 60 days will be assessed a Late fee of $25.00. Accounts over 90 days past due will be transferred to a collection agency for credit notification and debt collection. Accounts transferred to collections will be assessed any court fees and additional collection costs.

Please note: Our office has a 48 hour cancellation policy. Your appointment is time reserved especially for you to provide you with outstanding care for your dental needs. We strive to provide you with a courtesy reminder via e-mail, text or a phone call; however, it is ultimately your responsibility to remember your dental appointment. Please take note that there is a $25.00 fee for appointments cancelled with less than 48 hours notice. Any appointments missed on Saturdays will incur a $50 fee. If a patient has a history of Saturday missed appointments a deposit will be required to make a new Saturday appointment.

PATIENT'S SIGNATURE: _____ **DATE:** ___ / ___ / ___

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HIPAA Notification

This signing recognizes that I have read and understand the privacy policies regarding HIPAA. The HIPAA notice discusses the legal policies stating that our practice must not disclose any of our patient's health/medical information to any other party unless written authorization is received from that patient alone. If required by law, to report abuse, or for public health related injuries or illnesses, we may disclose your health/medical information.

Appointments will be confirmed over the phone, text message, e-mail, or in person in which case we may disclose your health/medical information to provide you with the proper information regarding your upcoming visit. Please note that before releasing any health/medical, and or financial information to a family member, friend, or other individual for your health care benefit, a signed and authorized form must be filled and signed by the patient themselves.

Please Sign_____

Con esta firma usted reconoce haber leído y entendido el aviso de las practicas de privacidad que se refieren a HIPAA (acto de la portabilidad y de la responsabilidad de su seguro medico de 1996).La preocupación esencial de HIPAA es proteger el uso y la divulgación de la información medica y registros administrativos de los pacientes, a menos que sea solicitado por algún paciente en particular. En situaciones específicas como casos de emergencia, abuso o enfermedad su información podría ser divulgada si es requerido por la ley.

Su citas serán confirmadas por teléfono, mensajes de texto, correo electrónico, o en persona. En este caso divulgaríamos su información con el propósito de recordarle su próxima visita. Antes de proporcionar cualquier información médica o financiera a cualquier miembro de su familia, amigo u otro individuo para su cuidado médico necesitaríamos su autorización firmada.

Firma_____