Satilla Family Dentistry

Welcome to Satilla Family Dentistry - Tell Us About Yourself

Name: _____
Last First MI Title

Preferred Name: _____ ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

SSN: _____ DOB: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-Mail Address: _____

Employer: _____ Occupation: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Domestic Partner

How did you hear about Satilla Family Dentistry? _____

Do you prefer to be contacted for appointment confirmation via e-mail or phone? *(Please circle preference)*

Insurance - Primary

Subscriber Name: _____ Relationship to Patient: _____ Subscriber DOB: _____

Subscriber SSN/ID: _____ Subscriber Employer: _____

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Company Phone: _____ Group Name: _____

Insurance - Secondary

Subscriber Name: _____ Relationship to Patient: _____ Subscriber DOB: _____

Subscriber SSN/ID: _____ Subscriber Employer: _____

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Company Phone: _____ Group Name: _____

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly Satilla Family Dentistry 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, including any finance charge of 18.5 % and recovery charges. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorized the use of this signature on all insurance submissions.

Responsible Party Signature: _____

Relationship: _____ Date: _____

Consent: I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

Patient/Guardian Signature: _____

Satilla
Family Dentistry

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: _____

Physician's Phone: _____

Date of last visit: _____

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: _____

Do you use tobacco in any form? ☐ Yes ☐ No

Have you had any metal rods, pins, or implants placed? ☐ Yes ☐ No

Are you taking any medications? ☐ Yes ☐ No

Please list each one: _____

Have you ever had any surgical procedures? ☐ Yes ☐ No

Please list each: _____

Yes	No	Conditions
☐	☐	Abnormal Bleeding
☐	☐	Alcohol Abuse
☐	☐	Allergies
☐	☐	Anemia
☐	☐	Angina Pectoris
☐	☐	Arthritis
☐	☐	Artificial Heart Valve
☐	☐	Asthma
☐	☐	Blood Transfusion
☐	☐	Cancer
☐	☐	Chemotherapy
☐	☐	Colitis
☐	☐	Congenital Heart Defect
☐	☐	Diabetes
☐	☐	Difficulty Breathing
☐	☐	Drug Abuse
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Facial Surgery
☐	☐	Fainting Spells
☐	☐	Fever Blisters
☐	☐	Frequent Headaches

Yes	No	Conditions
☐	☐	Glaucoma
☐	☐	HIV + AIDS
☐	☐	Heart Attack
☐	☐	Heart Murmur
☐	☐	Heart Surgery
☐	☐	Hemophilia
☐	☐	Hepatitis A
☐	☐	Hepatitis B
☐	☐	Hepatitis C
☐	☐	High Blood Pressure
☐	☐	Joint Replacement
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	Low Blood Pressure
☐	☐	Mitral Valve Prolapse
☐	☐	Pace Maker
☐	☐	Psychiatric Problems
☐	☐	Radiation Therapy
☐	☐	Rheumatic Fever
☐	☐	Seizures
☐	☐	Sexually Transmitted Disease
☐	☐	Shingles

Yes	No	Conditions
☐	☐	Sickle Cell Disease
☐	☐	Sinus Problems
☐	☐	Stroke
☐	☐	Thyroid Problems
☐	☐	Tuberculosis
☐	☐	Ulcers
☐	☐	Bisphosphonates

Yes	No	Allergies
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline

Yes	No	If Female, please answer
☐	☐	Are you taking Birth Control Pills?
☐	☐	Are you pregnant?
		Is so, # of Weeks: _____
☐	☐	Are you nursing?

Emergency Contact:

Name: _____ Relationship: _____

Address: _____ Phone: _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this informatio will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Printed Name: _____

Signature: _____ Date: _____

Satilla Family Dentistry

How can we help you today? _____

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

If so, why? _____

Are you currently in pain? ☐ Yes ☐ No

Have you ever had gum treatment? ☐ Yes ☐ No

Do you now or have you had any pain/discomfort in your jaw joint? (TMJ) ☐ Yes ☐ No

Are you under stress? (new job, moving, relationship) ☐ Yes ☐ No

Do you like your smile? ☐ Yes ☐ No

Is there anything you would like to change about your smile? ☐ Yes ☐ No

Are you happy with the color of your teeth? ☐ Yes ☐ No

Do your gums bleed? ☐ Yes ☐ No

How many times do you: floss/week?_____ brush/day? _____

Are your teeth sensitive to heat, cold, or anything else? ☐ Yes ☐ No

Have you lost any teeth? ☐ Yes ☐ No

Have you ever had a serious/difficult problem with any previous dental work? ☐ Yes ☐ No

Have you ever had any unfavorable dental experiences? ☐ Yes ☐ No

When was your last dental cleaning? _____

When was your last dental visit? _____

Why did you leave your previous dentist? _____

How can we accommodate you better during your dental visit? _____

Here at Satilla Family Dentistry we offer a wide variety of services to enhance and keep your smile beautiful. Please cirlce any services below you would like our friendly staff to discuss with you during your visit.

Tooth Whitening	Veneers	Night/Sport Guards
Sealants	Smile Makeover	Bonding
Partials/Dentures	Crown and Bridge	Implant Crowns

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You May Refuse To Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

Please Print Name

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice Of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please specifiy)

MISSED APPOINTMENT POLICY ACKNOWLEDGEMENT FORM

We are committed to the highest quality of care for all of our patients; therefore, we schedule all appointments in advance and make every attempt to confirm them one to two days in advance. When we schedule your dental visit, that time belongs to you and you deserve our undivided attention.

We value our relationship with you and want to be fair**. However, if you are unable to keep an appointment the following will apply:**

- We require a 2 business day notice if you need to cancel or reschedule.
- Three missed appointments may result in dismissal from the practice.
- Three same day cancelled or rescheduled appointments may result in dismissal from the practice.

Our staff is dedicated personally and professionally, to give you the concern, respect and care that makes our office a comfortable place to visit. We ask that you please call if you cannot keep your scheduled appointment time.

By signing below, you have read, and understand this agreement.

Patient Name_____

Signature_____ Date_____