

# Augusta SmileCare Patient Health Record

Date\_\_\_\_\_

Dr. Mr. Mrs. Ms.\_\_\_\_\_

Email\_\_\_\_\_

Address\_\_\_\_\_

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Home Phone\_\_\_\_\_ Work Phone\_\_\_\_\_ Cell  
Phone\_\_\_\_\_

Birthdate\_\_\_\_\_ Sex\_\_\_\_Marital  
Status\_\_\_\_\_Occupation\_\_\_\_\_

Social Security #\_\_\_\_\_Emergency Contact Name/Number  
\_\_\_\_\_

Whom may we thank for referring you to us?\_\_\_\_\_

## Medical Health

What is your general state of health? Excellent\_\_\_\_Good\_\_\_\_Fair\_\_\_\_Poor\_\_\_\_

Name and address and phone # of physician\_\_\_\_\_

Have you been under a physician's care during the last year?\_\_\_\_\_

Have you been treated in a hospital in the past two years?\_\_\_\_\_

Have you had major surgery?\_\_\_\_\_

History with general or IV anesthesia?\_\_\_\_\_ If Female: Are you pregnant or  
nursing?\_\_\_\_\_

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

Epilepsy/seizures\_\_\_\_\_ Kidney Problems\_\_\_\_\_ Cancer \_\_\_\_\_ Chemotherapy\_\_\_\_\_  
Radiation\_\_\_\_\_

Fainting/dizziness\_\_\_\_\_ Bruise/Bleeds easily\_\_\_\_ Stroke\_\_\_\_\_ Heart Problems\_\_\_\_\_ Chest  
Pain\_\_\_\_\_

Persistent Cough\_\_\_\_\_Emphysema\_\_\_\_\_Bronchitis\_\_\_\_\_Tuberculosis/PPD+\_\_\_\_\_  
Asthma\_\_\_\_\_

Sinus Problems\_\_\_\_\_ Anemia/Sickle Cell\_\_\_\_\_ Hepatitis\_\_\_\_\_ Liver Disease\_\_\_\_\_  
Pneumonia\_\_\_\_\_

Irregular Heart Beat\_\_\_\_\_ High Blood Pressure \_\_\_\_\_Rheumatic Fever\_\_\_\_\_ Heart Murmur\_\_\_\_\_

Mitral Valve Prolapse \_\_\_\_\_ Congenital Heart Lesions\_\_\_\_\_ Heart Surgery\_\_\_\_\_ Artificial Heart Valves\_\_\_\_\_

Pacemaker\_\_\_\_\_ Fibromyalgia\_\_\_\_\_ Venereal Disease\_\_\_\_\_ Thyroid Disease\_\_\_\_\_ AIDS/HIV+\_\_\_\_\_

Artificial Joints\_\_\_\_\_ Diabetes\_\_\_\_\_ Organ Transplants\_\_\_\_\_ Osteoporosis/penia\_\_\_\_\_ Snoring\_\_\_\_\_

Sleep Apnea\_\_\_\_\_ Dry Mouth\_\_\_\_\_ Tobacco Use\_\_\_\_\_ Anxiety\_\_\_\_\_ Arthritis\_\_\_\_\_

Do you have any condition, disease, or problem not previously listed?

\_\_\_\_\_  
\_\_\_\_\_

Please list all the medications you are taking, including over the counter drugs and herbs

Medications:	Dosage:	Times/day	Medications:	Dosage:
Times/day				

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you allergic to: Penicillin\_\_\_\_\_ Codeine\_\_\_\_\_ Local anesthetics \_\_\_\_\_ Latex \_\_\_\_\_ Other \_\_\_\_\_

### Dental Health

When was your last dental visit?\_\_\_\_\_ How often did you see your dentist?\_\_\_\_\_

Are you having any dental problems that require immediate attention?\_\_\_\_\_

Do you have frequent headaches?\_\_\_\_\_ Ear Aches?\_\_\_\_\_ How often?\_\_\_\_\_

Is there anything that will cause your muscles to be tired or sore or cause headaches?\_\_\_\_\_

Are your jaw joints painful or tender?\_\_\_\_\_ If yes, please describe\_\_\_\_\_

Have you had trauma to your jaw?\_\_\_\_\_ Do your jaw joints pop or click or grate?\_\_\_\_\_

Do your jaws ever feel tired or ache?\_\_\_\_\_ Have you ever been told you have TMJ?\_\_\_\_\_

Do you clench or grind your teeth?\_\_\_\_\_Does your bite feel comfortable?\_\_\_\_\_

Has there been a change in your bite?\_\_\_\_\_Have you ever been told that you have periodontal disease?\_\_\_\_\_

Have you ever had periodontal treatment?\_\_\_\_\_Do your gums bleed while cleaning?\_\_\_\_\_

Do your gums ever feel tender or swollen?\_\_\_\_\_How often do you brush?\_\_\_\_\_floss?\_\_\_\_\_waterjet\_\_\_\_\_

Do any of the following cause tooth discomfort?  
Hot\_\_\_\_\_Cold\_\_\_\_\_Sweets\_\_\_\_\_Chewing\_\_\_\_\_

Have you noticed any changes in your teeth?\_\_\_\_\_

Do you have loose teeth?\_\_\_\_\_Worn teeth?\_\_\_\_\_Broken or chipped teeth?\_\_\_\_\_Food Traps?\_\_\_\_\_

Can you chew on both sides of your mouth?\_\_\_\_\_Comfortably?\_\_\_\_\_

Do you lose fillings or break fillings?\_\_\_\_\_Do you usually have cavities?\_\_\_\_\_

Have you ever had orthodontic treatment?\_\_\_\_\_When?\_\_\_\_\_Do you have missing teeth?\_\_\_\_\_

Have they been replaced?\_\_\_\_\_Do you have a fixed bridge?\_\_\_\_\_Removable partial?\_\_\_\_\_

Full dentures?\_\_\_\_\_Dental Implants?\_\_\_\_\_Are you comfortable with the replacement?\_\_\_\_\_

How do you feel about the appearance of your smile?\_\_\_\_\_

What improvements would you like to make in your mouth?\_\_\_\_\_

Please add anything you feel is important  
\_\_\_\_\_

Signature\_\_\_\_\_date\_\_\_\_\_

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# FINANCIAL INFORMATION

**GUARANTOR INFORMATION:** Relationship to Patient: Self\_\_\_ Spouse\_\_\_ Other\_\_\_

Name:\_\_\_\_\_ Address:\_\_\_\_\_

Social Security#\_\_\_\_\_ Birthdate\_\_\_\_\_ Phone#:\_\_\_\_\_ Work#:\_\_\_\_\_

## **INSURANCE INFORMATION:**

*Primary Insurance:* \_\_\_\_\_ ID #\_\_\_\_\_ Group#\_\_\_\_\_

Insurance Plan Address:\_\_\_\_\_ Insurance Plan Phone #\_\_\_\_\_

Name of Insured:\_\_\_\_\_ Relationship to Patient:\_\_\_\_\_

Insured's Birth Date\_\_\_\_\_ Insured Address:\_\_\_\_\_

Insured's Employer Name:\_\_\_\_\_ Employer Address:\_\_\_\_\_

*Secondary Insurance:* (United Concordia Subscribers Only)

United Concordia : \_\_\_\_\_ ID# \_\_\_\_\_ Group# \_\_\_\_\_

Insurance Plan Address:\_\_\_\_\_ Insurance Plan Phone #\_\_\_\_\_

Name of Insured:\_\_\_\_\_ Relationship to Patient:\_\_\_\_\_

Insured's Birth Date\_\_\_\_\_ Insured Address:\_\_\_\_\_

Insured's Employer Name:\_\_\_\_\_ Employer Address:\_\_\_\_\_

## **FINANCIAL POLICY:**

Thank you for choosing Augusta SmileCare as your healthcare provider. We are committed to your treatment being successful. Please understand that payment of your bill is an integral part of your treatment. The following is a statement of Augusta SmileCare's Financial Policy, which we require you to read and sign prior to any treatment. \_\_\_\_\_Initial

**Payment in full is expected at the time of service. We accept cash, checks, Visa, Mastercard, Discover, and American Express. We offer extended payment plans with proper credit approval.**

\_\_\_\_\_Initial

**Prior to the initiation of any dental treatment, you must have an approved and signed financial agreement in place.** \_\_\_\_\_Initial

Any account with a balance over 90 will be turned over to collection receivables. The patient will pay all collection fees incurred in an effort to obtain payment. Non-sufficient funds fees for returned checks will be \$50.00. \_\_\_\_\_Initial

**REGARDING INSURANCE:** As a courtesy to our patients, we will accept assignment of benefits from most insurance companies, provided you meet all deductibles and co-insurance. It is important that you understand that your insurance policy is a contract between you, your employer, and the insurance company. Dr. John Massey is not a party to the contract. It is important that you understand your insurance benefits. Our office will be glad to assist you if you have any questions concerning your deductibles or coverage. \_\_\_\_\_Initial

If your insurance company has not paid your account in full within 60 days from the date of service, the balance will be due in full by you. Our office will continue to help you receive reimbursement from your insurance if this becomes necessary. Please be aware that some, and perhaps all, of the services provided may be considered non-covered services by your insurance company and not considered reasonable and necessary under your insurance plan's benefits. This does not release you of your financial responsibility. \_\_\_\_\_Initial

A finance charge will be added to all accounts not paid in full by 60 days, and for each billing cycle that follows. \_\_\_\_\_Initial

Regarding insurance plans where we are the participating provider, all co-insurance and deductibles are due prior to treatment. In the event that your insurance coverage changes to a plan where we are not a participating provider, refer to the above paragraphs. \_\_\_\_\_Initial

Our practice is committed to providing the highest quality of care for our patients. You are responsible for payment in full, regardless of any insurance company's arbitrary determination of usual and customary fees. Our fees are based on treatment received and not based on outcome. \_\_\_\_\_Initial

**MINOR PATIENTS:**

Then adult accompanying the minor and the parents (or guardians) are responsible for full payment and consent. If the adult accompanying minor is not the parent, a signed consent form from the parent or legal guardian must be signed and presented each visit for treatment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved method of payment by the parent or guardian. \_\_\_\_\_Initial

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns. I have read and have been given the opportunity to ask questions about the financial policy. \_\_\_\_\_Initial

Responsible party's signature:\_\_\_\_\_ Date:\_\_\_\_\_

# Informed Consent

INITIAL DIAGNOSTIC PROCEDURES: In order to help formulate treatment recommendations, the following diagnostic procedures may be performed: 1) a medical and dental history, 2) discussion of your dental problems, concerns, and desires, 3) necessary x-rays, 4) plaster casts of mouth and teeth, 5) examination of the mouth and associated structures, 6) photographs, and 7) conference with previous or concurrent treating health professionals. If additional diagnostic procedures or consultations are indicated, then they will be discussed with you. \_\_\_\_\_Initial

TREATMENT RECOMMENDATIONS: Are based on information gained from initial diagnostic procedures and previous experience and may vary for similar situations. The ultimate goal of treatment is to assist you in attaining optimum dental health and appearance. We will discuss with you the most appropriate and ideal treatment plan as well as reasonable alternative treatment plans. In those instances where supporting structures are compromised, recommendations can only be made after consultation with specialists. We will also inform you of a likely dental prognosis for each of these treatment plans and treatment prognosis if no treatment is initiated at this time. . \_\_\_\_\_Initial

REFERRAL TO OTHER SPECIALISTS: Dental restorative and prosthodontic treatment often require concurrent treatment with other specialties such as: Endodontics, Periodontics, Orthodontics, Oral Surgery, and Medical Doctors. \_\_\_\_\_Initial

ANESTHETICS: Most procedures are performed with a local anesthetic. In addition, sedative and pain medications both oral and IV can be used to help minimize anxiety and discomfort. In rare instances, allergic reactions may occur, so you are requested to inform our office staff of any known allergies you may have. Risks may include, but are not limited to numbness, inflammation of veins used for IV administration of medication, discoloration around the injection site, swelling, infection, bleeding, nausea, and vomiting. Some sedative or pain medications may cause drowsiness. Therefore, when these medications are used, you would need to make arrangements for transportation. This means that you as the patient cannot drive to or from our office on the day of your procedure. \_\_\_\_\_Initial

DENTAL PROCEDURE DURING PREGNACY: Elective procedures or procedures that can easily be postponed should generally wait until after childbirth. Treatment of dental pain and urgent procedures can be performed with relative safety to the fetus by minimizing the use of medications with known fetal effects. Therefore it is essential that you inform Dr. Massey of a confirmed or suspected pregnancy. You may be required to provide consent from your OB/GYN for treatment and necessary radiographs. \_\_\_\_\_Initial

MEDICAL HISTORY: I understand the medical and dental history is necessary to provide you as the patient with dental treatment in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective healthcare provider on my medical history. I will notify Dr. Massey of any change to my health or medication prior to treatment. \_\_\_\_\_Initial

TREATMENT: Upon such diagnosis, I authorize Dr. Massey or the designated staff person to perform all recommended treatment mutually agreed upon and to employ such assistance as required providing proper care. \_\_\_\_\_Initial

INFORMED CONSENT AND AUTHORIZATION: I certify that I have read and understand this *Informed Consent*, which outlines the general treatment considerations as well as the potential problems and complication of dental treatment. I understand that potential complications and problems may include, but are not limited to, those described in this document and discussed with me. I understand that during and following treatment, and in the future, conditions may become apparent that warrant additional or alternative treatment pertinent to the success of comprehensive treatment. Recognizing the potential

problems and risks of dental treatment, authorization is given for dental treatment to be rendered by the dentist and office staff. I also approve any modification in design, materials, or care, if it felt this is for my best interest. This consent is in force indefinitely unless revoked by me in writing. \_\_\_\_\_Initial

CONTACTS: I also give my permission to have Augusta Smile Care personally contact me and remind me of needed appointments through the U.S. mail, email, and voice messages. \_\_\_\_\_Initial

PAYMENT: I agree to be responsible for payment of all services rendered on my behalf or dependants. I understand that payment is due at the time of service unless other arrangements have been made. I authorize payment directly to Dr. Massey of any insurance benefits otherwise payable to me. I authorize the release of any information relating to dental claims. Secondary insurance is not filed by this office unless you have United Concordia insurance as your secondary. Our office will provide you with all the essential information in order to help you file your secondary insurance yourself. If your insurance has not paid your insurance claim within 90 days, the balance remaining on the account will be the guarantor's responsibility and full payment will be expected. Our office will continue to help you receive reimbursement from your insurance company if this becomes necessary. \_\_\_\_\_Initial

PURPOSE OF CONSENT: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. \_\_\_\_\_Initial

BROKEN APPOINTMENT POLICY: Appointments in our office are reserved exclusively for each patient and are customized for your individual needs. We require a two business day notice day for cancellation or rescheduling of an appointment. If an appointment is changed less than two business days there is a \$35.00 charge for hygiene reservations and a \$50.00 charge per hour for reservations with Dr. Massey. Please use consideration when changing a last minute appointment as our office will also if an emergency was to arise at the last minute. \_\_\_\_\_Initial

NOTICE OF PRIVACY PRACTICES: You have the right to read our Notice of Privacy before you decide whether to sign this Consent. Our Notice provides a description of our treatment payment, activities, and healthcare operations, and of the uses and disclosures we may make of your protected health information. A copy of our Notice accompanies this consent. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices as stated in our Notice of Privacy Practices. You may obtain a copy of our Notice of Privacy Practices, including any revision of our Notice, at anytime by contacting: **Business Manager:** 4424 Columbia Rd Suite D Martinez, GA 30907706-868-1322\_\_\_\_\_Initial

RIGHT TO REVOKE: You have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact person listed above. Please understand that revocation of this consent will not affect any action we took in reliance of this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent. \_\_\_\_\_Initial

SIGNATURE: I \_\_\_\_\_, have had full opportunity to read and consider the contents of this Consent form and Notice of Privacy Practices. I understand that by signing this Consent form, I am giving my consent to use and disclose my protected health information to carry out treatment, payment activities, and healthcare operations.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

If this Consent is signed by a personal representative on behalf of the patient (child), complete the following:

NAME/RELATIONSHIP TO PATIENT: \_\_\_\_\_

# Augusta SmileCare

## PERSONAL DENTAL NEEDS SURVEY

Name: \_\_\_\_\_

Date: \_\_\_\_\_

**\*Please rate on a scale of 1 to 5 the importance of watch of the following regarding your dental care. (The most important would be #1)**

\_\_\_ Preventative Dental Health Care

\_\_\_ Freedom from pain

\_\_\_ Excellence and Quality of Service

\_\_\_ Cost and Affordability

\_\_\_ Other \_\_\_\_\_

**\*Please rate, as above, what a dentist has to do to gain your confidence.**

\_\_\_ Show me what he/she is doing pr need to do so I can clearly understand what is happening.

\_\_\_ Listen to my concerns and explain thoroughly the procedure to be preformed.

\_\_\_ Make sure I feel comfortable and informed at all times.

**\*Please circle the level of fear you have about your dental visits (10 being the greatest fear).**

1    2    3    4    5    6    7    8    9    10

**\*I would like to know about these options available to me for maximizing my comfort and my experience during my visit (check all that apply).**

\_\_\_ Music and Earphones

\_\_\_ Sedative Medications

\_\_\_ IV Sedation

\_\_\_ Patient Education

Materials

**Are you concerned about the following? (Yes or No)**

\_\_\_ Existing discomfort?

\_\_\_ Whitening your teeth?

\_\_\_ Replacing old silver fillings?  
smile?

\_\_\_ Appearance of my

\_\_\_ Recurring or untreated gum disease?

\_\_\_ Prevention of decay?

\_\_\_ Mouth odor?

\_\_\_ Other \_\_\_\_\_