Augusta SmileCare
Family • Cosmetic • Implant
4424 Columbia Road, Suite D
Martinez, GA 30907
augustasmilecare@bellsouth.net
Office: 706-868-1322
Toll free: 1-877-868-1322
Fax: 706-650-1061

PATIENT HEALTH RECORD

Date_____ Dr. Mr. Mrs. Ms._____ E-mail_____

Address_____City_____State_____ Zip_____

Home Phone_____Work Phone_____Cell Phone_____

Birthdate_____ Sex_____ Marital Status_____ Occupation_____

SSN_____ Emergency, Contact Name, and Number_____

Whom/what may we thank for referring you? _____

If by search engine what key words did you use? _____

MEDICAL HEALTH

What is your general state of health? Excellent_____ Good_____ Fair_____ Poor_____

Name and phone number of your Physician_____

Have you been under a physician care during the last year?_____

Have you been treated in a hospital?_____

Have you had major surgery within the last year?_____

History with general or IV anesthesia?_____ If female, Are you pregnant or nursing?_____

Do you or have you had any of the following?

Epilepsy/Seizure_____	Kidney Problems_____	Cancer_____	Chemotherapy_____
Radiation_____	Fainting/Dizziness_____	Bruise/Bleeds easily_____	Stroke_____
Heart Problems_____	Chest Pains_____	Persistent Coughing_____	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_____	Artificial Heart Valve_____	Heart Surgery_____
Pacemaker_____	Fibromyalgia_____	Venereal Disease_____	Thyroid Disease_____
Artificial Joints_____	Organ Transplants_____	Diabetes____	AIDS/HIV+_____
Osteoporosis/Penia_____	Snoring_____	Sleep Apnea_____	Dry Mouth_____
Tobacco Use_____	Anxiety_____	Arthritis_____	

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

_____

_____

*Are you allergic to: Penicillin_____ Codeine_____ Local Anesthetics_____ Latex_____ Other_____

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

Medications	Dosage	Times/Day	Medications	Dosage	Times/Day

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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?_____ Do your gums bleed while cleaning?_____

Have you ever been told that you have periodontal disease?_____

Have you had periodontal treatment?_____ Do your gums feel swollen or tired?_____

How often do your brush?_____ Floss?_____ Waterjet?_____

Do any of the following cause tooth discomfort? Hot_____ Cold_____ Sweets_____ Chewing_____

Have you notices any changes in your teeth?_____

Do you have loose teeth?_____ Worn Teeth?_____ Broken or chipped? _____ Food Traps?_____

Can you chew on both side of your mouth?_____ Comfortably?_____

Do you lose or break fillings?_____ Do you usually have cavities?_____

Have you ever had orthodontic treatment?_____ When?_____

Do you have missing teeth?_____ Have they ever been replaced?_____

Do you have a fixed bridge?_____ Removable partial?_____ Full Denture?_____

Dental Implants?_____ Are you comfortable with the replacements?_____

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

What improvements would you like in your mouth?_____

Please add anything your feel is important._____

Signature_____ **Date**_____

FINANCIAL INFORMATION

Guarantor Information: Relationship to Patient: Self _____ Spouse _____ Other _____

Name: _____Address:_____City_____ State____

SSN#_____ Birth Date_____ Phone#_____ Work#_____ Zip_____

Dental Insurance Information:

- *Primary Insurance:* _____ ID#_____ Group# _____

Address: _____ City_____ State_____ Zip_____ Phone# _____

Name of Subscriber/Policy Holder _____ Relationship to Patient _____

Subscriber Birth Date_____ Address: _____ City_____ State_____ Zip_____

Subscriber's Employer_____ Employer's Address_____

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- *Secondary Insurance:* _____ ID#_____ Group# _____

Address: _____ City_____ State_____ Zip_____ Phone# _____

Name of Subscriber/Policy Holder _____ Relationship to Patient _____

Subscriber Birth Date_____ Address: _____ City_____ State_____ Zip_____

Subscriber's Employer_____ Employer's Address_____

Medical Insurance Information:

Medical Insurance: _____ ID#_____ Group# _____

Address: _____ City_____ State_____ Zip_____ Phone# _____

Name of Subscriber/Policy Holder _____ Relationship to Patient _____

Subscriber Birth Date_____ Address: _____ City_____ State_____ Zip_____

Subscriber's Employer_____ Employer's 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 of the estimate patient portion of all procedures is expected at the time of service. We accept cash, check, Visa, MasterCard, Discover, American Express, and Care Credit. We offer extended payment plan options with proper credit card 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 60 days will be turned over our third party collections agency. The patient will pay all collection fees incurred in an effort to obtain payment. _____ **Initial**

Non-sufficient fund fees s for returned checks will be $50. _____ **Initial**

REGARDING INSURANCE: As a courtesy to our patients, we will accept assignment of benefits from most insurance companies, providing you meet all deductible and co-insurances. It is important that you understand that *your insurance policy is a contract between you, your employer, and the insurance company Dr. Massey is not a part of that 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 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 reasonable and necessary under your 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 you 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**

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**

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

Responsible Party Signature_____ Date_____

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INFORMED CONSENT

Initial Diagnostic Procedure: 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 without 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 medication 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 medication can 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 Procedures During Pregnancy: Elective procedure or procedures that can easily be postponed should generally wait until after childbirth. Treatment of dental plan 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 may have my permission to ask the respective healthcare provider of my medical history. *I will notify Dr. massed of any changes 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 proper care. _____ **Initial**

Informed Consent and Authorization: I certify that I have read and understand the Informed Consent, which outlines the general treatment considerations as well as the potential problems and complications of dental treatment. I understand that potential complications and problem 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 felt this is for my best interest. This consent is in force indefinitely unless revoked by me in writing. _____ **Initial**

Contacts: I also give permission to have Augusta SmileCare 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 dependents. 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 relation to dental claims. Secondary is not filed by this office unless you have United Concordia as your secondary. *If your insurance has not paid you 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 for cancellation or rescheduling* of an appointment. If an appointment is changed less than two business days there is *a $35 charge for hygiene reservation* and *$50 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 out 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 out Notice of Privacy Practices, including any revision of our Notice, at any time by contracting: **Business Manager:** 4424 Columbia Rd Suite D Martinez GA 30907 (706)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 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 the 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/Signature:_____ Relationship to Patient: _____

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Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

How Your Health Information May Be Used To Provide Treatment:

We will use your health information within our office to provide you with the best possible dental care. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between hygienist, dental assistant, dentist and business office staff. In addition, we may share your health information with the physicians, referring dentist, clinical and dental laboratories, pharmacies, or other health care personnel providing your treatment.

To Obtain Payment:

We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

To Conduct Health Care Operations:

Your health information may be used in performance evaluations of our staff. Health information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as a part of their quality assurance and quality reviews. Your health information may be reviewed during the routine process of certification, licensing or credentialing activities.

In Patient Reminders:

Because we believe regular care is very important to oral and general health, we will remind you of a scheduled appointment or that it is time for you to contact us to make an appointment. We may contact you to follow up on your care and inform you of treatment options. These may include postcards, letters, telephone reminders, or electronic reminders (e-mail).

Abuse or Neglect:

We will notify government authorities if we believe a patient is the victim of abuse, neglect, or domestic violence. We will make this disclosure when compelled by our ethical judgment, required by law, or with the patient's agreement.

Public Health or National Security:

We may be required to disclose to federal officials or military authorities health information necessary to complete an investigation related to public health or national security.

For Law Enforcement:

As permitted or required by state or federal law, we may disclose your health information to law enforcement officials for certain law enforcement purposes, such as if you are a victim of a crime or in order to report a crime.

Family Friends or Caregivers:

We may share your health information to those you tell us will be helping you with your home hygiene, treatment, medications, or payment. In case of an emergency we will use our best judgment when sharing your information to those assisting in providing your care.

Authorization to Use or Disclose Health Information:

Other than what is stated above or where federal, state or local law requires us. You may revoke this authorization at any time in writing.

Patient Rights:

You have the right to request restrictions; our office will make every effort to honor reasonable restrictions. You may request that we only communicate with you and no other family members. You have the right to read, review and copy your health information, including complete chart, x-rays and billing records. There will be an additional charge to duplicate and assemble your copy. You have the right to amend your information if they are incorrect or incomplete. We will be happy to accommodate you as long as we maintain this information and you provide us with a reason for the change. You have the right to request how and where your information was used by our office for any reason other than for treatment, payment, or health operations. You have the right to obtain a copy of this notice. We are required by law to maintain the privacy of your health information. We are required to practice these policies but we do reserve the right to change the terms of our notice. You have the right to express complaints to the Secretary of Health and Human Services if you feel your rights have been compromised. Please let us know any concerns or complaints in writing.

Patient or Guardian Signature: _____ Date: _____

**Additional Persons Authorized To View/Discuss Your P.H.I.

Name: _____ Number: _____

Name: _____ Number: _____