MEDICAL DENTAL HISTORY

Welcome to our office. We will do our best to make your appointments as convenient and pleasant as possible. If at any time you have any questions regarding your treatment, your appointments, or fees, please feel free to ask.

In order to safeguard your health, it is important that you answer the following questions. Please remember that the answers to these questions are held in strict confidence.

NOTE: If patient is a minor, write name and relationship of responsible adult-address and occupation will pertain to responsible adult.

NAME _____ OCCUPATION _____

HOME ADDRESS _____ EMPLOYED BY _____

_____ MARITAL STATUS: _____

BUSINESS ADDRESS _____ S/S # _____

HOME TELEPHONE _____ AGE _____ BIRTHDATE _____ SEX _____ BUS. TEL. _____

WHOM MAY WE THANK FOR REFERRING YOU TO US? _____

NAME AND ADDRESS OF FAMILY PHYSICIAN _____

HUSBAND OR WIFE'S NAME _____

EMPLOYED BY _____ BUS. TEL. _____

BUSINESS ADDRESS _____ S/S # _____

ARE YOU PRESENTLY UNDER MEDICAL TREATMENT? ...yes no *If yes, please explain* _____

_____

IF YOU ARE TAKING THE FOLLOWING MEDICATIONS, *Please Circle*

Heart Medication	*Nitroglycerin*	*Pain Medication*	*Thyroid Medication*	*Antihistamines*	*Anticoagulants (Blood Thinner)*
Birth Control Pills	*Weight control medicine*	*Allergy Medication*	*Diuretics*	*Insulin*	*Aspirin*
Blood pressure Medication	*Immunosupressants*	*Tranquilizers*	*Cortisone (steroids)*	*Digitalis*	*Antibiotics/Sulphur drugs*

ANY OTHER MEDICATIONS (please list) _____

FOR OFFICE USE ONLY

MEDICATION	DOSAGE	DATE BEGAN	DATE ENDED	MEDICATION	DOSAGE	DATE BEGAN	DATE ENDED

HAVE YOU HAD ANY MAJOR OPERATIONS? *yes no If yes, please explain* _____

_____

HAVE YOU EVER BEEN TREATED FOR: *(please circle yes or no)*

Heart trouble	yes no	Bleeding problems	yes no	Sinus trouble	yes no
Congenital heart defect	yes no	Blood transfusion	yes no	Glaucoma	yes no
Heart murmur	yes no	Stomach problems	yes no	Skin problems	yes no
Artificial heart valves	yes no	Ulcers	yes no	Dizziness	yes no
Angina	yes no	Jaundice	yes no	Seizures	yes no
Heart attack	yes no	Liver disease	yes no	Epilepsy	yes no
Pacemaker	yes no	Kidney trouble	yes no	Nervous problems	yes no
Artificial joints	yes no	Respiratory or lung disease	yes no	Arthritis	yes no
Rheumatic fever	yes no	Emphysema	yes no	Cancer	yes no
AIDS or AIDS positive virus	yes no	Tuberculosis	yes no	Tumors/growths	yes no
High or Low blood pressure	yes no	Drug or alcohol addiction	yes no	Scarlet fever	yes no
Stroke	yes no	Psychiatric treatment	yes no	Allergies	yes no
Anemia or other blood disorder	yes no	Difficulty breathing	yes no	Asthma	yes no
AIDS Related Complex	yes no	Back or neck problems	yes no	Chronic cough	yes no

Venereal disease ..... *yes no* (Type) _____ (Date) _____

Hepatitis ..... *yes no* (Type) _____ (Date) _____

Please circle yes or no for the following questions:

HAVE YOU EVER BEEN REFUSED AS A BLOOD DONOR? . . . yes no If yes, please explain _____

HAVE YOU EVER BEEN TREATED WITH RADIATION/X-RAYS *(other than diagnostic)? yes no*

If so please explain _____

DO YOU HAVE A HISTORY OF FAINTING? . . . yes no If yes, please explain _____

DO YOU HAVE EXCESSIVE URINATION AND/OR THIRST? . . . yes no

DO YOU HAVE DIABETES? . . . yes no

Please circle yes or no to the following questions:

DO YOU WEAR CONTACT LENSES? . . . . yes no

DO YOU USE TOBACCO? . . . . yes no *(Type)* _____ *(Frequency)* _____

(WOMEN) ARE YOU PREGNANT? . . . . yes no DUE DATE _____

(WOMEN) ARE YOU NURSING? . . . . yes no

ARE YOU ALLERGIC TO:

Novocaine . . . . yes no Aspirin . . . . yes no Penicillin . . . . yes no

Sulfa drugs . . . . yes no Any other antibiotic . . . . yes no *(list)* _____

Any other medications, *(please list):* _____

Do you have any allergies or reactions to latex or any metals, such as nickel or costume jewelry? . . . . yes no

Are you allergic to any other substances? . . . . yes no *please list* _____

HAVE YOU EVER HAD A REACTION TO A LOCAL ANESTHETIC? . . . . . yes no

HAVE YOU EVER HAD NITROUS OXIDE *(laughing gas)* WITH DENTAL TREATMENT . . . . . yes no

HAS THE FEAR OF DENTAL TREATMENT EVER PREVENTED YOU FROM SEEKING DENTAL CARE? yes no

HAVE YOU EXPERIENCED ANY INJURY TO YOUR MOUTH, TEETH OR JAWS? . . . . . yes no

DO YOU EVER HAVE PAIN IN OR NEAR YOUR EARS? . . . . . yes no

DOES YOU JAW JOINT EVER POP, CLICK, HURT, OR LOCK? . . . . . yes no

DO YOU HABITUALLY CLENCH OR GRIND YOUR TEETH DURING THE DAY OR AT NIGHT? . . . . . yes no

HAVE YOU EVER HAD ORTHODONTIC TREATMENT? . . . . . yes no

IS ANY PART OF YOUR MOUTH SENSITIVE TO HOT, COLD, OR SWEETS? . . . . . yes no

DO YOUR GUMS BLEED? . . . . . yes no

HAVE YOU EVER HAD PERIODONTAL TREATMENT? . . . . . yes no

IF THERE IS ANYTHING ELSE RELATED TO YOUR HEALTH THAT IS NOT LISTED HERE, PLEASE EXPLAIN: _____

PERIODIC UPDATES

I HAVE REVIEWED MY MEDICAL-DENTAL HISTORY AND MADE THE NECESSARY CHANGES TO UPDATE IT AS OF THE DATE SIGNED BELOW:

SIGNED _____ DATE _____

SIGNED _____ DATE _____

SIGNED _____ DATE _____

SIGNED _____ DATE _____

PAYMENT POLICY: In compliance with the Truth in lending law here is our credit policy: It is customary to take care of fee at time service is rendered unless other arrangements have been made. To assist you with this we accept VISA and MasterCard credit cards.

On reconstruction cases (crown and bridge, partial, and dentures) 50% of the fee is due at first appointment and balance at time of insertion.

If you have dental insurance, we will accept assignment on that portion of your charges which are covered by insurance. However, it must be understood that you will be responsible for immediate payment of any deductible amount not covered by insurance; in addition, you will be responsible for any portion of the assigned amount not paid by your insurance company within 60 days.

_____ _____

_____ _____

If Dental Insurance assignment is accepted, I authorize payment directly to Drs. Harkins & Silliman of any group insurance benefits otherwise payable to me and agree to the release of information relating to this claim. I certify that the medical and dental history information is correct to the best of my knowledge and that I have read and accept the above credit policy terms.

I hereby authorize Drs. Harkins & Silliman and any of their designated employees, performing as allowed by the Georgia Dental Act, to take radiographs, administer treatment, local anesthetics, nitrous oxide sedation and to perform such procedures as may be deemed necessary or advisable in the diagnosis and treatment of my teeth, mouth and jaws.

_____ Social Sec. # _____ Date _____

Patient Signature (Guardian or parent if a minor)

ERIN K. HARKINS, D.M.D.
SCOTT B. SILLIMAN, D.M.D.

Family
Dentistry

Welcome to our office. It is our primary concern that your visit be as comfortable and as pleasant as possible. In order to provide the most prompt and 'individualized' treatment; please observe the following policies and requests.

APPOINTMENTS:

Please be on time for your appointment. A special amount of time has been reserved for your treatment. If you feel that you may be late, please call the office immediately. Patients that are 15 minutes late (or more) may need to be rescheduled. This is to insure that the following scheduled patients will be seen in a timely manner.

We require 24 to 48 hours notice if you must cancel or reschedule an appointment. If you Break an appointment or Cancel Short Notice you will be charged a $50.00 no show fee for each person booked. A deposit may be required before any other appointments are booked and then only one family member per day.

Because we treat patients individually and by appointment only, a significant amount of time is allowed for each patient. By notifying us immediately, this time can be give to another person who is in need of treatment.

There is a very strong correlation between broken appointments and rising health care costs. Therefore, in order for us to keep the cost of your dental care down, it is important for you to make your scheduled appointments.

INSURANCE:

We are happy to file your dental insurance for you. However, this service is provided as a courtesy.

It is your responsibility to keep track of insurance payments and communications. Your insurance company should send you an E.O.B. (Explanation of Benefits) following your treatment.

Any portion of the assigned amount not paid by your insurance company within 60 days is your responsibility. It is advisable that you contact your insurance carrier to find out why benefits were not covered. We will gladly reimburse you if your insurance company pays after this time and you have made an overpayment.

Please remember that dental insurance provides benefits. It does not guarantee payment for a service. We can call the insurance carrier to get a breakdown of coverage, but there is no guarantee that the actual coverage will be what we are quoted.

CHECK POLICY:

We accept pre-printed checks only.
There will be a $25.00 Charge on all returned checks.
We do not return checks through the bank once they have been returned for insufficient funds.
The account must be cleared by cash or money order.

Your cooperation with this policy will be greatly appreciated.

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Patient or Guardian Signature Date

Office Manager * Copy given upon request

9280 Highway 5/Suite C • Douglasville, Georgia • (770) 920-8067

ERIN K. HARKINS, D.M.D.
SCOTT B. SILLIMAN, D.M.D.
Family Dentistry

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name:_____

Address:_____

Telephone:_____ E-Mail:_____

Patient #:_____ Social Security #:_____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

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.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about 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 described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person(s): ERIN K. HARKINS, DMD / SCOTT B. SILLIMAN, DMD, LC

Telephone: 770-920-8067 Fax:_____

E-mail:_____

Address: 9280 Highway 5, Suite C, Douglasville, GA 30134

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person(s) listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received you revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature:_____ Date:_____

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

Personal Representative's Name:_____

Relationship to Patient:_____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.