FORSYTH
Dental Partners Inc.

Forsyth Dental Partners, Inc.
312 Tribble Gap Rd., Cumming, GA 30040
(770) 887-1399 • forsythdentalpartners.com

Patient Information

Name: _____
Preferred Name: _____
Birthdate: _____
Social Security #: _____
Address: _____
City/State/Zip: _____
Home Phone: _____
Work Phone: _____
Other Phone: _____
Sex: ☐ Male ☐ Female
Marital Status: ☐ S ☐ M ☐ W ☐ D
Other Family Members seen in the office:
include name and relation (parent, child, spouse)

_____
_____
_____

Referred by: _____
Doctor you plan to see: _____
Email: _____

Spouse/Parent/Emergency Info

Spouse (Parent's/Guardian's name if under 18):

_____
Spouse's Employer: _____
Spouse's Work #: _____

In case of an Emergency, please contact:

Name: _____
Relation to patient: _____
Home Phone: _____
Work Phone: _____
Other Phone: _____

Employer Information

Employer: _____
Employer's Address: _____

_____
_____
Employer Phone #: _____

Primary Dental Insurance

Insurance Company: _____
Address: _____
City/State/Zip: _____
Phone Number: _____
Group #: _____
Policy #: _____

Insured Name: _____
Patient's relation to insured: _____
Insured's Birthdate: _____
Insured's SS#: _____
Insured's Employer: _____

Person Responsible for Account

Name: _____
Billing Address: _____
Home #: _____ Work #: _____
SS#: _____

To the best of my knowledge, all above answers are correct. I am aware that I am responsible for all charges for services rendered on this account and that payment is due at the time of the service. I authorize the assignment of insurance benefits to the dentists.

Date: _____
Signature: _____

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Do you have, or have you had, any of the following diseases or medical problems?

Bleeding problems	☐ Y ☐ N	High blood pressure	☐ Y ☐ N	By-pass/Valve replacements	☐ Y ☐ N
Low blood pressure	☐ Y ☐ N	Heart attack	☐ Y ☐ N	Heart murmur	☐ Y ☐ N
Other heart problems	☐ Y ☐ N	Stroke	☐ Y ☐ N	Joint replacement	☐ Y ☐ N
Mitral valve prolapse	☐ Y ☐ N	Tumor or cancer	☐ Y ☐ N	Radiation treatment	☐ Y ☐ N
Diabetes	☐ Y ☐ N	Hepatitis	☐ Y ☐ N	Jaundice	☐ Y ☐ N
Kidney Problems	☐ Y ☐ N	Liver problems	☐ Y ☐ N	Arthritis	☐ Y ☐ N
AIDS/HIV	☐ Y ☐ N	Venereal Disease	☐ Y ☐ N	Glaucoma	☐ Y ☐ N
Thyroid problems	☐ Y ☐ N	Epilepsy	☐ Y ☐ N	Lung disease/ asthma	☐ Y ☐ N
Psychiatric treatment	☐ Y ☐ N	T. B./Tuberculosis	☐ Y ☐ N	Rheumatic Fever	☐ Y ☐ N
Alcohol/Drug problem	☐ Y ☐ N	Currently pregnant?	☐ Y ☐ N	Periodontal-Gum Surgery	☐ Y ☐ N
TMJ problems	☐ Y ☐ N	Osteoporosis	☐ Y ☐ N	Complications of dental treatment	☐ Y ☐ N

If you answered yes to any of the above questions, please explain further: _____

Do you have sleep apnea? ☐ Y ☐ N Do you snore? ☐ Y ☐ N Have you ever had a sleep study? ☐ Y ☐ N

Are you taking any medications or over the counter drugs? ☐ Y ☐ N If yes, please list each one:

_____

Are you taking any medications for Osteoporosis? ☐ Y ☐ N List meds: _____

Are you taking any medications to thin your blood? ☐ Y ☐ N List meds: _____

Physician's Name: _____ Phone: _____ Date of last visit: _____

Please list any serious medical conditions, hospitalization in the last two years, impending operations, or other medical or dental information that may possibly affect your dental treatment: _____

_____

Are you allergic to any of the following?

Latex ☐ Y ☐ N Codeine ☐ Y ☐ N Aspirin ☐ Y ☐ N Dental Anesthetics ☐ Y ☐ N Penicillin ☐ Y ☐ N

Other: _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence. It is my responsibility to inform this office of any changes in my medical status or personal information. I authorize the dental staff of Dr. Carpenter to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment. I authorize the release of any dental and medical information necessary to process insurance claims or to aid in the treatment by a specialist.

Signature: _____ Date: _____

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FINANCIAL AGREEMENT

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your responsibility. Please read and sign prior to seeing the doctor.

- We accept cash, check, VISA, Master Card, American Express and Discover.
- If needed, we are happy to extend payment over 4 months. Payments are made in 4 equal amounts monthly by an auto debit either on the 1st or the 15th of the month.
- We also provide a third party interest free payment plan through CareCredit®.

Payment is due at the time of service. Insurance will be accepted for the initial cleaning and exam appointments. However, payment is due at the time of service for initial emergency appointments.

On subsequent visits, we will accept your insurance if you obtain approval from our office staff prior to the date of service. We will file your insurance claims as a courtesy to you. Several insurance companies send the dental reimbursement checks directly to the patient. These payments are due immediately on your outstanding dental bill. By applying these payments promptly to your account, we will be able to continue to file your insurance. Otherwise, we will ask you to pay in full at the time of service and let your insurance company reimburse you. If your insurance company has not paid the full balance within 45 days, arrangements will need to be made with our office to satisfy this balance within 15 days. If your insurance company pays more than the balance due, we will refund the difference.

Insurance is a contract between you and your insurance company. We are not a party of this contract. We file insurance claims as a courtesy to our patients. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary charges", etc. other than to supply factual information as necessary. You are responsible for the timely payment on your account.

Appointment Confirmations: Please inform us of your preferred method of contacting you for appointment reminders.

- Email: _____
- Cell Phone Text: _____
- Telephone Messaging: _____

Broken Appointment Policy: We require a 48 hour notice to reschedule a reserve appointment. A broken appointment fee may be charged on broken appointments without sufficient notice.

Regarding minors: The adult accompanying a minor will be responsible for payment of services. Minors must always be accompanied by an adult.

Thank you for your understanding of our financial policy. Please let us know if you have any questions or concerns.

_____ _____

Signature Date

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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
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Patient is a minor and no parent/adult was available to sign
- Other (please specify)