WELCOME

Date: _____

Patient Information

Name: _____
Last First MI

Email address: _____

Mailing Address: _____

_____

Phone # (H)_____ (W) _____ (Other) _____

Can we call you at work? ☐ Yes ☐ No

Date of Birth: _____ Sex: ☐ Male ☐ Female SS#: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Minor

Occupation: _____ Employer: _____

Employer Address: _____ Phone: _____

How did you hear about our practice? _____

Emergency contact: Name: _____ Relation: _____ Phone #: _____

Phone #: (H) _____ (W) _____

Primary Care Physician: Name: _____ Fax Number: _____

Address: _____

_____

Financial Information

Name of person responsible for this account: _____

Relationship to patient (if other than self): _____ Phone # _____

License Number: _____

The Dental Office Of Lithonia

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ○ Yes ○ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ○ Yes ○ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ○ Yes ○ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ○ Yes ○ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ○ Yes ○ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ○ Yes ○ No _____
Are you on a special diet? ○ Yes ○ No
Do you use tobacco? ○ Yes ○ No
Do you use controlled substances? ○ Yes ○ No

Women: Are you
Pregnant/Trying to get pregnant? ○ Yes ○ No Taking oral contraceptives? ○ Yes ○ No Nursing? ○ Yes ○ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

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

AIDS/HIV Positive ○ Yes ○ No	Cortisone Medicine ○ Yes ○ No	Hemophilia ○ Yes ○ No	Radiation Treatments ○ Yes ○ No
Alzheimer's Disease ○ Yes ○ No	Diabetes ○ Yes ○ No	Hepatitis A ○ Yes ○ No	Recent Weight Loss ○ Yes ○ No
Anaphylaxis ○ Yes ○ No	Drug Addiction ○ Yes ○ No	Hepatitis B or C ○ Yes ○ No	Renal Dialysis ○ Yes ○ No
Anemia ○ Yes ○ No	Easily Winded ○ Yes ○ No	Herpes ○ Yes ○ No	Rheumatic Fever ○ Yes ○ No
Angina ○ Yes ○ No	Emphysema ○ Yes ○ No	High Blood Pressure ○ Yes ○ No	Rheumatism ○ Yes ○ No
Arthritis/Gout ○ Yes ○ No	Epilepsy or Seizures ○ Yes ○ No	High Cholesterol ○ Yes ○ No	Scarlet Fever ○ Yes ○ No
Artificial Heart Valve ○ Yes ○ No	Excessive Bleeding ○ Yes ○ No	Hives or Rash ○ Yes ○ No	Shingles ○ Yes ○ No
Artificial Joint ○ Yes ○ No	Excessive Thirst ○ Yes ○ No	Hypoglycemia ○ Yes ○ No	Sickle Cell Disease ○ Yes ○ No
Asthma ○ Yes ○ No	Fainting Spells/Dizziness ○ Yes ○ No	Irregular Heartbeat ○ Yes ○ No	Sinus Trouble ○ Yes ○ No
Blood Disease ○ Yes ○ No	Frequent Cough ○ Yes ○ No	Kidney Problems ○ Yes ○ No	Spina Bifida ○ Yes ○ No
Blood Transfusion ○ Yes ○ No	Frequent Diarrhea ○ Yes ○ No	Leukemia ○ Yes ○ No	Stomach/Intestinal Disease ○ Yes ○ No
Breathing Problem ○ Yes ○ No	Frequent Headaches ○ Yes ○ No	Liver Disease ○ Yes ○ No	Stroke ○ Yes ○ No
Bruise Easily ○ Yes ○ No	Genital Herpes ○ Yes ○ No	Low Blood Pressure ○ Yes ○ No	Swelling of Limbs ○ Yes ○ No
Cancer ○ Yes ○ No	Glaucoma ○ Yes ○ No	Lung Disease ○ Yes ○ No	Thyroid Disease ○ Yes ○ No
Chemotherapy ○ Yes ○ No	Hay Fever ○ Yes ○ No	Mitral Valve Prolapse ○ Yes ○ No	Tonsilitis ○ Yes ○ No
Chest Pains ○ Yes ○ No	Heart Attack/Failure ○ Yes ○ No	Osteoporosis ○ Yes ○ No	Tuberculosis ○ Yes ○ No
Cold Sores/Fever Blisters ○ Yes ○ No	Heart Murmur ○ Yes ○ No	Pain in Jaw Joints ○ Yes ○ No	Tumors or Growths ○ Yes ○ No
Congenital Heart Disorder ○ Yes ○ No	Heart Pacemaker ○ Yes ○ No	Parathyroid Disease ○ Yes ○ No	Ulcers ○ Yes ○ No
Convulsions ○ Yes ○ No	Heart Trouble/Disease ○ Yes ○ No	Psychiatric Care ○ Yes ○ No	Venereal Disease ○ Yes ○ No
			Yellow Jaundice ○ Yes ○ No

Have you ever had any serious illness not listed above? ○ Yes ○ No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Dental Insurance Information

Do you have Dental Coverage: ☐ Yes ☐No

Insurance Company: _____

Insurance Company address and phone # : _____

Policy Holders Name: _____

Policy Holders SSN: _____

Policy Holders Date of Birth: _____

Policy Holders Employer: _____

Group Number: _____ ID number: _____

Dental History

Previous Dentist: _____

Date of Last Visit: _____

How Many times do you brush daily: _____ Floss_____

Do you use electric toothbrush: _____

Do you wake up with soreness in your jaw? ☐ Yes ☐ No

Have you ever had gum disease therapy or deep cleaning? ☐Yes ☐ No

Do your gums bleed when brushing? ☐Yes ☐ No

What type of toothpaste do you use? _____

Do you suffer from bad breath? ☐ Yes ☐ No

Are any of your teeth sensitive? ☐ Yes ☐ No

Do you grind or clench your teeth? ☐ Yes ☐ No

Would you be interested in cosmetically replacing older dark fillings with new tooth colored restorations? ☐ Yes ☐ No

Would you be interested in teeth whitening? ☐ Yes ☐No

Are you deeply concerned about the finances required to return your mouth to excellent dental health? ☐ Yes ☐ No

If you could change anything about your smile what would it be? _____

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

This notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The Practice may condition receipt of treatment upon execution of this consent.

May we discuss your medical condition with any member of your family? YES NO
If YES, please name the members allowed:

_____

_____

_____

This consent was signed by:_____

Signature _____ Date:_____

Informed Consent Form For Treatment

You, the patient, have the right to accept or reject dental treatment recommended by the dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment. Please do not consent to treatment unless/until you discuss potential benefits, risks, and complications with the dentist and all your questions are answered. By consenting to treatment, you acknowledge your willingness to accept known risks and complications, no matter how slightly the probability of occurrence.
It is very important that you provide the dentist with accurate information before, during, and after treatment. It is equally important that you follow the dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dental specialists, and return for scheduled appointments. If you fail to follow the advice of the dentist, you may increase the chances of a poor outcome. If you are a woman on oral birth control medications, you must consider the fact that antibiotics might make oral birth control less effective. Please consult with your physician before relying on oral birth control medications if the dentist prescribes, or if you are taking antibiotics.

Examination and X-Rays
By signing this form, I understand that any dental visit may require radiographs (x-rays) in order to complete the examination, diagnosis, and/ or treatment plan.

Drugs, Medication, and Sedation
By signing this form, I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness, swelling, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). They may cause drowsiness and a lack of awareness and coordination, which can be increased by the use of alcohol or other drugs, including cannabis. I understand and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of the anesthetic medication and drugs that may have given to me in the office for my treatment. I understand that failure to take medications as prescribed for me may offer risks of continued or aggravated infection, pain, and/or potential resistance to affect treatment of my condition. I understand that antibiotics can reduce the effectiveness of oral contraceptives.

Changes In Treatment Plan
By signing this form, I understand that during treatment, it may be necessary to change or add procedures because of issues found while working on teeth that were not discovered during the initial examination; the most common being root canal therapy following routine restorative procedures. I give the dentist permission to make any or all changes and additions necessary.

I understand that dentistry is not an exact science, therefore the dental office cannot guarantee results. I understand that each dentist is an individual practitioner and is only responsible for the dental care rendered to me. I understand that the dentist is not responsible for any dental care provided to me by another dental or specialty office.

This form is intended to provide you with an overview of potential risks and complications. Please discuss the potential benefits, risks, and complications of recommended treatment with the dentist. Be certain the dentist has addressed all your concerns to your satisfaction before beginning treatment.

By signing this consent, I agree that I have read, understood, and accept the information stated above.

Patient Signature_____ **Date**_____

Print Patient Name_____

THE DENTAL OFFICE OF LITHONIA
7660 COVINGTON HIGHWAY, SUITE 1
LITHONIA, GEORGIA 30058

Office Policy Regarding Use of A Controlled Substance Prior to Dental Treatment

With more widespread use of Cannabis, commonly known as marijuana, we feel it is necessary to adopt an office policy regarding use of a controlled substance prior to dental treatment. We ask that the patient always be honest with our office with any drugs or supplements they are taking, including marijuana. Marijuana can interfere with other medications we use in the dental office. Use of a controlled substance can result in poor healing and effect your ability to consent to treatment. Cannabis can increase the risks of bleeding and complications after procedures such as cleaning, extractions, root canals, fillings, and implants. Cannabis comes in many different strains, each with a slightly different effect on the human body. Some can be higher in levels of THC, some cause increased anxiety while others have more sedative effects. The different modes of consumption(smoking, vaping, eating) results in different effects. Smoking and vaping have more of an immediate effect, while edibles can be less predictable such as lasting longer, and having a stronger effect.

The Dental Office Of Lithonia requires avoiding all controlled substance use, including Cannabis, at least 48 hours prior to any dental appointment. Please be honest and reschedule your appointment if you have used a controlled substance within the 48 hours prior to the appointment. We reserve the right to refuse treatment if use is suspected.

Please sign this form below to acknowledge you have read and been informed of this policy.

I have been advised of the risks of personal injury if I use a controlled substance prior to any dental procedure. I understand and voluntarily agree that I will not use any controlled substance, such as cannabis, within 48 hours of any dental appointment. I also understand that the dentist and/or staff has the right to refuse treatment if they suspect I am under the influence of a controlled substance.

Patient Name (Please Print)

Patient Signature **Date**

Dental Insurance Coverage

Patient Name_____

As a courtesy to our patients, we will file your insurance claims on your behalf. All insurance information must be COMPLETE and up to date if insurance is to be billed for you. Our office does verify coverage and benefits with your insurance company, but that does not mean it is a guarantee of payment. The patient will be responsible for any balance not covered by their insurance. It is the patient's responsibility to call their insurance company to check on their coverage prior to the appointment, as well as getting an explanation of benefits (EOB) or claims status/payments after the appointment.

I understand that I am responsible for payment for whatever my insurance does not cover or pay in full.

_____ _____

Signature Date

The Dental Office of Lithonia

7660 Covington Hwy

Lithonia, Georgia 30058

770-482-2964

Broken appointment policy and Cancelation policy:

Welcome to The Dental Office of Lithonia. Our policy is as follows:

When we book an appointment for you, as our patient, the appointment time is reserved just for you. Our office policy is for you to please call 24 hours in advance if you are unable to keep this scheduled appointment. If we do not hear from you to confirm or cancel your appointment within the 24 hours of your appointment and after our multiple attempts, we reserve the right to remove you from our schedule and fill that appointment slot with another patient. We will allow a one-time no show less than 24-hour notice of cancelation. After that a $50.00 broken appointment fee will be charged to your account. This fee will be due and payable by you prior to your next dental appointment.

We do understand that medical emergencies do occur. We will take these emergencies into consideration on a case by case basis. We value you as a patient and only ask that you value our time as well. However, you will be considered for termination from the practice once you have accumulated three no show or broken appointments. It is certainly our hope that it does not reach that point.

Thank you for your understanding. Thank you for choosing The Dental Office of Lithonia. We look forward to treating your dental need for the years to come.

Dr. Michael Chen, D.M.D

Patient signature:_____

Office copy

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7660 Covington Hwy

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Dr. Michael Chen, D.M.D

Patient copy