
Date: _____

Last: _____ First: _____ Middle: _____

- ❑ Mr.
- ❑ Mrs.
- ❑ Ms.
- ❑ Miss.

Marital Status: _____ DOB: ___ / ___ / _____

Social Security #: _____ -____- _____ Male or Female

Email: _____ How did you learn about our office ? _____

Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____ Work #: _____

Employer: _____ Occupation: _____

Dental Insurance: Y | N Company Name: _____ ID#: _____

Primary Insured: _____ (If Other) SS#: _____ DOB: ___ / ___ / _____

Spouse: _____ Phone #: _____

In case of EMERGENCY, who may we notify? _____ Phone#: _____

Person Responsible for Account (If other than patient): _____

# Medical History

Primary Care Physician: _____ Phone #: _____

Have you been hospitalized or undergone surgery in the last 2 years? Y | N Specify: _____

Are you currently under the care of a physician for an ongoing medical condition? Y | N Specify: _____

Are you currently pregnant? Y | N Trimester: _____ Are you currently nursing? Y | N

# Medical History Continued...

Are you allergic to any medications, epinephrine, food dye, latex, etc.? Y | N | If yes, please list:
_____
_____

Please list ALL medications you are taking and what they are for: (Include over the counter, prescription, birth control, etc.)
_____
_____
_____
_____

Do you have any history of the following: (Please circle)

Heart Problems (Murmur/Pacemaker/Valve Problem) | High Blood Pressure | Stroke | Rheumatic Fever | Cancer

Hepatitis | Jaundice | Diabetes | High Cholesterol | Epilepsy | Prolonged Bleeding/Anemia | Arthritis | Acid Reflux

Osteoporosis | AIDS or HIV + | Tuberculosis | Asthma/Respiratory Problems | Emotional Stress/Depression | Artificial Joints

Prosthetics | Apnea/CPAP Therapy

I understand the above information is necessary to provide me with dental care in a safe and effective manner. I have answered all questions truthfully to the best of my knowledge. I will not hold my dentist or any of his staff members responsible for any errors or omissions on my part. I hereby authorize the performance of dental services for myself/ or _____ (child or other). I also consent to any advisable and necessary dental procedures, medications and anesthetics to be administered by the attending dentist or his supervised staff for diagnostic purposes and treatment. _____. (Initial)

# Dental History

Dental Complaint: _____

I consider my teeth/smile to be: Perfect | Crooked | Discolored | Chipped | Painful

Do you wear removable dental appliances? Y | N | Dentures | Retainers | Night Guard | Other: _____

Have you ever worn braces? Y | N Do you have halitosis (bad breath)? Y | N

Do you experience discomfort of your mouth, teeth, or gums? Y | N Specify: _____

Do you use whitening products? Strips | Toothpaste | Trays | OR Sensitivity Toothpaste

I understand the above information is necessary to provide me with dental care in a safe and effective manner. I have answered all questions truthfully to the best of my knowledge. I will not hold my dentist or any of his staff members responsible for any errors or omissions on my part. I hereby authorize the performance of dental services for myself/ or _____ (child or other). I also consent to any advisable and necessary dental procedures, medications and anesthetics to be administered by the attending dentist or his supervised staff for diagnostic purposes and treatment. _____ (Initial)

THE UNDERSIGNED UNDERSTANDS THAT ALL FEES ARE DUE AT TIME OF SERVICE

Patient authorizes Dr. Nino DeLeon, PeachTree Family Dentistry to furnish information to insurance carriers concerning treatment and hereby assign all payment for dental services rendered to myself or my dependent. I understand that I am responsible for any amount not covered by insurance or that is in discussion with the insurance carrier. **A SERVICE FEE OF .75% PER MONTH WILL BE APPLIED TO ALL ACCOUNTS WITH A 30 DAY BALANCE OR GREATER.** If legal action is taken for collection or the account is referred to an attorney for collection; the undersigned agrees to pay all collection costs and attorney fees. Each person signing is cojointly responsible for this account to include children or other parties by this insurance or private pay.

Patient or responsible parties are hereby notified that all charges are due and payable at time of treatment unless credit terms have been applied or previous arrangements have been made.

**A FEE OF $50.00 WILL BE CHARGED FOR MISSED AND/OR APPOINTMENTS CANCELLED WITHOUT 24 HOUR NOTICE.**

Signature: _____ Date: _____

Responsible Party (If other than primary insured): _____ Date: _____

# Notice of Privacy Practices

Military and Veterans: We may release PHI as required by military authorities. We may also release this information about personnel appropriate foreign military authority.

We may release PHI about you to Federal Officials for intelligence, counterintelligence, and other national security activities by law.

You May:

Obtain a paper copy of this notice upon request.

You have the right to request restrictions on our use and disclosure of your PHI by submitting in writing a request of such to the front office manager.

## To Our Valued Patients:

This is to give insight into the new privacy acts enacted on April 13, 2003. PeachTree Family Dentistry is required by laws to maintain the privacy of Protected Health Information (PHI) and to provide you with vital information of our legal duties and privacy practices in regard to your past, present, and future dental needs.

- We may use your information to provide data and coordinate treatment with associate dentists.
- We may use your information for various payment related functions.
- We may contact your insurance provider to determine benefit and payment options.
- We will bill you or a third party for the cost of services administered to you.
- We may disclose your PHI to law enforcement as required by law or subpoena.
- If you are involved in a lawsuit, we may disclose your PHI in response to a court or administrative order.
- We may release your PHI to a coroner or medical examiner or to a funeral director to enable them to carry out their duties.
- We may use or disclose your PHI to notify or assist family members, personal representative or caregiver responsible for your care, location, and general condition.
- We may use and disclose your PHI when necessary to prevent a serious threat to your and others health and well-being.

Signature: _____ Date: _____

# General Dentistry Informed Consent Form

1. EXAMINATION AND X-RAYS I understand that during the initial visit and subsequent recall visits radiographs may be required to ensure a complete examination, proper diagnosis and treatment plan.

2. DRUGS, MEDICATION, AND SEDATION I have been informed and understand that antibiotic, analgesics, and other medications can cause allergic reactions causing redness, swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). They may cause drowsiness and lack of awareness and medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection, pain, and potential resistance to effect treatment of my condition. I understand that antibiotics can reduce the effectiveness of oral contraceptives.

3. NITROUS OXIDE "Laughing Gas" SEDATION I have been informed and understand that the use of nitrous oxide sedation, while often used for relief of stress, anxiety, some pain and gagging can cause some unpleasant side effects. Side effects while infrequent can include nausea/vomiting, perspiration, shivering or behavior problems (excessive talking, laughing, dreams).

4. DENTAL INJECTIONS I have been informed and understand that dental injections are a necessary component to modern dentistry and have some inherent risks. In the extremely rare instance that an anesthetic needle becomes separated from a syringe surgical removal will be required. I also understand that temporary or permanent numbness of my lips, cheek and/or tongue may result from the anesthetic and/or needle used for a procedure.

5. CHANGES IN TREATMENT PLAN I understand that during treatment, it may be necessary to change or add procedures because of conditions found while working on teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any or all changes and additions as necessary.

6. FILLINGS I understand that care must be exercised when chewing on fillings immediately after treatment as your lips, cheeks and/or tongue may be numb for several hours after treatment. Tooth sensitivity is a common after-effect of a newly placed filling.

7. CROWNS, BRIDGES, VENEERS AND BONDING I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realized that the final opportunity to make changes in my new crowns, bridge or cap (including shape, fit, size, placement, and color) will be done before cementation. It has been explained to me that, in very few cases, cosmetic procedures may result in the need for future root canal treatment, which cannot always be predicted or anticipated. I understand that cosmetic procedures may affect tooth surfaces and may require modification of daily cleaning procedures.

8. PERIODONTAL TREATMENT I understand that I have a serious condition causing gum inflammation and/or bone loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including non-surgical cleaning, gum surgery and/or extractions. I understand the success of a treatment depends in part on my efforts to brush and floss daily, receive regular cleaning as directed, following a healthy diet, avoid tobacco products and follow other recommendations.

9. TEMPOROMANDIBULAR JOINT DYSFUNCTIONS (TMJ) I understand that symptoms of popping, clicking, locking and pain can intensify or develop in the joint of the lower (near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. However, symptoms of TMJ associated with dental treatment are usually transitory in nature and well tolerated by most patients. I understand that should the need for treatment arise, then I will be referred to a specialist for treatment, and the cost of which is my responsibility.

10. REMOVABLE PARTIALS, DENTURES I realize that full or partial dentures are artificial, constructed of plastic, metal and or porcelain. The problems of wearing those appliances have been explained to me including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new denture (including shape, fit, size, placement, and color) will be "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not the initial denture fee.

CONSENT: *I understand that dentistry is not an exact science, therefore: reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorize. I understand that each Dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that no other Dentist other than the treating dentist is responsible for my dental treatment.*

Printed Name: _____

Signature of Patient/Guardian: _____ Date: _____

Witness: _____ Date: _____

PeachTree
Family Dentistry