**GENERAL INFORMATION**

**The following information is confidential and for our records only.**

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patients Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sex \_\_\_\_\_\_\_ Weight \_\_\_\_\_\_\_\_ Height \_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_/\_\_\_\_/\_\_\_ Age\_\_\_\_\_\_\_\_\_

Marital Status \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security #\_\_\_\_-\_\_\_-\_\_\_\_

Parent/Spouse’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Spouse’s Social Security # \_\_\_-\_\_\_-\_\_\_\_\_ Parent/Spouse’s Date of Birth \_\_\_/\_\_\_\_/\_\_\_

Residence Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street City State Zip

Home Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employed by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Position \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hrs\_\_\_\_\_

Business Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Business Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Spouse Employed by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Business Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

General Dentist \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How long have you been under his/her care? \_\_\_\_\_\_\_\_\_

Who may we thank for referring you to this office? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you covered by dental insurance? \_\_\_\_\_\_\_\_\_\_\_\_

Name and Address of Carrier \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name and Address of Physician (Medical Doctor) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s (Medical Doctor) Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person Responsible for This Account \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person to Notify in Case of Emergency \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who may we talk to about your account and treatment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phn#\_\_\_\_\_\_\_\_\_\_\_\_

**GENERAL HEALTH**

Circle One

………………….. What is your estimation of your general health? GOOD – FAIR – POOR

Yes No Are you now under the regular care of a physician?

If so, for what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was your last physical examination?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes No Have you had any major operations, hospitalization or illnesses?

If so, for what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes No Are you taking any medications?

If so, please list. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

………………… Have you ever had an allergic reaction to any of the following:

\_\_\_\_ Penicillin \_\_\_\_ Sleeping pills (Barbiturates)

\_\_\_\_ Sulfa drugs \_\_\_\_ Tetracycline

\_\_\_\_ Codeine \_\_\_\_ Dental anesthetic (Novocaine)

\_\_\_\_ Aspirin \_\_\_\_ Nitrous Oxide (Laughing Gas)

\_\_\_\_ Milk \_\_\_\_ Eggs

\_\_\_\_Other (Please provide ANY other allergy not listed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes No Do you smoke, or use any tobacco product? If so how much per day? \_\_\_\_\_\_

Yes No Do you drink alcohol?

Yes No Have you ever used recreational drugs?

Yes No Are you taking any diet pills?

Yes No Has any member or your family had tuberculosis, diabetes, heart disease,

allergies, bleeding problems or cancer?

If yes, who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

………………. Do you have or have you ever had: (PLEASE CHECK)

\_\_\_\_ Seasonal Allergies \_\_\_\_ Dizziness \_\_\_\_ Asthma or difficulty breathing \_\_\_\_ Frequent headaches \_\_\_\_ Sinus problems \_\_\_\_ Diabetes- A1C: \_\_\_\_

\_\_\_\_ Rheumatic fever \_\_\_\_ Anemia or other blood disorder \_\_\_\_ Thyroid or parathyroid disease \_\_\_\_ Arteriosclerosis

\_\_\_\_ Dry Mouth \_\_\_\_ High or low blood pressure

\_\_\_\_ Rashes or skin disorders \_\_\_\_ Heart attack

\_\_\_\_ Glaucoma \_\_\_\_ Heart murmur

\_\_\_\_ G.E. Reflux/ Chronic Heartburn \_\_\_\_ Mitral Valve Prolapse

\_\_\_\_ Kidney or bladder trouble \_\_\_\_ Heart Stent

\_\_\_\_ Ulcers (stomach or duodenal) \_\_\_\_ Heart Valve Replacement \_\_\_\_ Sexually related disease \_\_\_\_ Pacemaker

\_\_\_\_ Frequent vomiting or diarrhea \_\_\_\_ Painful or frequent urination

\_\_\_\_ Stroke \_\_\_\_ Cancer: What type-\_\_\_\_\_\_

\_\_\_\_ Tumors or growths \_\_\_\_ Chemo or Radiation therapy

\_\_\_\_ Frequent fractures/dislocations \_\_\_\_Osteoporosis

\_\_\_\_ Arthritis or rheumatism \_\_\_\_ Painful or swollen joints

\_\_\_\_ Condition requiring cortisone or other steroids

\_\_\_\_ Swelling of the hands, feet, or eyes

\_\_\_\_ Hepatitis, jaundice, or other liver disease

\_\_\_\_ Shortness of breath or chest pains upon exertion

\_\_\_\_ Tuberculosis, emphysema or other lung disease

\_\_\_\_ Epilepsy, seizures, convulsions or fainting spells

\_\_\_\_ Back Problems \_\_\_\_ Other

Circle One

Yes No Are you excessively nervous or depressed?

Yes No Have you ever been treated for nervous or mental disorders?

Yes No Are you, or have you ever, taken Bisphosphonates?

Yes No Have you had abnormal bleeding after a cut or a tooth extraction?

Yes No Have you had an orthopedic total joint replacement? (hip, knee, finger, elbow)

Yes No Have you ever been told by a physician/dentist that you need to pre-medicate   
with an antibiotic before a dental appointment?

**WOMEN ONLY:**

Yes No Are you pregnant?

Yes No Are you taking birth control pills?

Yes No Do you have menstrual problems?

Yes No Have you reached menopause (Change of Life)?

Yes No Are you taking hormone replacement therapy?

**DENTAL HEALTH**

Yes No Do you consider yourself in good dental health?

Yes No Do you think that your teeth are affecting your health in any way?

Yes No Are you dissatisfied with the appearance of your teeth?

Yes No Are you dissatisfied with your chewing ability?

Have you ever had:

\_\_\_\_ Orthodontic treatment (Braces) \_\_\_\_ Oral Surgery (Extraction, etc.)

\_\_\_\_ Periodontal treatment \_\_\_\_ Your teeth ground or bite adjusted

\_\_\_\_ A bite plate or other appliance

Yes No Have you noticed any loosening of your teeth?

Yes No Does food tend to become caught between your teeth?

Yes No Do you suffer from pain and/or swelling of your gums?

Yes No Are your teeth sensitive to heat, cold, or sweets?

Yes No Do your gums often bleed when you brush your teeth?

Yes No Do you have any unpleasant odor or taste in your mouth?

Yes No Do you frequently have fever blisters, mouth ulcers, or sores in your mouth or on   
 your lips?

Yes No Are you missing any teeth?  
 Reasons: Decay ( ) Gum Disease ( ) Other ( )

Yes No Have missing teeth been replaced?

Yes No Do you ever had any soreness, pain, clicking or popping in the area in front of your ears?

Do you:

\_\_\_\_ Clench or grind your teeth while awake or asleep?

\_\_\_\_ Breath primarily through your mouth?

When did you last have your teeth cleaned before this appointment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you see your dentist? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often and when do you brush your teeth? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use: Hand tooth brush ( ) Electric toothbrush ( )

Is your toothbrush: Soft ( ) Medium ( ) Hard ( )

What else do you use to clean your teeth? Floss Toothpick Waterpick

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Circle One

Yes No Do you feel apprehensive when you are having a dental treatment?

Yes No Would you like to use nitrous oxide (laughing gas)?

Yes No Does the fear of pain make you postpone your dental treatment?

Yes No Is it important to you to keep your teeth?

Anything not listed that you would like to discuss? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**The information I have provided is complete and accurate to the best of my knowledge. I consent to whatever procedures are deemed necessary to diagnose my oral condition. I authorize treatment to be rendered, a credit check should I ask for credit, and assume financial responsibility for all treatment rendered. I acknowledge that all non-current balances and accounts over 60 days will be charged a service charge of 35% on the unpaid balance. Any professional courtesy and/or budget account balances will be added back to the account. The cost incurred in collecting this account including court costs, agency fees, and attorney fees will be borne by the account**.

**TREATMENT FEES:**

I understand that any fee estimate for this dental care can only be extended for a period of three (3) months from the date of the patient examination.

In consideration for the professional services rendered to be by this practice, I agree to pay the charges for the services at the time of treatment. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition. In addition, I further agree to pay all costs and reasonable attorney fees if I suit be instituted here under.

I grant my permission to you or your assignee to telephone me to discuss this statement or my treatment and file any insurance towards my treatment.

**HIPPA:**

With your acknowledgement below, you consent to the use and disclosure of your protected health information by Adairsville Periodontal and Implant Dentistry, our staff, and our business associates for treatment, payment, and health care operations. For s more detailed description of uses and disclosures for these purposes, please review our NOTICE of Privacy Practice. The terms of this Notice my change. If the terms of change, you may obtain a revised Notice by contacting Adairsville Periodontal and Implant Dentistry at 7707737227. We will also post any revised notice in the office. You have the right to request that we restrict uses or disclosures of your protected health information, which we are otherwise permitted to make for treatment, payment, and health care operations, although we are not required to agree to these restrictions. However, if we agree to further restrictions, they are bonding. Finally, you may refuse to consent to the use or disclosure of your protected health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse disclosure of your Protected Health Information. This form is also used to obtain acknowledgment of receipt of OUR NOTICE of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

Patient’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Written Financial Policy**

Thank you for choosing Leroy B. Alford, D.D.S PC. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patient as possible by offering several payment options.

**Payment Options:**

You may choose from:

* Cash, Check, Visa, Mastercard, America Express, or Discover Card

We offer a 5% courtesy accounting adjustment to patients who pay for their treatment with cash or check prior to completion of care for treatment plans of $1000 or more.

* \*\*Convenient Monthly Payment Plans from Care Credit

Allow you to pay over time with No Annual fees or pre-payment penalties

Please note:

Leroy B. Alford DDS, PC requires payment prior to the beginning of your treatment. If you choose to discontinue care before treatment is completed, you will receive a refund less the cost of care received.

We accept payment in thirds for treatment over $5000.00. For plans requiring multiple appointments, alternative payment arrangements may be provided.

For patients with dental insurance, we are happy to work with your carrier to maximize your benefits and directly bill them for reimbursement for your treatment. \*\*\*

A fee if $35 is charged for patients who miss or cancel more than one (1) time in a calendar year without a 48-hour notice.

Leroy B. Alford DDS,PC charges $45 for returned checks.

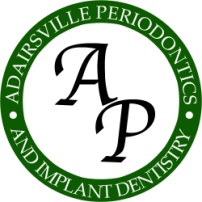
If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry that you want or need.

Patient, Parent, or Guardian Signature Date

Patient Name (Please Print)

\*\*Care Credit is subject to credit approval.

\*\*\*If we do not receive payment from your insurance carrier within 90 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.



Adairsville Periodontics and Implant Dentistry

Leroy B. Alford DDS

PATIENT COMMUNICATION CONSENT FORM

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***TEXT MESSAGE ALERTS***

I authorize the office of Dr. Alford to send text message appointment reminders to me on my provided cell phone number. By accepting these terms, I agree that all individuals associated with my account may receive alerts referencing the account guarantor. Text message charges from my cell phone provider may apply.

Account Guarantor's Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My signature below indicates that I represent and warrant that I am the person legally responsible for all use of the accounts, that I am at least 18 years of age, and that I agree to all terms and conditions of use for the text messaging services. I understand that this authorization can only be revoked in writing.

**No, I do not wish to use this way of communication.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature (Sign either way of your decision) Date

It is important to note that text communication is not always secure. Text messages can be intercepted and for this reason, we do not communicate personal health information through this method.

***EMAIL CORRESPONDENCE***

By giving us your email address, you allow us to correspond about any accounts that you are responsible for via a valid signature and secured email address. Appointment verification, treatment plan correspondence, invoice amounts, and other information can be given to you via the email address you provide. My signature below indicates that I represent and warrant that I am the person legally responsible for all use of the accounts, that I am at least 18 years of age, and that I agree to all terms and conditions of use for the text messaging services. I understand that this authorization can only be revoked in writing.

Email Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **No, I do not wish to use this way of communication**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature (Sign either way of your decision) Date

It is important to note that email communication is not always secure. Email messages can be intercepted and for this reason, we do not communicate personal health information through this method.