2751 Warm Springs Rd Suite B. Columbus GA 31904. O: (706) 689-2905 F: (706) 689 7490

HEALTH HISTORY & REGISTRATION

TODAY' DATE_________________

PATIENT'S NAME________________________________ SEX: M F BIRTHDATE_____________

HOME ADDRESS___________________________ CITY ________________ STATE______ ZIP CODE______________

PREVIOUS ADDRESS ______________________________ CITY_______________ STATE_____ ZIP_________

(If less than 3 years) CELL PHONE PROVIDER

CELL PHONE#_____________________ HOME#_______________________ WORK#_________________ __________________

PLEASE CIRCLE ONE: SINGLE MARRIED SEPERATED DIVORCED WIDOWED SOCIAL SECURITY#______________________________

SPOUSE NAME: ________________________ SPOUSE DATE OF BIRTH____________________ CELL/HOME#________________________

GUARDIAN'S NAME *** IF PATIENT IS A MINOR PLEASE PROVIDE THE FOLLOWING:

(MOTHER OR FATHER) ______________________________ DATE OF BIRTH_________________ CELL/HOME#_____________________

WORK INFORMATION

EMPLOYER: ________________________ POSITION:___________________________ TIME EMPLOYED:_________________

WORK ADDRESS: ____ARE YOU A STUDENT? ______________________

EMERGENCY CONTACT INFORMATION

NAME: _____________________________CELL#______________________________HOME#____________________________

RELATION: __________________________ADDRESS:____

INSURANCE INORMATION

INSURANCE NAME: _____________________________

INSURANCE CO.ADDRESS_______________________________

____

INSURED'S NAME____________________________

SOC.SEC. #_____________________ DOB___________________

INSURED'S EMPLOYER: _________________________________

MEMBER ID: _______________________ GROUP ID: __________

IF YOU HAVE 2 DENTAL INSURANCE COVEARGE PLEASE COMPLETE:

INSURANCE NAME: _____________________________

INSURANCE CO.ADDRESS_______________________________

____

INSURED'S NAME____________________________

SOC.SEC. #_____________________ DOB___________________

INSURED'S EMPLOYER: _________________________________

MEMBER ID: _______________________ GROUP ID: __________

	YES	NO
How long since you've seen a dentist?		
Last complete dental exam date:		
Are you having problems now?		
What?		
Do you wear dentures? (Partials or Full)		
Are you unhappy with your dentures?		
Would you like to know more about Permanent Replacements?		
Have you had a bad dental experience in the past?		
Do your gums Bleed, feel Tender or Irritated?		
Have you had any Periodontal (Gum) Treatments?		
Are you sensitive to Hot, Cold, or Sweets?		
Are you unhappy with the appearance of your teeth?		
Are you aware of Grinding or Clinching of your teeth?		
Do you have Headaches, Earaches, or Neck Pains?		
Have you worn Braces on your teeth?		
Do you have discolored teeth that bother you?		
Name of Previous Dentist:		
City: State:		
Please rate the following according to what would prevent you From having Dental Treatment done (1 highest/ 4 Least): Fear of Pain # Cost of Treatment # Missing work#		

	YES	NO
Do you have any current health problems?		
Are you under a Physician's care now?		
For what?		
Are you currently taking any medications?		
If YES, what?		
Are you pregnant?		
Do you smoke?		
Family Physician: Phone#:		

Are you allergic or have reacted adversely to any of the following Medications?

Aspirin Percodan Erythromycin Darvon Local Anesthetic Valium
Nitrous Oxide Codeine Penicillin Latex

Are you aware of being allergic to any other medications or any other information we should know? ____

Circle any of the following which you presently have or have had:

Heart Failure	A.I.D.S	Bruise Easily
Heart Disease or Attack	Hepatitis A (infectious)	Emphysema
Angina Pectoris	Hepatitis B (Serum)	Tuberculosis
High Blood Pressure	Hepatitis C	Asthma
Heart Murmur	Liver Disease	Hay Fever
Rheumatic Fever	Yellow Jaundice	Sinus Trouble
Congenital Heart Lesions	Blood Transfusion	Hay Fever
Scarlet Fever	Drug Addiction	Allergies or Hives
Artificial Heart Valve	Hemophilia	Diabetes
Heart Pacemaker	Fever Blisters	Thyroid Disease
Heart Surgery	Epilepsy or Seizures	X-ray or cobalt Treatment
Artificial Joints (Hip/Knee)	Fainting or Dizzy Spells	Arthritis
Anemia	Nervousness	Rheumatism
Stroke	Psychiatric Treatment	Cortisone Medicine
Kidney Trouble	Sickle Cell Disease	Pain in Jaw Joints
Ulcers	Glaucoma	Alcoholism
Cosmetic Surgery	Chemotherapy	Bleeding Problems
Digestive Issues	Cancer or Leukemia	Syphilis or Gonorrhea

CONSENT: The undersign hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment of dental services provided in this office for myself or dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance charge will be added to any overdue balance. I also assign all insurance benefits to the Doctor.

Patient Signature (Parent of Child) ________________________ Date: ______________ Dentist Signature________________________

COOK DENTAL CARE, PC

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name ____

Address ____

Telephone_________________________________ Email ___________________________

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 of your protected health information, and of other important matters about your protected health information. A copy or 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 out Notice, at any time by contacting:

COOK DENTAL CARE P.C.
2751 WARM SPRINGS ROAD SUITE B
COLUMBUS, GEORGIA 31904
(706) 689-2905

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 Consent Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent.

Signature

I, ___________________________________, have had full opportunity to read and consider the contents of the Consent form and d 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 _______________________________

COOK DENTAL CARE, P.C.
2751 WARM SPRINGS ROAD SUITE B
COLUMBUS, GEORGIA 31904
OFFICE (706) 689-2905/ FAX (706) 689-7490

INSURANCE AGREEMENT

The basic policy of our office is the payment is made at the time that services are rendered. If you have dental insurance coverage, we would be pleased to file an insurance claim at no charge as part of our service to you. We will also provide you with an estimate of the amount of your insurance coverage before services are rendered.

Please understand, however, that your insurance is a contract between you and your insurance company, and **that you are responsible for any additional charges that your insurance does not cover**. Since the federal law requires insurance companies to reply to each claim within 30 days. The unpaid balance will be your responsibility to pay. If needed, you will be required to contact your insurance carrier for follow-up or reimbursement.

IF THE ACCOUNT SHOULD BECOME DELIQUENT AND MUST BE REFERRED TO A COLLECTION AGENCY, I AGREE TO PAY COLLECTION CHARGES OF 33% IN ADDITION TO THE CHARGES AGREED UPON FOR TREATMENT.

Your signature below indicated that you have read this statement understanding that you are responsible for any unpaid balance that is either not paid or not covered by your insurance company.

Signature ____Date______________________

Picture ID and insurance card will be requested.

COOK DENTAL CARE, PC
2751 WARM SPRINGS RD SUITE B
COLUMBUS, GA 31904
OFFICE 706-689-2905

BROKEN APPOINTMENT POLICY

Please read carefully, this policy is enforced and will apply to all types Of insurance and non-insured patients:

Our practice is dedicated to quality care and exceptional service. We respect the importance of your time and work very hard to schedule appointments that accommodate the busy scheduling needs for all of our patients. In return we ask that patients make every effort not to change reserved dental appointments. Broken and missed appointments create scheduling problems for other patients, as well as the practice.

If you find that you must change your appointment, we require a minimum of 48-hour notice during normal business hours before 5 PM (Mon-Thurs) 1 PM (Fridays), so that we may accommodate another patient. A charge of $45.00 will be applied for all broken and missed appointments without a 48-hour advance notification.

Thank you for your cooperation in this matter.

Signing this letter signifies that you have ready and understand our office policy concerning broken appointments:

Patient's Name: ______________________________________

Signature (patient and/ or guardian): _______________________________

Date: ____________________________

Staff member initials: _________________