Infinite Smiles, P.C.
9700 Medlock Bridge Rd Ste 108
Johns Creek, GA 30097

www.InfinitesmilesGA.com
(770)609-1281
infinitesmilesga@yahoo.com

Patient Information

Chart #. _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ SS #. _____ Prev. Visit: _____

Email Address: _____ Best time to call: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) _____ (Fax) _____ (Other)

Address: _____

_____ (City) _____ (State) _____ (Zip Code)

Insurance Information

Insurance ID Number/Group Number

_____

Name of Insured: _____ (Last) _____ (First) _____ (MI)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Date of Birth:

_____

Responsible Party Social Security Number:

_____

Employer and Insurance Phone Number:

_____

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Medical & Dental History

- [ ] *Pre-Med
- [ ] Allergy - Amox
- [ ] Allergy - Anesthesia
- [ ] Allergy - Aspirin
- [ ] Allergy - Codeine
- [ ] Allergy - Erythro
- [ ] Allergy - Hay Fever
- [ ] Allergy - Latex
- [ ] Allergy - Penicillin
- [ ] Allergy - Sulfa
- [ ] Allergy- epinephrine
- [ ] Allergy- Morphine
- [ ] Allergy-hydrocodone
- [ ] Anemia
- [ ] Arthritis
- [ ] Artificial Joints
- [ ] Asthma
- [ ] Blood Disease
- [ ] Cancer
- [ ] Crohn's
- [ ] Diabetes
- [ ] Dizziness
- [ ] Epilepsy
- [ ] Excessive Bleeding
- [ ] Fainting
- [ ] Glaucoma
- [ ] Head Injuries
- [ ] Heart Disease
- [ ] Heart Murmur
- [ ] Hepatitis A
- [ ] Hepatitis B
- [ ] Hepatitis C
- [ ] Herpes
- [ ] High Blood Pressure
- [ ] HIV
- [ ] Jaundice
- [ ] Kidney Disease
- [ ] Liver Disease
- [ ] Mental Disorders
- [ ] MVP
- [ ] Nervous Disorders
- [ ] Other
- [ ] Pacemaker
- [ ] Pregnancy
- [ ] Radiation Treatment
- [ ] Respiratory Problems
- [ ] Rheumatic Fever
- [ ] Rheumatism
- [ ] Sinus Problems
- [ ] Stomach Problems
- [ ] Stroke
- [ ] Tuberculosis
- [ ] Tumors
- [ ] Ulcers

Please List any and all medications you are taking currently:

*

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Do you have any other health issues or allergies?

*

WOMEN ONLY: Are you pregnant?

◯ Yes ◯ No

Please mark any of the following to indicate Yes in response to the question:

☐ Have you ever had complications following dental treatment?

☐ Are you currently under the care of a physician due to a specific condition?

☐ Have you been hospitalized within the last 5 years due to a surgery or illness?

☐ Are you currently taking any prescription or non-prescription medications?

☐ Do you use tobacco (smoking or chewing)?

☐ Do you require the use of corrective lenses (contacts or glasses)?

☐ Do you have any other conditions, diseases, etc., not listed above that we should be aware of?

If any of the previous questions are marked, please explain:

When was your last visit to the dentist (if at a different office)?

What is the reason for your dental visit today?

Please mark any of the following to indicate Yes in response to the question:

☐ Do your gums bleed when you brush or floss?

☐ Do your teeth experience sensitivity to cold or hot temperatures?

☐ Are any of your teeth currently causing you pain?

☐ Do you grind your teeth (either consciously, or during sleep)?

☐ Are any of your teeth loose, or are you concerned about any teeth loosening?

☐ Do you currently have any dental implants, dentures, or partials?

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

* ☐ I authorize Infinite Smiles to release any information, including the dignosis and records of treatment, or examination for myself and my dependant(s) to third-party insurance carriers, and/or other healthcare providers. Any information includes; radiographs, study models, photographs, and other diagnostic aids deemed necessary. By checking the box and signing below I am giving my consent to Infinite Smiles to use and disclose my protected health information to carry out treatment, payment activities and healthcare operations.

* ☐ I understand the office's HIPAA policy, with a copy being available upon request:

* ☐ To the best of my knowledge, all of the preceding information is true and correct.

Financial and Insurance Office Policies

* ☐ It is the responsibility of the patient to confirm that the dentist is participating with the insurance plan. Our office will file claims to your insurance company for professional services rendered.

Please remember, INSURANCE COVERAGE IS A LEGAL CONTRACT BETWEEN THE PATIENT AND THE INSURANCE COMPANY. Benefits may differ depending upon what type of contract you have with the carrier on your behalf. It is NOT possible for our staff to keep track of the individual requirements of each plan. We will give you an estimate of insurance payment based on the information we are given, however, we are not able to provide a guarantee of any benefits.

We require payment in full for your out-of-pocket portion at the time of service.

If your account is turned over to a collection agency, there will be a $50.00 processing/filing fee as well as a fee of 40% of your balance added to your account that you will be responsible for.

I HAVE READ AND UNDERSTAND THE OFFICE POLICY STATED ABOVE AND AGREE TO ACCEPT FINANCIAL RESPONSIBILITY AS DESCRIBED.

Authorization

☐ Infinite Smiles offers a variety of payment options to meet your needs. Our office accepts payment by cash, checks, Visa, MasterCard, American Express and Discover. We also offer out-of-office financing through CareCredit. This plan allows our patients to proceed with treatment while making affordable low interest or possibly interest-free payments. We will gladly bill your dental insurance and utilize the maximum benefits available to you for treatment performed here at Infinite Smiles. Please keep in mind that we do not base our diagnosis on what your insurance company allows, but rather what is best for you. I authorize the payment from my insurance carrier to submit payment directly to Infinite Smiles to be applied directly to payment of all services to any outstanding balances on my account. Your dental contract is between you and your insurance company, and payment for all services is ultimately your responsibility. We will estimate your out of pocket portion not covered by insurance, which is due at the time services are rendered. If our estimation is lower than what the insurance pays, the patient is ultimately responsible for any remaining balance.

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Referral Information

Name of person, office, or other source referring you to our practice:

*

Signature of patient, parent, or guardian:

Signature: _____ Date:

Relationship to Patient:

Response Date:

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To Our Patients

BROKEN APPOINTMENTS without the patient, parent or legal guardian calling 48-hours in advance, will be assessed a no-call/no-show fee of $50.00.

SAME DAY CANCELLATIONS received on the day of your appointment, will be assessed a $25.00 cancellation fee.

LATE SHOWS - if you show up for your appointment more than 15 minutes late without prior notification, we reserve the right to reschedule for a later date/time, and you might be subject to a cancellation fee of $25.00. Keep in mind, that if you do not keep your appointment, another patient might have been inconvenienced. Please note that these fees will be automatically added to your account, and collected at the time of your next visit. We understand that emergencies do arise, but please try to call us in advance. Thank you for your loyalty and understanding.

Signature: _____ Date: _____

Response Date: _____