Patient Number _____ A B C

HEALTH HISTORY & REGISTRATION

PATIENT INFORMATION

PATIENT'S NAME Last _____ First _____ Middle Initial _____ SEX: M F BIRTHDATE _____ AGE _____

Soc. Sec. # _____ If Patient is a Minor, give Parent's or Guardian's Name _____ TODAY'S DATE _____

Who May We Thank for Referring You to our Office? _____ Reason for this Visit _____

RESPONSIBLE PARTY INFORMATION

NAME Last _____ First _____ Middle Initial _____ MARITAL STATUS _____

RESIDENCE Street _____ Apt. # _____ City _____ State _____ Zip _____

MAILING ADDRESS Street _____ Apt. # _____ City _____ State _____ Zip _____

HOW LONG AT THIS ADDRESS _____ HOME PHONE _____ CELL PHONE _____

WORK PHONE _____ E-MAIL _____

PREVIOUS ADDRESS (if less than 3 yrs.) Street _____ City _____ State _____ Zip _____ How Long _____

SOCIAL SECURITY # _____ BIRTHDATE _____ DRIVER'S LICENSE # _____ RELATION TO PATIENT _____

EMPLOYER _____ OCCUPATION _____ NO. YEARS EMPLOYED _____

RESPONSIBLE PARTY'S SPOUSE

NAME _____ (LAST / FIRST / MIDDLE)

EMPLOYER _____ OCCUPATION _____ ( ) NO. YEARS EMPLOYED

SOC. SEC. # _____ BIRTHDATE _____

HOME PH. _____ CELL PH. _____

WORK PH. _____ E-MAIL _____

EMERGENCY INFORMATION: RELATIVE NOT LIVING WITH YOU.

NAME _____ RELATIONSHIP _____

ADDRESS _____ CITY, STATE _____

HOME PH. _____ CELL PH. _____

WORK PH. _____

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name _____

Insurance Co. _____ E-MAIL _____

Insurance Co. Address _____

Insured's Employer _____

Insured's Soc. Sec. # _____ Group # _____ Local # _____

If you have double dental insurance coverage, complete this for the second coverage.

Insured's Name _____

Insurance Co. _____ E-MAIL _____

Insurance Co. Address _____

Insured's Employer _____

Insured's Soc. Sec. # _____ Group # _____ Local # _____

It is important that I know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.

DENTAL HISTORY	YES	NO
HOW LONG SINCE you have seen a dentist?		
Last COMPLETE Dental Exam, Date:		
Last FULL MOUTH X-RAYS, DATE: (16 Small Films or Panoramic)		
Are you having PROBLEMS now?	☐	☐
WHAT?		
Is your present dental health POOR?	☐	☐
Do you wear DENTURES? (Partials or Full)	☐	☐
Are you UNHAPPY with your dentures?	☐	☐
Would you like to know more about PERMANENT REPLACEMENTS?	☐	☐
Are you APPREHENSIVE about dental treatment?	☐	☐
Have you had any PERIODONTAL (GUM) treatments?	☐	☐
Do your gums BLEED, or feel TENDER or IRRITATED?	☐	☐
Are your teeth SENSITIVE to hot, cold, sweets, pressure? (circle)	☐	☐
Are you UNHAPPY with the APPEARANCE of your teeth?	☐	☐
Are you aware of GRINDING or CLENCHING your teeth?	☐	☐
Do you have HEADACHES, EARACHES, or NECK PAINS?	☐	☐
Have you worn BRACES on your teeth (ORTHODONTICS)	☐	☐
Do you have DISCOLORED teeth that bother you?	☐	☐
Would you like your smile to LOOK BETTER or DIFFERENT?	☐	☐
Do you REGULARLY use DENTAL FLOSS?	☐	☐

Name of Previous Dentist:

City: State:

How do you feel about your teeth?

Please RANK the following in the order in which they would KEEP YOU FROM having dental treatment.

FEAR of pain # LACK of concern #

COST of treatment # MISSING work time #

MEDICAL HISTORY	YES	NO
Do you have any CURRENT HEALTH PROBLEMS?	☐	☐
Are you under a PHYSICIAN'S CARE now?	☐	☐
For what?		
What MEDICATIONS are you currently taking?		
Have you ever taken Fen-Phen/Redux?	☐	☐
Are you PREGNANT?	☐	☐
Do you use cigars/cigarettes, pipe or chewing tobacco? (circle)	☐	☐

PLEASE ✔ YES OR NO OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:

	YES	NO		YES	NO		YES	NO
AIDS/HIV Pos.	☐	☐	Fainting	☐	☐	Psychiatric care	☐	☐
Anaphylaxis	☐	☐	Food allergies	☐	☐	Rapid weight gain/loss	☐	☐
Anemia	☐	☐	Glaucoma	☐	☐	Radiation treatment	☐	☐
Arthritis (Rheumatism)	☐	☐	Headaches	☐	☐	Respiratory disease	☐	☐
Artificial heart valves	☐	☐	Heart murmur	☐	☐	Rheumatic/scarlet fever	☐	☐
Artificial joints	☐	☐	Heart problems (please describe)	☐	☐	Shingles	☐	☐
Asthma	☐	☐	_____			Shortness of breath	☐	☐
Atopic (Allergy Prone)	☐	☐	Hemophilia (Abnormal bleeding)	☐	☐	Skin rash	☐	☐
Back problems	☐	☐	Herpes	☐	☐	Spina Bifida	☐	☐
Blood disease	☐	☐	Hepatitis	☐	☐	Stroke	☐	☐
Cancer	☐	☐	High blood pressure	☐	☐	Surgical implant	☐	☐
Chemical dependency	☐	☐	Jaw pain	☐	☐	Swelling of feet or ankles	☐	☐
Chemotherapy	☐	☐	Kidney disease or malfunction	☐	☐	Thyroid disease or malfunction	☐	☐
Circulatory problems	☐	☐	Liver disease	☐	☐	Tobacco habit	☐	☐
Cortisone treatments	☐	☐	Material allergies	☐	☐	Tonsillitis	☐	☐
Cough (persistent)	☐	☐	(latex, wool, metal, chemicals)			Tuberculosis	☐	☐
Cough up blood	☐	☐	Mitral valve prolapse	☐	☐	Ulcer/Colitis	☐	☐
Diabetes	☐	☐	Nervous problems	☐	☐	Venereal disease	☐	☐
Epilepsy	☐	☐	Pacemaker/heart surgery	☐	☐			

ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING MEDICATIONS?

Aspirin Local Anesthetic Erythromycin Latex (balloons, gloves, etc.)

Nitrous Oxide Codeine Penicillin

Are you aware of being allergic to any other medications or substances?

If yes, please list:

Is there any other Medical or Dental information that you feel I should know about?

FAMILY PHYSICIAN _____ PHONE _____ E-MAIL _____

PATIENT Signature (Parent of Child) _____ Date: _____ DENTIST Signature _____

Consent Form- Oral Cancer Screening

Our office strives to bring its patients state-of-the-art technology to provide you with the latest advancements in oral health. We have recently introduced the OralID™ screening device into our office. The ORalID™ examination will allow us to visualize any oral mucosal abnormalities including cancer and dysplasia (pre-cancer) before they can be detected by the naked eye.

Similar to other cancers, early detection of Oral Cancer is critical. Studies have shown that early detection of oral cancer with technologies like the OralID™ dramatically improves the survivability of the disease. If oral cancer is detected in its later stages, which typically occurs during conventional oral cancer exam, the chances of survival are dramatically reduced.

Who is at risk?

- Age 17+ years
- Tobacco Use
- Alcohol Use
- HPV Infection

If you have any questions about risk factors, please feel free to talk to our hygiene staff. We recommend all of our patients be screened with the OralID™ to reduce the mortality of late stage detection.

$45 Fee for this Service

☐ Yes, I request your staff perform an examination with the OralID™

_____ _____ _____

Signature Name Date

☐ No, I prefer to not have this examination at this visit

_____ _____ _____

Signature Name Date

Edge Center for Family Dentistry, P.C.
Policies and procedures for identity theft prevention and detection and Red Flags Rule compliance

Policy

It is the policy of Edge Center for Family Dentistry, P.C. to follow all federal and state laws reporting requirements regarding identity theft. Specifically, this policy outlines how we will (1) identify, (2) detect and (3) respond to "red flags." A "red flag," as defined by this policy includes a pattern, practice, or specific account or record activity that indicates possible identity theft.

It is the policy of Edge Center for Family Dentistry, P.C. that this Identity theft prevention and detection and Red Flags Rule compliance program is approved as of May 1, 2009, and that the policy is reviewed and approved no less than annually.

It is the policy of Edge Center for Family Dentistry, P.C. that the Office Manager is assigned the responsibility of implementing and maintaining the Red Flags Rule requirements. Furthermore, it is our policy that this individual will be provided sufficient resources and authority to fulfill these responsibilities. At a minimum, it is our policy that there will be one individual or job description designated as the privacy official.

It is the policy of Edge Center for Family Dentistry, P.C. that, pursuant to the existing HIPAA Security Rule, appropriate physical, administrative and technical safeguards will be in place to reasonably safeguard protected health information and sensitive information related to patient identify from any intentional or unintentional use or disclosure.

It is the policy of Edge Center for Family Dentistry, P.C. that its business associates must be contractually bound to protect sensitive patient information to the same degree as set forth in this policy. It is also our policy that business associates who violate their agreement will be dealt with first by an attempt to correct the problem, and if that fails by termination of the agreement and discontinuation of services by the business associate.

It is the policy of Edge Center for Family Dentistry, P.C. that all members of our workforce have been trained by the May 1, 2009 compliance date on the policies and procedures governing compliance with the Red Flags Rule. It is also our policy that new members of our workforce receive training on these matters within a reasonable time after they have joined the workforce. It is our policy to provide training should any policy or procedure related to the Red Flags Rule materially change. This training will be provided within a reasonable time after the policy or procedure materially changes. Furthermore, it is our policy that training will be documented, indicating participants, date and subject matter.

Procedures

I.Identify red flags. In the course of caring for patients, we may encounter inconsistent or suspicious documents, information or activity that may signal identity theft. Edge Center for Family Dentistry, P.C. identifies the following as potential red flags, and this policy includes procedures describing how to detect and respond to these red flags below:

1. A complaint or question from a patient based on the patient's receipt of :
    - A bill for another individual;
    - A bill for a product or service that the patient denies receiving;
    - A bill from a health care provider that the patient never patronized; or
    - A notice of insurance benefits (or explanation of benefits) for health care services never received.
2. Records showing medical treatment that is inconsistent with a physical examination or with a medical history as reported by the patient.
3. A complaint or question from a patient about the receipt of a collection notice from a bill collector.
4. A patient or health insurer report that coverage for legitimate hospital stays is denied because insurance benefits have been depleted or a lifetime cap has bee reached.
5. A complaint or question from a patient about information added to a credit report by a healthcare provider or health insurer.
6. A dispute of a bill by a patient who claims to be the victim of any type of identity theft.
7. A patient who has an insurance number but never produces an insurance card or other physical documentation of insurance.
8. A notice or inquiry from an insurance fraud investigator for a private health insurer or a law enforcement agency, including but not limited to a Medicare or Medicaid fraud agency.

II. Detect red flags. Edge Center for Family Dentistry, P.C. staff will be alert for discrepancies in documents and patient information that suggest risk of identity theft or fraud. We will verify patient identity, address and insurance coverage at the time of patient registration/check-in.

Procedure:

1. When a patient calls to request an appointment, the patient will be asked to bring the following at the time of the appointment:
    - Driver's license or other photo ID;
    - Current health insurance card; and
    - Utility bills or other correspondence showing current residence if the photo ID does not show the patient's current address. If the patient is a minor, the patient's parent or guardian should bring the information listed above.
2. When the patient arrives for the appointment, the patient will be asked to produce the information listed above. **This requirement may be waived for patients who have visited the practice within the last six months.**

3. If the patient has not completed the registration form within the last six months, registration staff will verify current information on file and, if appropriate, update the information.
4. Staff should be alert for the possibility of identity theft in the following situations:
    - The photograph on a driver's license or other photo ID submitted by the patient does not resemble the patient.
    - The patient submits a driver's license, insurance card, or other identifying information that appears to be altered or forged.
    - Information on one form of identification the patient submitted is inconsistent with information on another form of identification or with information already in the practice's records.
    - An address or telephone number is discovered to be incorrect, non-existent or fictitious.
    - The patient fails to provide identifying information or documents.
    - The patient's signature does not match a signature in the practice's records.
    - The Social Security number or other identifying information the patient provided is the same as identifying information in the practice's records provided by another individual, or the Social Security number is invalid.

III. Respond to Red Flags. If an employee of Edge Center for Family Dentistry, P.C. detects fraudulent activity or if a patient claims to be a victim of identity theft, we will respond to and investigate the situation. If the fraudulent activity involves protected health information (PHI) covered under the HIPAA security standards, we will also apply its existing HIPAA security policies and procedures to the response.

Procedure:
If potentially fraudulent activity (a red flag) is detected by an employee of Edge Center for Family Dentistry, P.C.:

1. The employee should gather all documentation and report the incident to his or her Office Manager.
2. The Office Manager will determine whether the activity is fraudulent or authentic.
3. If the activity is determined to be fraudulent, then Edge Center for Family Dentistry, P.C. should take immediate action. Actions may include:
    - Cancel the transaction;
    - Notify appropriate law enforcement;
    - Notify the affected patient;
    - Notify affected physician(s) name; and
    - Assess impact to practice.

If patient claims to be a victim of identity theft:

1. The patient should be encouraged to file a police report for identity theft if he/she has not done so already.
2. The patient should be encouraged to file the ID Theft Affidavit, which we can provided for you, developed by the FTC, along with supporting documentation.
3. Edge Center for Family Dentistry, P.C. will compare the patient's documentation with personal information in the practice's records.

4. If following investigation, it appears that the patient has been a victim of identity theft, Edge Center for Family Dentistry, P.C. will promptly consider what further remedial act/notifications may be needed under the circumstances.
5. The physician will review the affected patient's medical record to confirm whether documentation was made in the patient's medical record that resulted in inaccurate information in the record. If inaccuracies due to identity theft exist, a notation should be made in the record to indicate identity theft.
6. The practice medical records staff will determine whether any other records and/or ancillary service providers are linked to inaccurate information. Any additional files containing information relevant to identity theft will be removed and appropriate action taken. The patient is responsible for contacting ancillary service providers.
7. If following investigation, it does not appear that the patient has been a victim of identity theft, Edge Center for Family Dentistry, P.C. will take whatever action it deems appropriate.

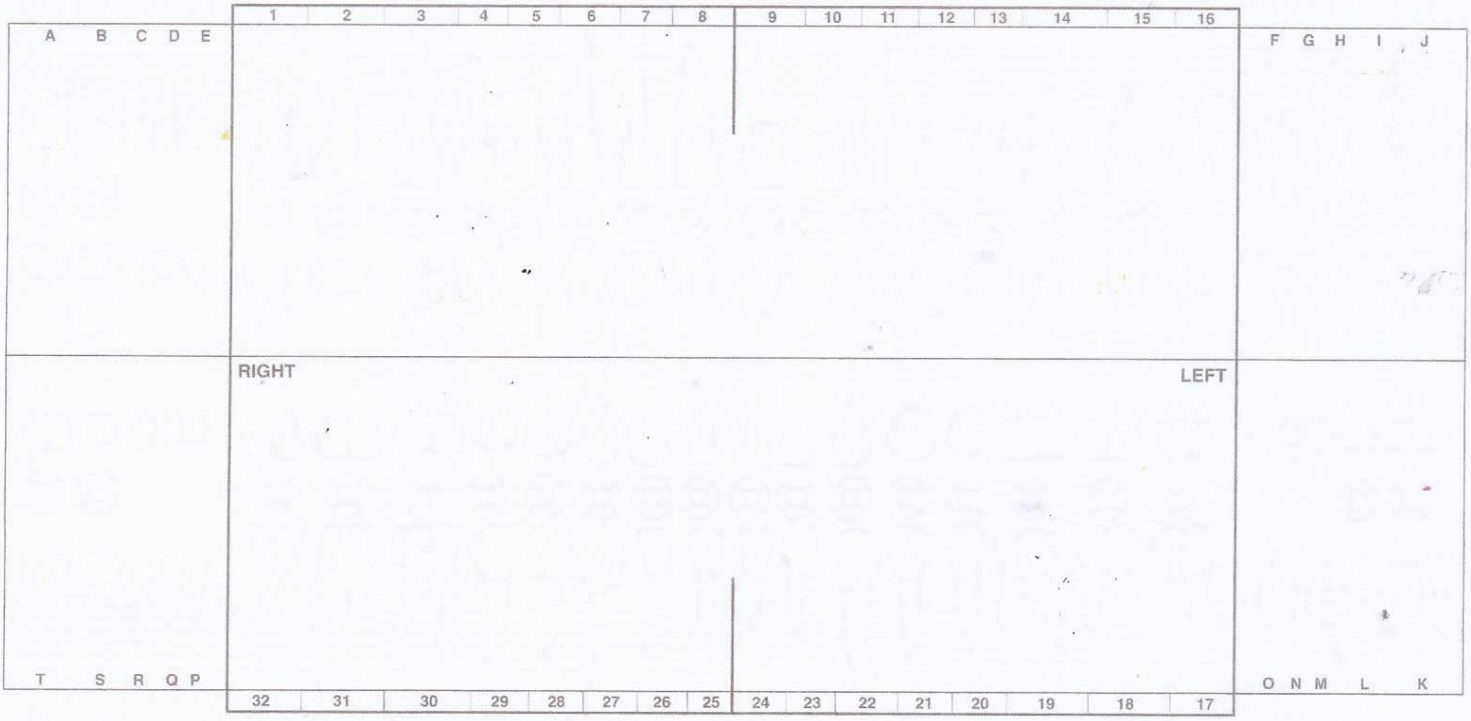
I have read and understand the Red Flags Rule policies and procedures.

Signature of Patient or Parent/Guardian:

_____

Date: _____

COMPLETED TREATMENT



INITIAL PERIODONTAL EXAM:

GINGIVAL INFLAMMATION:	☐ Slight	☐ Moderate	☐ Severe
SOFT PLAQUE BUILDUP:	☐ Slight	☐ Moderate	☐ Heavy
HARD CALCULUS BUILDUP:	☐ Light	☐ Moderate	☐ Heavy
STAINS:	☐ Light	☐ Moderate	☐ Heavy
HOME CARE EFFECTIVENESS:	☐ Good	☐ Fair	☐ Poor
PERIODONTAL CONDITION:	☐ Good	☐ Fair	☐ Poor
PERIODONTAL DIAGNOSIS:	☐ Normal	☐ Gingivitis	
PERIODONTITIS:	☐ Early	☐ Moderate	☐ Advanced
MUCOGINGIVAL DEFECTS #s:			

CLINICAL DATA:

OCCLUSION: ☐ Class I ☐ Class II ☐ Class III ☐ Crossbite: _____

T.M.J. EXAM: ☐ Normal ☐ Popping ☐ Deviation ☐ Tooth Wear ☐ Pain

INITIAL SOFT TISSUE EXAM:

☐ Lips ☐ Floor of Mouth ☐ Palate ☐ Tongue ☐ Neck & Nodes

PATIENT'S TREATMENT DECISIONS:

☐ DOCUMENTATION OF DENTAL RECORD COMPLETED

☐ PATIENT INFORMED OF TX. RECOMMENDATIONS AND CONSENTS TO TX. (ALTERNATIVES DISCUSSED.)

☐ PATIENT WANTS NO TX. OR PARTIAL TX. INFORMED OF CONSEQUENCES AND RISKS INVOLVED.

INITIAL X-RAY FINDINGS:

X-RAYS TAKEN: ☐ FM-PAS ☐ BWX ☐ PANO. ☐ OTHER _____

	QUADRANTS UR	UL	LR	LL
☐ NO BONE LOSS				
☐ SLIGHT BONE LOSS (04600)				
☐ MODERATE BONE LOSS (04700)				
☐ MAJOR BONE LOSS (04800)				
☐ BEGINNING FURCATION (04700)				
☐ ADVANCED FURCATION (04800)				

☐ OTHER: _____

SHADE

Teeth	Upper	Lower
Cents		
Lats		
Cusp		
Posts		

PERIODONTAL SCREENING & RECORDING

SEXTANT SCORE

MONTH DAY YEAR

EXISTING PROSTHESIS:

MAX: _____ DATE PLACED: _____ CONDITION: _____

MAND: _____ DATE PLACED: _____ CONDITION: _____

REFERRALS:

PERIO: _____ ORTHO: _____ ENDO: _____

ORAL SURG: _____ MD: _____ OTHER: _____

NOTES

CONSENT

The undersigned hereby authorizes the 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 dental 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 my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the Doctor and that I am still fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred. I further understand that a late charge will be added to any overdue balance. I understand that where appropriate, credit reports may be obtained.

PATIENT Signature (Parent of Child) _____ Date: _____ DENTIST Signature _____

The Edge Center for Family Dentistry, PC
3420 Acworth Due West Road Kennesaw, GA 30144

STATEMENT OF OFFICE POLICY

Our basic policy requires **PAYMENT IN FULL AT THE TIME SERVICES ARE RENDERED.** INSURANCE PATIENTS are an exception in that they pay only **estimated** co insurance amount when services are rendered, and the balance remaining after insurance has paid. If you have an account over 30 days, other than pending insurance coverage, you may be charged a monthly finance charge and sent to collections.

YOUR PERSONAL APPOINTMENT TIME

We offer a variety of appointment times to accommodate even the busiest of schedules. Our office hours are Monday thru Friday from 8am-5pm, closed daily for lunch from 1-2pm. **Your appointment time is reserved exclusively for you.** You are given an appointment card with the date and time you agree to. Further as a courtesy to you, we text/email/call to remind you of your appointment 2 weeks/2days/2hours prior to your appointment. **WE REQUIRE 24 HOUR NOTICE IF YOU ARE UNABLE TO KEEP YOUR CLEANING APPOINTMENT AND 48 HOUR NOTICE FOR CROWN AND BRIDGE/ROOT CANAL/WISDOM TEETH REMOVAL. THERE WILL BE A $60 FEE FROM A BROKEN CLEANING APPOINTMENT AND $150 FOR CROWN AND BRIDGE/ROOT CANAL/WISDOM TEETH REMOVAL**. IT IS YOUR RESPONSIBILITY TO REMEMBER AND KEEP YOUR APPOINTMENTS.

INSURANCE

As a courtesy, WE WILL FILE DENTAL CLAIMS FOR YOU. However, due to the wide variety of benefit programs, we have no control over how much your insurance will reimburse for your dental services. **Your particular program may base allowances on a fee schedule, which may not coincide with our fees. Please remember the financial obligation is between you and this office, NOT this office and the insurance company.**

The office does accept assignment of insurance benefits to further make things convenient for you. We will require:

- Copy of insurance card, insurance phone number and group number.
- Copy of driver's license, parent or guardians if patient is a minor.
- Any estimated co-payment in full.

Without the above documents we cannot begin treatment without payment in full from you.

For the first time emergency patients, payment in full is required for services rendered. Patients will be responsible to file insurance themselves. **Patients with an outstanding claim of 60 days or more for no significant reason will be charged a monthly finance charge as well as the patient is *now* responsible for the balance and will be required to collect the outstanding amount from insurance personally.** This means you need to be involved and call the insurance company to expedite the payment of YOUR bill.

PAYMENT OPTIONS

Anyone who has an extensive treatment plan has various avenues available in this office to make completion of payment necessary for treatment to be rendered. **We do not offer in house payment plans.**

- **CREDIT CARDS**: Master Card, Visa and Discover.
- **CARE CREDIT**: Dental Credit. You may apply in our office or via internet.
- **BANK LOAN**: Contact your bank for a loan in order to get dental work expenses paid.

_____ _____

Signature Today's Date