



Worthington Family Dentistry, P.C.
3362 Greystone Way
Valdosta, GA 31605
(229) 242-0063

Patient Information

Date _____

Name _____ Sr., Jr., III, IV
(Last) (First) (Initial)

Home Phone _____ Work Phone _____

Cell Phone _____ Other/Fax _____

Social Security # _____

Mailing Address _____

City _____ State _____ Zip _____

E-mail _____

Gender: **M** **F** Age _____ Birthdate _____

Name of Insurance Provider _____

Patient Employer _____

Occupation _____

Emergency Contact _____ Phone # _____

Who may we thank for referring you? _____

Medical History

Physician/Pediatrician Name _____ Phone # _____

Date of last visit _____

Please list and give date of any major illness or surgery:

Have you ever had a blood transfusion? YES NO

If YES, when? _____

Are you pregnant? YES NO

Are you nursing? YES NO

Are you taking birth control pills? YES NO

Have you ever had excessive bleeding that required treatment? YES NO

Are you taking aspirin or blood thinning medications? YES NO

Please check if you have or have had any of the following
(if so, please indicate date of diagnoses):

_____ AIDS _____ HIV positive _____ Hepatitis A, B, C

_____ Persistent Cough _____ Coughing up blood _____ Tuberculosis

_____ Venereal Disease _____ Genital Herpes

_____ Artificial Heart Valves _____ Artificial Joints _____ Cancer

_____ Chemotherapy _____ Radiation Treatment _____ Diabetes

_____ Hemophilia _____ Excessive Bleeding _____ Anemia

_____ Sickle Cell Disease _____ Leukemia _____ Blood Disease

_____ High Blood Pressure _____ Headaches (Frequent) _____ Stroke

_____ Swelling of feet/ankles _____ Mitral Valve Prolapse _____ Heart Attack

_____ Heart Murmur _____ Chest Pain _____ Pacemaker

_____ Rheumatic Fever _____ Other Heart Problems

_____ COPD _____ Sinus Problems _____ Asthma

_____ Tobacco Habit _____ Other Respiratory Disorder

_____ Liver Disease _____ Yellow Jaundice _____ Stomach Ulcers

_____ Kidney Disease _____ Arthritis, Rheumatism _____ Thyroid Problem

_____ Epilepsy/Fainting _____ Osteoporosis _____ Other Bone Disease

_____ Skin Rash _____ Tonsillitis _____ Psychiatric Care

_____ Nervous Problem _____ Jaw Pain _____ Back Problem

_____ Chemical Dependency

Dental History

Reason for Today's visit? _____

Previous Dentist _____ Phone # _____

Date of last Dental Visit _____ Date of last Dental x-rays _____

Are you in pain right now? YES NO

Are you anxious/ nervous about today's visit? YES NO

Have you ever had a bad dental experience? YES NO

Check if you have had problems with any of the following:

- | | |
|--|--|
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Bleeding Gums |
| <input type="checkbox"/> Food collecting between teeth | <input type="checkbox"/> Periodontal Treatment |
| <input type="checkbox"/> Sores or growths in mouth | <input type="checkbox"/> Teeth drifting/separating |
| <input type="checkbox"/> Loose teeth | |
| <input type="checkbox"/> Clicking or grinding of "jaw joint" | <input type="checkbox"/> Grinding teeth |
| <input type="checkbox"/> Pain in "jaw joint" | <input type="checkbox"/> Mouth breathing |
| <input type="checkbox"/> Sensitivity to cold | <input type="checkbox"/> Sensitivity to hot |
| <input type="checkbox"/> Sensitivity to sweets | <input type="checkbox"/> Sensitivity when biting |
| <input type="checkbox"/> Broken teeth or fillings | |

When was your last cleaning appointment? _____

How often do you brush? _____ Floss? _____

Do you use a whitening toothpaste or over the counter whitening product? YES NO

Confirmation

To the best of my knowledge, all the preceding information is true and correct. If I have changes to my health, or if my medications change, I will inform this office upon my next visit.

Signature _____ Date _____

Primary Dental Insurance

Subscriber on Insurance _____
(Last) (First) (Initial)

Relation to Patient _____ Birthdate _____ SSN _____

Address (if different from patient) _____

City _____ State _____ Zip _____ Phone # _____

Subscriber Employer _____ Occupation _____

Business Address _____ Work Phone _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

(Please give insurance card to receptionist so a copy can be made)

Additional Insurance

Is patient covered under medical/secondary insurance? YES NO

Subscriber on Insurance _____
(Last) (First) (Initial)

Relation to Patient _____ Birthdate _____ SSN _____

Address (if different from patient) _____

City _____ State _____ Zip _____ Phone # _____

Subscriber Employer _____ Occupation _____

Business Address _____ Work Phone _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Insurance Authorization

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for all services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure payment of benefits. **I understand that I am financially responsible for all charges whether or not paid by insurance.**

Signature _____ Date _____



Financial Policies and Agreement

Estimates.

Our office will be happy to give you an estimate of costs for proposed treatment. Sometimes complications arise necessitating a change in treatment and its associating cost. We always try to inform you if complications are likely. Patients are expected to pay for the treatments that are performed, at the time they are performed.

Insurance.

Your insurance policy is an agreement between you and your insurance provider. We will be happy to work with your provider and file all the documentation necessary for your treatment. You will be responsible for covering any fees not covered by your insurance provider.

Payment.

You are expected to pay for your treatment before you leave our office. This includes co-payments and any estimated fees not covered by your insurance provider. This may be done with cash, check, Mastercard, Visa, or American Express.

Qualified applicants may finance their dental care through Care Credit Healthcare Financing. You can apply online by visiting www.carecredit.com or by calling their toll-free number at 1-800-365-8295. Further information is available at our office upon request.

In select circumstances, in-office financing may be available. To determine what financing may be available, you may fill out a credit application. This authorizes Worthington Family Dentistry to access your credit information for the purposes of extending additional finance options. Please check with a staff member to see if you qualify.

Cancellations:

We ask you to please give us a **24-hour notice** if you need to cancel your appointment with our office.

I have read the above, understand and agree to all of these policies.

Name: _____ Date: _____

**ACKNOWLEDGEMENT
OF
PRIVACY PRACTICES**

Worthington Family Dentistry
3362 Greystone Way
Valdosta, GA 31605
229-242-0063

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers for my health care services
- Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____ Date: _____

Signature: _____

Relationship to Patient: _____

Dependent family members also covered by this acknowledgement:

For Office Use Only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

- The patient refused to sign
- Communication barriers
- Emergency situation
- Other