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
_____Persistant 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		

Any other Health Problems:

_____

_____

_____

ALLERGIES (Any medications that make you itch, swell, or make you sick.)	

CURRENT MEDICATION (please list all Medications that you are presently taking) (please notify us during each visit if this information has changed since your last visit)	
Name	Dosage

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:

_____Bad Breath
_____Food collecting between teeth
_____Sores or growths in mouth
_____Loose teeth

____Bleeding Gums
____Periodontal Treatment
____Teeth drifting/separating

_____Clicking or grinding of "jaw joint"
_____Pain in "jaw joint"

____Grinding teeth
____Mouth breathing

_____Sensitivity to cold
_____Sensitivity to sweets
_____Broken teeth or fillings

____Sensitivity to hot
____Sensitivity when biting

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:

____

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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