PATIENT REGISTRATION

Date: _____
How did you hear about us? _____

Mother's Information: Birth Date _____/_____/_____
Name _____
◯ Mother ◯ Stepmother ◯ Guardian
Employer_____
Work Phone (_____Ext._____
Home Phone (____)_____
Cell Phone (_____) _____
SSN _____DL#_____
Address: _____
City,State,Zip: _____
Email_____

Father's Information: Birth Date _____/_____/_____
Name _____
◯ Father ◯ Stepfather ◯ Guardian
Employer_____
Work Phone (_____Ext._____
Home Phone (____)_____
Cell Phone (_____) _____
SSN _____DL#_____
Address: _____
City,State,Zip: _____
Email_____

ACCOUNT RESPONSIBLE PARTY INFORMATION (must be at least 18)
Responsible Party Name: _____ Relationship To Patient: _____
Soc Sec: ____-____-_____ Birth Date: ____/_____/_____ ◯ Male ◯ Female
Address: _____ City, State, Zip: _____
Home Phone: _____ Work Phone: _____ EXT: _____ Cell Phone: _____

PRIMARY INSURANCE INFORMATION

Insurance Company Name: _____
Ins. Phone #: _____ Employer: _____
Policy Holder Name: _____
Birth Date: _____ Soc Sec: ____-____-_____
Relationship to patient: ___ Self ____ Spouse ____ Child
Medicaid or Member ID # _____

SECONDARY INSURANCE INFORMATION

Insurance Company Name: _____
Ins. Phone #: _____Employer: _____
Policy Holder Name: _____
Birth Date: _____ Soc Sec: ____-____-_____
Relationship to patient: ___ Self ____ Spouse ____ Child
Medicaid or Member ID # _____

CHILDREN UNDER THE AGE OF 18

First Name:_____Last Name:_____Middle:_____ Preferred Name:_____
Birth Date:____/_____/_____ Age:_____◯ Male ◯ Female Social Security #:_____
Insurance Company Name:_____Medicaid or Member ID#:_____
First Name:_____Last Name:_____Middle:_____ Preferred Name:_____
Birth Date:____/_____/_____ Age:_____◯ Male ◯ Female Social Security #:_____
Insurance Company Name:_____Medicaid or Member ID#:_____
First Name:_____Last Name:_____Middle:_____ Preferred Name:_____
Birth Date:____/_____/_____ Age:_____◯ Male ◯ Female Social Security #:_____
Insurance Company Name:_____Medicaid or Member ID#:_____
First Name:_____Last Name:_____Middle:_____ Preferred Name:_____
Birth Date:____/_____/_____ Age:_____◯ Male ◯ Female Social Security #:_____
Insurance Company Name:_____Medicaid or Member ID#:_____

DENTAL AND MEDICAL HISTORY FORM

PATIENT NAME: _____ **BIRTH DATE:** _____

Please describe any tips/tricks that will help our team provide a positive experience for your child's visit:

_____

DENTAL CONCERNS

What is the primary reason for today's visit? ☐ Cleaning ☐ Dental Emergency/Pain ☐ Consult for Decay

What area are you having problems with? _____ How long has this been bothering? _____

DENTAL HABITS

Does your child currently… (**check all that apply**)

☐ Suck Thumb/Finger ☐ Suck/Bite Lips ☐ Bite/Chew Nails ☐ Tongue Thrust ☐ Bottle Feed

☐ Use Pacifier ☐ Tongue/Cheek Chew ☐ Clench/Grind Teeth ☐ Mouth Breather ☐ Breast Feed

HYGIENE ROUTINE

(check all that apply)

☐ Fluoride Toothpaste ☐ Consume Fluoridated Water ☐ Brushing by Child: ___ /day ☐ Fluoride Mouthwash ☐ Dental Floss: ____/week ☐ Brushing by Parent: ___/day

MEDICAL HISTORY

Are immunizations current? ☐ Yes ☐ No Date of Last Exam: _____ Child's physician Name: _____
Phone: (_____) _____- _____ Address: _____

History of Hospitalizations / Operations / Emergency Room Care / Recent Illnesses (explain):

_____

Current Medications Name & Reason: _____

_____

Has your child been diagnosed and/or treated for any of the following… (**check all that apply**)

☐ Blood Disorder/Anemia	☐ Tuberculosis(TB)	☐ Diabetes	**ALLERGIES:**
☐ Abnormal Bleeding/Hemophilia	☐ Asthma/Reactive Airway	☐ Sickle Cell Trait	☐ Drug: _____
☐ Immune Disorder/HIV/AIDS	☐ Tonsillitis	☐ Vision Problems	☐ Food: _____
☐ Cancer/Tumor/Leukemia	☐ Congenital Birth Defects	☐ Hearing Problems/Deaf	☐ Seasonal
☐ Heart Murmur/Defect/Surgery	☐ Premature/Low Birth Weight		☐ Hives
☐ Epilepsy/Seizures/Convulsions	☐ Cleft Lip/Palate		☐ Latex
☐ Cerebral Palsy	☐ Autism Spectrum		☐ Other (specify):_____
☐ Cystic Fibrosis	☐ ADD/ADHD		
☐ Kidney Problems	☐ Eating Disorder		
☐ Liver Disease/Jaundice/Hepatitis	☐ Speech Disorder		
☐ Stomach/GI Disorders	☐ Mental/Cognitive/Social Delay	◯ **NO CONDITION**	◯ **NO ALLERGIES**

Any other condition not listed: _____

I affirm that the above information I have given is correct to the best of my knowledge. It will be held in confidence and it is my responsibility to inform this office of changes in the patient's medical status.

Guardian Signature: _____ Print Name: _____ Date: _____

Appointment Agreement

We are honored that your family has entrusted Soft Heart Dentistry for your dental care. We strive to give each patient the individual attention they deserve. Therefore, we ask that you arrive on time for your appointment. If you arrive late to your appointment, we may need to reschedule your appointment. If we are able to see you, we cannot guarantee that all treatment will be completed. If a second appointment is missed, the patient may be dismissed from our practice, or required to make non-refundable deposit before scheduling another appointment.

Cancellation Policy

If you need to cancel or reschedule your appointment, we ask for a 24-hour notice of cancellation. If we do not receive a 24-hour notice, you will be charged a $40.00 fee for the scheduled appointment. This fee cannot be charged to your insurance company. You will be responsible for payment of the broken appointment fee. Broken appointment fee will need to be paid before scheduling an appointment.

If necessary, you may change your appointment two business days before the appointment.

We will call you 2 business days prior to your appointment to confirm. Appointments not confirmed will automatically be cancelled. We may also call you the day before your appointment to remind you of your appointment.

SATURDAY APPOINTMENT AGREEMENT

If you/patient **cancel, no show, or call on day of** Saturday appointment to reschedule, we will not be able to schedule you/patient another Saturday for a grace period of one month. Saturday appointment are high demand and we reserve the time slot for you/patient.

I acknowledge the appointment agreement above.

Signature: _____ Print Name: _____Date:_____

Relationship to patient: ◯ Self ◯ Parent ◯Legal Guardian

Insurance/Payment Policy

Welcome to Soft Heart Dentistry. We hope to make your appointment as pleasant as possible and ease your potential financial burden as much as possible. Please review our insurance and payment policies below to help you understand your financial responsibilities.

All deductible and fee amounts not covered by insurance are due at the time of service.

Insurance claims

Our office will file a claim for services rendered to your insurance. Services are rendered and charged to you, not your insurance company. Please understand that the contract is between you and the insurance company and payment for services is your responsibility.

If at the end of 45 days, your insurance company has not paid, you are responsible for the entire balance. Our office will not enter into dispute with your insurance company over your claim. Upon request, we will supply you with a copy of the claim.

Please be advised that you may be billed for services that your insurance company will not cover due to exclusions or plan limitations. At times, insurance may pay the composite (white) restoration at an alternate procedure, resulting in a possible balance for which you are responsible. Upon request a pre-treatment estimate can be sent to your insurance company.

Interest on late payments

Please pay all charges on time. We charge interest at the rate of 1 percent per month for charges not paid within 30 days. We recommend patients understand their insurance benefits and monitor their plans for prompt payment.

For your convenience, we accept cash, check, or credit cards (Visa, MasterCard, Discover, and American Express.) If you provide us with a check with insufficient funds or with a stop payment, you will be charged a $30.00 processing fee.

Collection costs

We will charge the patient's account for our collection costs if we refer the account to an outside agency or attorney for collection.

I have read and understand the insurance and payment policy above.

Signature: _____ Print Name:_____ Date:_____

Relationship to patient: ◯ Self ◯ Parent ◯Legal Guardian

CONSENT FOR INTERNET COMMUNICATIONS

I grant my permission to Soft Heart Dentistry to upload and store confidential patient information including account information, appointment information and clinical information to the secured website for Soft Heart Dentistry. I also understand State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand Soft Heart Dentistry will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my patient information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that Soft Heart Dentistry has the right to monitor, retrieve, store, upload and use my patient information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand Soft Heart Dentistry will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the website on my behalf. I understand Soft Heart Dentistry CAN NOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will respect the privacy of your health information. There are several circumstances in which we may have to use or disclose your health care information:

•We may have to disclose your health information to another health care provider or a hospital if it is necessary for our office to refer you to them for consultation or treatment.

•We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your service.

•We may need to use your personal information to remind you of your appointments.

I understand that all email communications in which I engage may be forwarded to other providers for the purposes of providing treatment to me. This may include but not be limited to sending your x-rays and/or minimal personal information to other providers via email. We strive to keep all patient information secure but unfortunately there is no assurance of confidentiality of information when communicating this way.

I have read and understand this policy and agree to the terms.

Signature: _____ Print Name:_____ Date:_____

Relationship to patient: ◯ Self ◯ Parent ◯Legal Guardian

Acknowledge Receipt of Privacy Practices

Patient name: _____ Date of Birth: _____

I have received either a paper or an electronic copy of the Notice of Privacy Practices for Soft Heart Dentistry. I understand that I am entitled to receive a paper copy of the Notice if I ask for it, even if I have already agreed to receive only an electronic copy.

Signature: _____ Print Name:_____ Date:_____

Relationship to patient: ◯ Self ◯ Parent ◯Legal Guardian

Soft Heart Dentistry

860 Duluth Highway Suite 1030
Lawrenceville GA, 30043

I, the undersigned parent or guardian of the child or children named below, appoint the caregiver(s) named below during any present or future visit to Soft Heart Dentistry. The purpose of this Authorization is to permit the children to receive dental treatment when I cannot be present.

Patient Name: _____
Patient Name: _____
Patient Name: _____
Patient Name: _____
Patient Name: _____
Patient Name: _____

Caregiver's Name: _____ Relationship to patient: _____
Caregiver's Name: _____ Relationship to patient: _____
Caregiver's Name: _____ Relationship to patient: _____

The caregiver has to be **18 years** old or older and must present a valid form of identification at all appointments. The caregiver has the power and authority, on my behalf to receive and disclose all health information and to make all decisions, related to the dental treatment of my child or children. The caregiver may execute in my name any consent for treatment and commit me to pay all charges for dental treatment to which the caregiver consents. Every act the caregiver lawfully does pursuant to this Authorization shall be binding on me. I understand that I will be liable for all charges for dental treatment to which the caregiver consents pursuant to this Authorization. This Authorization shall remain in effect until completion of dental treatment of the child(ren) at Soft Heart Dentistry or until I revoke this Authorization.

I HAVE READ AND I UNDERSTAND THIS AUTHORIZATION.

Signature of parent or guardian: _____ Date signed_____

Printed Name of Parent or Guardian_____