PLEASE PRINT AND FILL OUT COMPLETELY

PATIENT'S NAME_____ADDRESS_____APT #_____

CITY_____STATE_____ZIP_____HM #_____WK#_____DOB_____

PATIENT'S SS # _____ SEX _____ MARITAL STATUS _____ EMPLOYER _____

Cell#_____EMAIL_____**REFERRED BY**_____

Best form of contact: Calls Text Email

GUARDIAN(under 18)_____ADDRESS_____APT #_____

CITY_____STATE_____ZIP_____HM #_____WK #_____DOB_____ CELL

GUARDIAN'S SS #_____SEX_____MARITAL STATUS_____EMPLOYER_____

SUBSCRIBER'S NAME_____ADDRESS_____APT #_____

CITY_____STATE_____ZIP_____HM #_____WK #_____DOB_____

SUBSCRIBER SS #_____SEX_____MARITAL STATUS_____EMPLOYER_____

INS. CO_____PLAN NAME_____INS. PH.#_____RELATION TO PATIENT_____

MEDICAL HISTORY-Certain illnesses and drugs may make it necessary to alter our treatment. In our endeavor to render the best possible oral health care to you (or your child), it is necessary to have the following information. HAVE YOU EVER HAD OR HAVE

		YES	NO
1.	Asthma, hay fever, sinusitis, or other allergies (**PLEASE CIRCLE WHICH ONE)**	____	_____
2.	Allergy to Penicillin, aspirin, local or general anesthetic , or other drugs:(**PLEASE CIRCLE WHICH ONE)**	____	_____
3.	Blood pressure or heart problems/ joint replacements (**PLEASE CIRCLE WHICH ONE)**	____	_____
4.	Rheumatic fever or heart murmur (**PLEASE CIRCLE WHICH ONE)**	____	_____
5.	A pacemaker or open heart surgery (**PLEASE CIRCLE WHICH ONE)**	____	_____
6.	Diabetes, liver, kidney, thyroid, or lung problems (**PLEASE CIRCLE WHICH ONE)**	____	_____
7.	Ulcers or stomach problems (**PLEASE CIRCLE WHICH ONE)**	____	_____
8.	Hepatitis or jaundice (**PLEASE CIRCLE WHICH ONE)**	____	_____
9.	Epilepsy or nervous disorders (**PLEASE CIRCLE WHICH ONE)**	____	_____
10.	Bleeding or clotting disorders(**PLEASE CIRCLE WHICH ONE**)	____	_____
11.	Arthritis	____	_____
12.	Herpes or canker sores(**PLEASE CIRCLE WHICH ONE**)	____	_____
13.	Acquired immune deficiency syndrome (HIV or AIDS)	____	_____
14.	Any other illness**(PLEASE SPECIFY, IF YES)**	_____	_____
15.	Do you smoke or use tobacco products?	_____	_____
16.	Are you presently taking any medicine?_____ **SPECIFY:**_____		_____
17.	Are you presently under the care of a physician?_____		_____
18.	When was your last physical exam?_____		
19.	Have you ever been hospitalized?_____ Date:_____ Reason:_____		
20.	Have you had X-ray treatment or chemotherapy?	_____	_____
21.	Are you presently on a diet?	_____	_____
22.	Women: Are you taking birth control pills?: (Yes / No) Are you pregnant?: (Yes / No)		

Patient/Guardian Signature X: Date:

DENTAL HISTORY _____

PATIENT NAME

DATE OF LAST DENTAL EXAM:_____

DATE OF LAST FULL MOUTH X-RAY_____WHERE TAKEN_____

	yes	no
1. Have you had trouble from previous dental care?		
2. Do you have pain in your jaw or near your ears?		
3. Do you have any unhealed injuries or inflamed areas in or around your mouth?		
4. Have you experienced any growths or sore spots in your mouth?		
5. Does any part of your mouth hurt when clenched?		
6. Have you ever had Novocaine or other local anesthetic?		
7. Have you ever had nitrous oxide (laughing gas)?		
8. Have you ever had general anesthesia?		
9. Have you ever had any reaction or allergic symptoms to Novocaine, local or general anesthesia?		
10. Have you ever had any difficult extractions in the past?		
11. Have you ever had prolonged bleeding following extractions in the past?		
12. Do your gums bleed?		
13. Do you have a bad taste in your mouth or mouth odor?		
14. Have you ever had instructions on the care of your gums?		
15. Do you chew on only one side of your mouth?		
16. Do you habitually clench or grind your teeth during the night or day?		
17. Is any part of your mouth sensitive to pressures or irritants (hot, cold or sweets)?		

Is there any other problem not covered above that you would like to discuss?

X_____ _____

Patient/Guardian Signature Date Witness Date

Medical Information Release Form
(HIPAA RELEASE FORM)

Name: _____Date of Birth: ____ /____/_____

Release Information:

[ ] I authorize Athens Oconee Dentistry to send bill statements via text.

[ ] I authorize the release of my information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

[ ] Spouse/Significant Other: _____

[ ] Child(ren): _____

[ ] Parents: _____

[ ] Other: _____

[ ] Information is not to be release to anyone

Messages

Please call: [ ] My Home [ ] My Work [ ] My Cell

If unable to reach me:

[ ] You may leave a detailed message.

[ ] Please leave a message asking me to return your call.

The best time to reach me is (day) _____between (time) _____

Patient/Guardian Signature: X_____ Date: ___/___/____

Witness: _____ Date: ___/___/____

This ***Release of Information*** will remain in effect until terminated by me in writing.

Dr. Brent Nail
2235 Resurgence Drive
Watkinsville, GA 30677

In our continued commitment to provide the highest quality dental care available to all our patients and to have those services comfortably affordable, we are pleased to offer you these options for payment.

THERE WILL BE A 3% SURCHARGE ADDED TO ANY PAYMENT MADE WITH A CREDIT CARD
(There is no fee added to any debit card/FSA/HSA transactions)

Personal Credit Cards	**Payment in full discount**
○ Visa ○ Discover ○ MasterCard ○ American Express	We are happy to offer a 5% discount for services over $1000 when paid upfront in full with a check only.

We are pleased to offer two financing options which are administered for us by:
In Office Financing
Care Credit
Please ask our administrative staff for details and credit applications.

We are committed to support you in understanding your dental health, so that you will always be able to make the best choices.

We will, as a courtesy, process your insurance benefits in our office, which will relieve you of this time consuming, sometimes-complicated task.

We are not contracted with any insurance plan, however we will file your insurance plan as long as it is a PPO **(the difference in office fee, and insurance allowed amount is your responsibility).** I agree that I am fully responsible for the total payment of all procedures performed in this office-this includes any treatment that is not a benefit of my dental insurance. I understand that all services are due to be paid in full within sixty (60) days of the date of service, regardless of whether my insurance benefits have been received. One and one-half percent (1.5%) per month interest (18% per year) will be charged on accounts 60 days from treatment date. A 30% fee will be attached to any accounts that have to be turned over to a collection agency or goes to small claims court.

MISSED APPOINTMENTS

Appointment times are reserved especially for you. If for any reason you should need to change your appointment, a 3 business day notice is required to avoid a $75 broken appointment fee. Please help us serve you better by keeping your scheduled appointments. We are here to assist you in any way possible. Please make your questions and concerns known to our team…Our goal is to ensure that you have an outstanding experience.

3 broken appointments within a 24-month period will result in dismissal from our practice.

X_____ _____

Signature (Responsible Party) Date

Athens Oconee Dentistry
Dr. Brent Nail

Broken Appointment Policy

When you reserve a time with us please make every attempt to make your appointment. This time is set aside specifically for you. Two weeks prior to your appointment you will receive a courtesy reminder by email, text message, or an automated phone call. When you receive this message, please reply with a call, text or email to CONFIRM the time that you have already reserved with us.

If you do not confirm your reserved time with our office 3 business days prior to your reserved time, you run the risk of being taken off our schedule.

We have a 3 Business Day cancellation policy. If you need to change or reschedule your reserved time with us please give us a 3 business day notice to avoid a charge of $75.00 and so that we will be able to fill this time with others waiting for treatment. If your appointment time with us is on Monday, please confirm with us by Wednesday of the prior week. If you cancel without a 3 business day notice or fail to show for your confirmed appointment more than twice you will be required to pre-pay for future appointments with our office at the time of your reservation.

3 broken appointments within a 24-month period will result in dismissal from our practice.

X_____ _____

Patient Signature Date

Text Message Opt In

Please check the box below if you consent and opt in to receive text communications, including Appt Reminders and Patient Feedback from Athens Oconee Dentistry. You agree to receive appointment reminders, confirmation messages, and important updates by opting in. Standard messaging rates may apply. Message frequency may vary. (You may opt-out at any time by replying "STOP")

☐ I opt in to receive text messages from Athens Oconee Dentistry.

Contact Information Form

Please complete the following information:
Full Name: _____

Phone Number: (___) _____ - _____

Email Address: _____

Preferred Contact Method: (Please circle one)
Phone Email Text Message

Additional Notes: