ART OF THE SMILE NEW PATIENT QUESTIONNAIRE

PATIENT INFORMATION DATE ____________

Name ____________ ____________ ____________
LAST FIRST MI

Preferred Name ____________

Info ____________ ____________ MALE FEMALE
SSN DOB

Phone ____________ ____________ ____________
HOME WORK CELL

Email Address ____________

Mailing Address ____________
____

HEALTH INFORMATION
HAVE YOU EVER HAD ANY OF THE FOLLOWING?: (Check all that apply.)

____ AIDS	____ Growths	____ Pregnancy (current)
____ Anemia	____ Hay fever	____ Prosthetic heart valve
____ Arthritis	____ Head Injury	____ Radiation
____ Artificial Joint(s)	Heart disease	____ Repiratory problems
____ Asthma	____ Heart murmur	____ Rheumatism
____ Blood Disease	____ Hepatitis	____ Sinus problems
____ Cancer	____ High blood pressure	____ Stomach problems
____ Diabetes	____ HIV	____ Stroke
____ Dizziness	____ Jaundice	____ Tuberculosis
____ Epilepsy	____ Kidney disease	____ Tumors
____ Excessive bleeding	____ Liver disease	____ Ulcers
____ Fainting	____ Mental disorder(s)	____ Venereal disease
____ Fever blisters	____ Nervous disorder(s)	____ (other) ____
____ Glaucoma	____ Pacemaker	____

What medications are you currently taking?: ____________

Do you have any allergies to medications?: ____________

Have you been admitted to the hospital within the last 2 years? YES NO
If yes, please explain: ____________

Are you currently under the care of a physician? YES NO
If yes, please explain: ____________
Name of Physician: ____________

Do you have any health problems that need further clarification?: YES NO
If yes, please explain: ____________

Dr. Signature ____________

REFERRAL INFORMATION

How did you hear about our office?:

DENTAL HISTORY

Reason for today's visit: ______________________

Approximate date of last dental visit: ________

Have you ever had any complications following dental treatment?: YES NO

If yes, please explain: ______________________

Do you use tobacco products? YES NO If yes, how often? ________

Do your gums bleed when you brush? YES NO floss? YES NO

Are you aware of bad breath? YES NO ______________________

Rate your smile on a scale of 1 to 10 (1 being the lowest): ________

Why? ______________________

____

Are you interested in whitening your teeth? YES NO

Are you interested in cosmetic dentistry? YES NO

Would you like to speak with Dr. Tekin privately about your smile? YES NO

EMERGENCY CONTACT

Name ______________________

LAST FIRST MI

Relationship to patient: ______________________

Phone ________ ________ ________

HOME WORK CELL

Who is financially responsible for this account?

Who is responsible for this account? (circle one): PATIENT OTHER

If other, please explain: ______________________

Employer of Patient: ______________________

Occupation of Patient: ______________________

Address of Employer: ______________________

____

INSURANCE INFORMATION

Insured ____
LAST FIRST MI

SSN ____________ ID # ____________ DOB ____________

Insured Relationship to Patient: SELF SPOUSE/PARTNER PARENT

Employer ____

Insurance Company Name ____

Insurance Company Phone # ____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment without fail.

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by Dr. Tekin, I agree to pay therefore the reasonable value of said services to Dr. Tekin at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I have read the above conditions of treatment and payment and agree to their content.

____ ____________
Signature of Patient or Guardian Date

ART OF THE SMILE
DR. BROCK F. TEKIN, D.M.D.
3280 HOWELL MILL RD. NW. SUITE 112
ATLANTA, GA 30327

OUR DENTAL OFFICE PRIVACY POLICY

As dental professionals, Dr. Tekin and his staff implemented this Health Information Privacy Policy and Procedures to protect the interest of our patients and to fulfill our legal obligations under the Health Insurance Portability and Accountability Act of 1996
(HIPAA), the amended modifications of 2002 and state law that provide greater information are important to us. We will not use your health information for marketing communications. We may use your health information:

♦ To other dental specialists if you are referred

♦ To provide you with appointment reminders

♦ To you or to anyone you designate in writing

♦ To obtain payment for services we have provided for you

♦ When required by law

As a patient you have a right to view or transfer you dental records for a fee.

If you want more information about the privacy practices of this dental office, or if you are concerned that we may have violated your privacy rights, please contact our office or the U.S. Department of Health and Human Services.

We support your right to the privacy of your health information.

Contact officer: Dr. Brock F. Tekin, D.M.D., PC
3280 Howell Mill Rd. NW.
Suite 112
Atlanta, GA 30327
Phone: 404-355-5332
Fax: 404-355-5991

ACKOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I have received a copy of this office's Notice of Privacy Practices.

____

Print Your Name / Date

____

Signature / Date

I, ________________________, am the "personal representative" and have legal authority to make health care decisions about the following patient:

____

Please Print Patient Name Here

AUTHORIZATION FOR ADDITONAL DISCLOUSURE:

I authorize the following individuals to have access to my health information.

	Name:	Relationship:
1)	__________________________	___________________
2)	__________________________	___________________
3)	__________________________	___________________

____

Signature / Date

FOR OFFICE USE ONLY

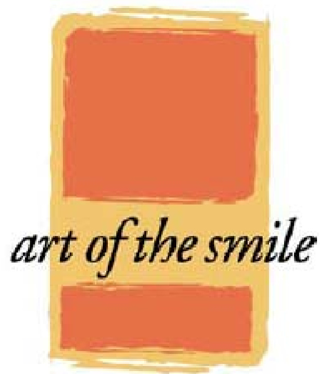
We attempted to obtain written acknowledgement of receipt of Our Notice of Privacy Practices, but acknowledgement could not be obtained because:

______ Individual refused to sign

______ Communication barriers prohibited obtaining the acknowledgement

______ An emergency situation prevented us from obtaining acknowledgement

______ Other (Please Specify) ____



APPOINTMENT CANCELLATION POLICY

When you schedule an appointment with our office, we are reserving clinical time specifically for you. Since we are reserving this time especially for you, we kindly request that if you are unable to keep your appointment please provide ***at least two business days' notice during our business hours of operation*** so that we may offer the appointment to someone who may be waiting. If you are unable to give two business days' notice, please understand that a charge of $50/hour *may* apply to your account. Obviously, there are situations that can occur which would prevent you from being able to provide us with the notice that we prefer, and we try to be as accommodating as possible in these circumstances. However, continuous cancellations will outweigh these circumstance and fees can and will be applied regardless.

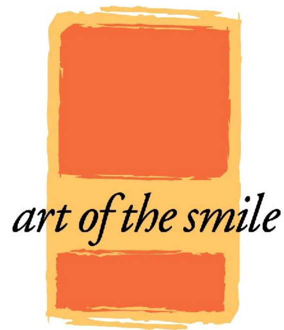
By signing below, you are stating that you have read and understand the guidelines set above.

____

Signature Date

____

Print



INSURANCE GUIDELINES

As a courtesy to our patients, our office will file insurance forms and assist in making collections from insurance companies. If your insurance has not contacted us regarding your visit **within 90 days from the date of your visit**, we will ask that *you* pay for your visit.

As our patient, we expect you to provide our office with proper documentation and/or any changes of your insurance and personal information **prior to your appointment**. Without advance notice of changes, we are unable to verify coverage and you will be responsible for paying for your visit at the time of service.

As the policyholder, you should understand the limits of your policy. Our office is happy to assist in answering questions to the best of our ability and file your claims. We will also provide an estimate of coverage and out-of-pocket expense for any treatment recommended and/or scheduled; please keep in mind that it is just that, **an estimate,** and not a guarantee of benefits.

It is your obligation to reimburse our office for any treatment **not covered** by your insurance. Our office does not define or perform treatment based on what insurance allows; we plan and perform treatment according to what is most beneficial to your dental health.

By signing below, you are stating that you have read and understand the guidelines set above.

____ ________________________

Signature Date

____

Print