thornton
DENTAL WELLNESS
Family & Cosmetic Care

NEELY D. THORNTON, DMD

WWW.THORNTONDENTALWELLNESS.COM
Tel: 770-422-7727

ARTISTRY • INTEGRITY • PASSION

707 WHITLOCK AVE SUITE C-25
MARIETTA, GA 30064

PATIENT INFORMATION

Date: ☐NEW PATIENT ☐UPDATE

Patient:
LAST FIRST MI PREFERRED TITLE

☐MALE ☐FEMALE ☐CHILD* ☐STUDENT** ☐SINGLE ☐MARRIED ☐DIVORCED ☐WIDOWED

*IF CHILD, PROVIDE PARENT/GUARDIAN NAME(S) BELOW:

PARENT/GUARDIAN NAME(S)

**IF STUDENT, PLEASE COMPLETE: ☐FULL-TIME ☐PART-TIME

SCHOOL/LOCATION

Patient Date of Birth: Patient SSN:

Address:
ADDRESS LINE 1
ADDRESS LINE 2
CITY ST ZIP CODE

HOME:
CELL:
OTHER:

E-Mail:

Referral? ☐Yes ☐ No Referred by:

EMERGENCY INFORMATION

In case of emergency, please provide information for the nearest relative or designated contact person not at the patient's address:

NAME RELATIONSHIP Tel:

EMPLOYMENT INFORMATION

Employer: Occupation:

Address:
ADDRESS LINE 1
ADDRESS LINE 2
CITY ST ZIP CODE

WORK:
DIRECT:
OTHER:
PAGER:
FAX:

E-Mail:

INSURANCE INFORMATION

Subscriber:
LAST FIRST MI PREFERRED TITLE

Subscriber Date of Birth: Subscriber SSN:

Subscriber Employer:

Patient Relationship to Subscriber: ☐SELF ☐SPOUSE ☐CHILD ☐OTHER

PRIMARY INSURANCE CARRIER:

Group/Policy No.: ID No.:

Address:
CITY ST ZIP CODE

TEL:
TOLL-FREE:
FAX:

SECONDARY INSURANCE CARRIER:

Group/Policy No.: ID No.:

Address:
CITY ST ZIP CODE

TEL:
TOLL-FREE:
FAX:

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PREVIOUS DENTIST INFORMATION

Dentist: _____ Telephone: _____

Clinic/Facility: _____

Reason for changing: _____

DENTAL HISTORY

ORAL HEALTH: ☐EXCELLENT ☐GOOD ☐FAIR ☐POOR

Date of Last Dental Visit: _____ Treatment Type: _____

☐Y☐N Are you currently having dental discomfort? If yes, explain: _____

☐Y☐N Any unhappy/unpleasant dental experiences? If yes, explain: _____

☐Y☐N Any injuries to mouth/teeth/head? If yes, explain: _____

☐Y☐N Any missing teeth other than wisdom teeth or orthodontic extractions?

☐Y☐N Have missing teeth been replaced? If yes, when?_____

☐Y☐N Orthodontic appliances now or in the past?

☐Y☐N Any concerns about the appearance of your teeth?_____ Color?_____ Size?_____
Crowding/Spacing?_____

☐Y☐N Concerned about gum disease? History of gum disease? ☐Y☐N

☐Y☐N Gums bleed when brushing or flossing?

☐Y☐N Does it hurt to bite or chew?

☐Y☐N Do you clench or grind your teeth? If so, do you wear a night guard or splint? ☐Y☐N

☐Y☐N Do you want to become a regular continuing care patient in our practice?

☐Y☐N Do you want your mouth properly restored and pain free?

☐Y☐N Does any type of dental treatment make you nervous? If yes, please explain below:

_____

The most important concerns regarding my dental treatment are:

_____

Have you ever used a bisphosphonate medication such as Fosamax, Actonel, Atelvia, Didronel and Boniva? ☐Y☐N

Have you ever taken Fen-Phen/Redux? ☐Y☐N Have you ever had a blood transfusion? ☐Y☐N

If yes, please describe and give approximate dates:_____

Any additional concerns/comments?

_____

CHILD/MINOR PATIENTS: PLEASE ANSWER THE FOLLOWING QUESTIONS:

☐Y☐N Any mouth habits? (thumb sucking, nail biting, mouth breathing, nursing/bottle habits, pacifier, etc.)

_____

☐Y☐N Any unusual speech habits? If yes, explain: _____

☐Y☐N Any lost teeth? If yes, list: _____

☐Y☐N Does the patient receive assistance with brushing and flossing? If yes, how often?

_____

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PRIMARY PHYSICIAN INFORMATION

Physician: ..... Telephone: .....

MEDICAL HISTORY

GENERAL HEALTH: ☐EXCELLENT ☐GOOD ☐FAIR ☐POOR

☐Y☐N Under a physician's care now?
☐Y☐N Any hospitalization in the past 5 years? .....
☐Y☐N Any serious illnesses/surgeries? .....
☐Y☐N Use tobacco in any form? If Yes, Type: ..... How long? .....
☐Y☐N Drink Alcohol?_____ How many a day?_____
☐Y ☐N Recreational Drugs?_____ What kind/how long/how much?_____
☐Y☐N Taking any prescription or daily OTC medications/drugs? *If yes, list details in the Medication Section.*
☐Y☐N **Is pre-medication required before dental visits due to heart condition or artificial joint?**

FEMALE PATIENTS: ☐Y☐N Currently nursing? ☐Y☐N Currently pregnant/trying? Due Date: .....

ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐NONE

☐ACID REFLUX	☐CHEMOTHERAPY	☐HEART DISEASE	☐RESPIRATORY DISEASE
☐AIDS/HIV	☐CIRCULATORY PROBLEMS	☐HEART MURMUR	☐RHEUMATIC/SCARLET FEVER
☐ANEMIA	☐CORTISONE TREATMENTS	☐HEPATITIS A/B/C	☐SHORTNESS OF BREATH
☐ANOREXIA/BULIMIA	☐COUGH, PERSISTENT	☐HIGH BLOOD PRESSURE	☐SINUS PROBLEMS
☐ANXIETY	☐DIABETES	☐KIDNEY DISEASE	☐STROKE
☐ARTIFICIAL HEART VALVE	☐DIZZINESS/FAINTING	☐LIVER DISEASE	☐SURGICAL IMPLANT
☐ARTIFICIAL JOINTS	☐EPILEPSY/SEIZURES	☐MITRAL VALVE PROLAPSE	☐THYROID CONDITION
☐ARTHRITIS, RHEUMATISM	☐FOOD ALLERGIES	☐NERVOUS PROBLEMS	☐TUBERCULOSIS
☐ASTHMA	☐FREQUENT HEADACHES	☐PACEMAKER	☐ULCERS/COLITIS
☐BLOOD DISEASE	☐GLAUCOMA	☐PSYCHIATRIC TREATMENT	☐VENEREAL DISEASE
☐CANCER	☐HEARING PROBLEMS	☐RADIATION	
☐CHEMICAL DEPENDENCY	☐HEART ATTACK/SURGERY	☐OTHER – PLEASE LIST:	

ALL PATIENTS: ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD ANY REACTION TO THE FOLLOWING? (CHECK ALL THAT APPLY):

☐ASPIRIN	☐CODEINE	☐LACTOSE INTOLERANCE	☐SLEEPING PILLS	☐NONE
☐ANESTHETIC – LOCAL	☐DAIRY	☐METAL SENSITIVITY	☐SULFA DRUGS	
☐BARBITURATES	☐LATEX	☐NITROUS OXIDE SEDATION	☐PENICILLIN/OTHER ANTIBIOTICS	
☐OTHER – PLEASE LIST:		WHAT IS THE REACTION?		

MEDICATION INFORMATION

ALL PATIENTS: ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐NONE

☐ANTIBIOTICS/SULFA DRUGS	☐ANTIHISTAMINES/ALLERGY	☐DAILY ASPIRIN	☐BLOOD PRESSURE MEDICATIONS
☐BLOOD THINNERS	☐CANCER/CHEMO MEDICATIONS	☐CORTISONE/STEROIDS	☐HEART MEDICATION/DIGITALIS
☐INSULIN	☐NITROGLYCERIN	☐ORAL CONTRACEPTIVES	☐OSTEOPOROSIS MEDICATIONS
☐OTHER DIABETIC MEDICATIONS	☐RECREATIONAL DRUGS	☐THYROID MEDICATIONS	☐TRANQUILIZERS
☐OTHER (PLEASE LIST BELOW)			

DRUG NAME	DOSAGE	REASON PRESCRIBED

Is there anything important about your medical condition we have not asked? ☐Y☐N If yes, please

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describe:_____

Financial Guidelines

Please allow us to welcome you to our office. We hope to make your visit as pleasant as possible. Our goal is to assist you in the settlement of your account with the same quality and professionalism that our dental care provides. Your review of our financial guidelines at this time will help greatly to avoid future misunderstandings.

Our relationship and our contract with you is that of Dentist-Patient. We do not provide services to insurance companies and have no responsibility to assure that the insurance company is supportive of your dental care.

Any contract that exists between you and your insurance company for dental care reimbursement does not obligate us to comply with the provisions of your policy. We will assist you in filing your claims. Services are rendered to you, which make you the responsible party. Insurance companies are businesses, not healthcare advisors. If you are unsure of any of the specific requirements of your insurance company please ask them. Do not solely depend on us to be familiar with all the different types of insurance plans.

Often insurance companies will use the term “usual and customary” or similar such language when denying charges for dental care. The implication is that the doctor charges too much for a given procedure or visit. Universal “usual and customary” fee schedules do not exist. The amount an insurance company reimburses for a procedure will vary with the company, the type and quality of the policy. Our fee schedule is the same for everyone.

Payment is expected at time of service for all procedures not covered by your insurance. When payment from the insurance company has not been received within 60 days of treatment, it will be your responsibility to contact the insurance company and to send office payment in full at that time. We accept cash, check, all major credit cards and Care Credit as forms of payment. In the event of account default, you will be responsible for said balance as well as any collection costs, including attorney and court fees. A delinquent account creates an uncomfortable environment for everyone.

We reserve time with the doctor or hygienist to serve your dental needs. If you are unable to make your reserved time, we require at least 48 hour notice to avoid a minimum charge of $54.00 per hour scheduled. We need time to care for each of our loyal patients. This broken appointment policy is out of courtesy to ALL of our patients who need appointments.

By signing this agreement, I understand the policy as defined above and agree to abide by it.

Signature: _____ Date:_____

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ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Updated 2013

My signature confirms that I have been informed of my rights to privacy regarding my protected personal and health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand the terms in which my personal health and identification information may be used.

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.

Signature: _____ Date:_____

RELATIONSHIP TO PATIENT: ☐ADULT PATIENT ☐PARENT ☐GUARDIAN ☐OTHER

Please list any dependent children under the age of 18 also covered by this acknowledgement:

☐ I give permission for the following communications to be used by Thornton Dental Wellness **(please check all that apply)** :

☐ Cell phone: ☐Text Message reminders permitted
☐ Home phone ☐ Work ☐ E-Mail:

☐ I am granting permission for Thornton Dental Wellness to disclose their identity to anyone who may answer my home, work or cell phone.

☐ I am granting permission for Thornton Dental Wellness to leave a message with any person who may answer my phone or on my voicemail of the following numbers **(please check all that apply)**:

☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ None- please just ask for a call back
☐ Other (Please explain)

I would like to give permission for the following person(s) to have access to personal information including but not limited to appointments, treatment, and billing of me and any dependent children listed above:

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 – please list:

*Copy of *Notice of Privacy Practices* can be obtained at the front desk

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PATIENT CONSENT- PAYMENT AUTHORIZATION – SIGNATURE ON FILE

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status of if my medication changes, I shall inform the dentist and staff at the next appointment without fail.

I hereby authorize my insurance company to pay the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I hereby authorize Thornton Dental Wellness to release any information concerning my health or dental care, advice, treatment or supplies provided. This information is to be used in administering dental claims and/or discussing treatment options with other dental professionals.

I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered.

By signing below, I acknowledge that I have read and understand the statements mentioned above.

Signature: _____ Date:_____

PATIENT CONSENT FOR INTERNET COMMUNICATIONS

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any changes, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand the 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 the dental practice 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 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 the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading y patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice cannot and does not assume any responsibility for my use or misuse of patient information transmitted, monitored, stored, uploaded or received using the site or the services.

By signing below, I acknowledge that I have read the information regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site.

Signature: _____ Date:_____

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PHOTOGRAPY RELEASE

I hereby authorize Thornton Dental Wellness to take photographs, slides, and/or videos of my face, jaws, mouth and teeth.

I understand that the photographs, slides, and/or videos will be used as a record of my care, and may be used for educational purposes in study club meetings, lectures, seminars, demonstrations, and professional publications (journals, magazines).

I further understand that if the photographs, slides, and/or videos are used in any publication or as a part of a demonstration, my name or other identifying information will be kept confidential.

I do not expect compensation, financial or otherwise, for the use of these images.

Please initial one of the following:
____I do not mind if my face and or teeth are used in any of the above situations.

____I only agree to have my teeth shown.

____I do not wish to have my photos used at all.

Patient Name/Signature_____ Date_____

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Assignment of Medical Benefits Form

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits: I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Thornton Dental Wellness.

For Medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance or the agreed amount for services rendered.

Authorization to Release Information I hereby authorize Thornton Dental Wellness

To: (1) release any information necessary to insurance carriers regarding my illness and treatments;

(2) Process insurance claims generated in the course of examination or treatment; and

(3) Allow a photocopy of my signature to be used to process insurance claims for the period of lifetime.

This order will remain in effect until revoked by me in writing. I have requested medical services from:

(Practice Name)_____

On behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I hereby affirm that any payment made to me by my Insurance Carrier will be immediately transferred to Thornton Dental Wellness upon receipt for services rendered.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement EOB or Check.

A photocopy of this assignment is to be considered as valid as the original.

Patient Signature/Date_____

OFFICE USE ONLY_____

All pertinent paperwork has been reviewed by attending dentist _____

Signature_____

Date_____