Oral Surgery Specialists
Of Atlanta

3280 Howell Mill Rd
Suite 240
Atlanta, GA 30327
(404) 351-5335
www.oralsurgeryspecialistsatlanta.com

General Information

Patient Name: ______________________________ Age:________ Sex: _________

Preferred Name: ____

DOB: ________________ Marital Status: _____ Employer: _____________________

Occupation: _____________________________

Email: ____

Address: ____ Apt #: _____

City: ________________________________ State: ___ Zip Code: _______________

Home #: ________________ Cell #: ________________ Work #: _________________

Insured's Employer: ____

Insured's Name: ____

Insured's Social Security #: ___________________ Insured's DOB: _______________

Relationship to Insured: ____

Dental Insurance Company: ____

I.D. #: ________________________ Group #: ____________________________

Emergency Contact: ____

Relationship: ________________________ Phone #: __________________________

Referred by:
- ☐ Dentist: _________________________
- ☐ Word of mouth: ____________________
- ☐ Internet
- ☐ Other

Reason for Referral: ____

Who is financially responsible for this bill? ___________________________________

Have you or any members of your family been a patient of our office? ☐ Yes ☐ No
If yes, name of family member: ______________________________________

Dentist: ______________________________ Phone: ________________________

Physician: ____________________________ Phone: ________________________

Medical History

Name: ______________________________

Height: _________________ Weight: ________________________ Age: ___________________________

1. Date and reason for last medical examination: ____

2. Current Medications: ____

____

____

3. Date of previous surgeries and / or hospitalizations: _______________________________________

____

4. Problems associated with general anesthesia: ____

5. Are you allergic to:

- ☐ Local anesthetics
- ☐ Sulfa Drugs
- ☐ Aspirin / Ibuprofen / Acetaminophen
- ☐ Latex
- ☐ Penicillin / Amoxicillin / Keflex
- ☐ Other Antiobiotics
- ☐ Codeine / Hydrocodone / Percocet / Tramadol
- ☐ Other: __________________________
- ☐ None

6. Do you have any of the following diseases or problems?

- ☐ Congestive Heart Disease
- ☐ Low / High Blood Pressure
- ☐ Heart Birth Defect
- ☐ Heart Attack
- ☐ Heart Surgery / Valve replacement
- ☐ Chest Pain
- ☐ Rheumatic Fever
- ☐ Heart Murmur
- ☐ Collagen or Vascular Disease
- ☐ Anemia
- ☐ Bleeding Problem
- ☐ Other Blood Disorder
- ☐ Stroke
- ☐ Convulsions or Seizures
- ☐ Neurologic Disorder
- ☐ Anxiety or Psychiatric Conditions
- ☐ Fainting Spells
- ☐ Neck injury
- ☐ Kidney Disease
- ☐ Osteoporosis / Osteopenia
- ☐ Prosthetic Joint(s)
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Hepatitis or Liver Disease
- ☐ Stomach Ulcers / Reflux
- ☐ Immune Deficiency
- ☐ AIDS / HIV Positive
- ☐ Arthritis
- ☐ Hay Fever
- ☐ Respiratory Disease
- ☐ Sinusitis
- ☐ Asthma
- ☐ Tuberculosis
- ☐ Emphysema / COPD
- ☐ Glaucoma
- ☐ Tumor or cancerous growth
- ☐ Radiation treatment or chemotherapy
- ☐ Alcohol or drug abuse problem
- ☐ Smoke or chew tobacco
- ☐ Pregnant or nursing
- ☐ Other: __________________________
- ☐ None

Patient / Guardian: ______________________________________ Date: ______________________

Doctor Signature: ____ Date: ______________________

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Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name and Address: ____

____

____

I have been provided access to a copy of the Notice of Privacy Practices for the above named practice.

______________________________	______________________
Signature	Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ☐ An emergency existed and a signature was not possible at the time.
- ☐ The individual refused to sign.
- ☐ A copy was mailed with a request for a signature by return mail.
- ☐ Unable to communicate with the patient for the following reason:
  ____
- ☐ Other: ____

Prepared By: ____

Signature: ____

Date: ______________________

Financial Policy

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship.

-Payment is due at time of service
-We accept cash, checks, Mastercard, Visa, Discover or AMEX
-Care Credit Financial payment plans are available

ADULT PATIENTS AND MINORS ACCOMPANIED BY AN ADULT

Adult patients and adults accompanying a minor patient are responsible for payment at the time of service. Special financial arrangements can be made with the business office before treatment begins.

UNACCOMPANIED MINORS

Proposed treatment sometimes changes during the procedure due to the needs of the situation. To assure quality care of the patient, it may be necessary to proceed without the consent of the parent or guardian if they have left the facility. The parent or guardian is responsible for payment the day of treatment, and will be financially responsible for the necessary changes in the minor's treatment.

INSURANCE IS A CONTRACT BETWEEN YOU, YOUR EMPLOYER AND YOUR INSURANCE COMPANY

We will be happy to assist you with your insurance, in order to help you receive the most benefit possible. ***We do require payment in full at the time of service.***

RESCHEDULED OR MISSED APPOINTMENTS

We request the courtesy of 48 hours' notice should you need to reschedule or cancel your appointment. Missed appointments without 48 hours' notice are billed at $50.00 per 30 minutes of appointment time. Please help us serve you better by keeping scheduled appointments.

LATE ACCOUNTS

Balances due for 60 days will be considered delinquent. We reserve the right to forward accounts which are delinquent to an independent service for collection.

____ ______________________

Patient or Guardian Signature Date