VINCENT DENTAL PATIENT REGISTRATION

Name: ____ Preferred Name: ________________________

Address: ____

____

Date of Birth: __________________ Phone #: ___________________________ (HOME/ CELL /WORK)

Email (We Will Not Share): ______________________________ Marital Status: ___________________

Place of Employment: ______________________________ Occupation: ________________________

Dental Insurance Co: ________________________________ Group#: __________________________

Social Security #: ____________________________ Member ID #: _____________________________

Whom May We Thank For Referring You to Our Office? ____

Family Information

	Husband or Father (please circle)	**Wife or Mother** (please circle)
Name		
Address	_________________________________ _________________________________	_________________________________ _________________________________
Phone #		
Employer		

Person to Contact in Case of Emergency: ____

AUTHORIZATION AND RELEASE - CONSENT FOR TREATMENT

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform Vincent Dental if my minor child or I ever have a change in health.I hereby authorize Dr. Daniel Vincent or designated staff to take x-rays, study models, photographs and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my (or my child's) dental needs. Upon such diagnosis, I authorize Vincent Dental to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

Explanation of Insured's Financial Responsibility

I understand that I am financially responsible for all changes rendered to my dependents or me whether or not paid or reimbursed by my insurance provider(s). I authorize the use of my signature and assign benefits to Vincent Dental on all insurance submissions. I understand that in the event that my account becomes 90 days past due it will be turned over to collections and I will be responsible for the additional 30% collection expense incurred. Payment is due in full at time of treatment unless prior arrangements have been approved.

Name: ____ **Date:** _____________________

Signature: ____________________________________**Relationship to patient:** _______________

MEDICAL HISTORY

Please indicate which of the following apply. Circle YES or NO for each item.

Heart (surgery, disease, attack) YES NO
Chest pain YES NO
Congenital Heart Disease YES NO
Heart Murmur YES NO
High Blood Pressure YES NO
Artificial Heart Valve YES NO
Rheumatic Fever YES NO
Artificial Joints YES NO
If yes, which joints? ____________________
When was the surgery? __________________

Arthritis/Rheumatism YES NO
Cortisone Medicine YES NO
Swollen Ankles YES NO
Stroke YES NO
Diet – Special Restricted YES NO
Kidney Trouble YES NO
Ulcers YES NO
Diabetes YES NO
Thyroid Problems YES NO

Emphysema YES NO
Chronic Cough YES NO
Tuberculosis YES NO
Asthma YES NO
Allergies or Hives YES NO
Latex Allergy or Sensitivity YES NO
Sinus YES NO
Gag Reflex YES NO

Radiation Therapy YES NO
Chemotherapy YES NO
Tumors YES NO
Cancer YES NO
If yes, when? __________________________
What kind? ____________________________

Hepatitis (B, C) YES NO
Venereal Disease YES NO
Herpes YES NO
Cold Sores/Fever blisters. YES NO
H.I.V. Positive YES NO
AIDS YES NO

Blood Transfusion YES NO
Glaucoma YES NO
Hemophilia YES NO
Sickle Cell Disease YES NO
Bruise Easily YES NO
Liver Disease YES NO
Yellow Jaundice YES NO
Neurological Disorders YES NO
Epilepsy or Seizures YES NO
Nervous/Anxious YES NO
Smoke YES NO
Drug Addiction YES NO
Psychiatric / Psychological Care YES NO

Any other disease or condition? YES | NO
lf so, please list: ________________________
____
____

Are you taking any medications? YES | NO
lf so, please list: ________________________
____
____

Are you allergic to any medications? YES | NO
lf so, please list: ________________________
____
____

When was the last time you saw your medical doctor? ____________________________
Physician's Name: _______________________
Telephone #: ____________________________

Women, are you:
Pregnant? **YES | NO**
Nursing? **YES | NO**
Taking BC Pills? **YES | NO**

Do you take any of the following?

Fosamax **YES | NO** Aredia **YES | NO**
Zometa **YES | NO** Bonefos **YES | NO**

other blood thinner: _____________________

Patient Name: ____**Date:** ____________

Patient's Signature: ____

Vincent Dental
3850 Holcomb Bridge Road, Suite 125
Peachtree Corners, GA 30092
(770) 449-5999

Financial Policy and Agreement

1. **Pay as you go** - For your convenience, you may choose to pay your obligations at each visit.
   We accept cash, credit/debit cards (Visa, Mastercard, American Express, Discover, CareCredit, and Alphaeon).
2. **Flexible monthly payment options through CareCredit** - with this option, you'll enjoy these benefits:

- The possibility of 3-6 month no interest option with a minimum of $300
- Convenient low monthly payments
- Credit decision received immediately
- Quick and easy application in our office, online, or over the phone

At the time of service, you are responsible for the deductible as well as your percentage of the services rendered according to your insurance. If your insurance has not paid 60 days from the date of service, the **full outstanding balance becomes your responsibility**. We must emphasize that as dental care providers our relationship is with **YOU**, not your insurance company or any other third-party payer. While filing your insurance is a courtesy that we extend, THE CHARGES ARE YOUR RESPONSIBILITY from the date services are rendered.

Appointments over 1 hour require a $50 deposit, this will go towards your co-payment.
We do require a **48-hour notice** for changing appointments. We are committed to providing you with the best possible dental care. We are **happy** that you have chosen our practice.

How will you be paying today? **Credit/Debit Card** **Cash** **CareCredit**

Statements are mailed to patients by default. However, we do provide the option to electronically send statements as well. Do you prefer to receive billing notifications via:

- ☐ Text
- ☐ Email
- ☐ Both

Responsible Party Signature____

Vincent Dental Notice of Privacy Practices

1. I understand that my healthcare information concerning my diagnosis, treatment, payment and insurance will be disclosed when necessary for filing my insurance, and in communicating with other health professionals on the course of my treatment at their office. Limited information will also be disclosed to businesses supporting the operations of this office such as dental or medical labs, hospitals, accountant, computer support, billing personnel, answering services and consultants. These businesses are restricted in the use and disclosure of your information by government authorities. If a family member or person is paying for your healthcare with your knowledge, we may disclose information to that family member or person.

2. I understand that my files are stored on computers in the business office. Only staff have access to this office at any time. I understand that this office will make every effort to keep my information secure and correct any violation of my privacy if this should occur.

3. I understand that I have the right to access, copy or inspect and correct my healthcare information, the right to restrict disclosures and obtain an accounting of disclosures. I have the right to voice my concerns about privacy to the practice and/or the Secretary of Health and Human Services within 180 days of my discovery of a disclosure violation without fear of retaliatory acts by this office. I may correct my records in the form of a letter signed by me. I also have the right to revoke my authorization for disclosure.

4. I understand that I will receive communication from this office in the form of phone calls and postcards to remind me of an existing appointment, or that it is time to schedule an appointment. I may receive mail containing financial information, such as ledgers or bills. Communicator may also be sent to me in the form of fax, e-mails or other electronic means. Complete messages concerning my health information may be left on my personal home or work voicemail.

I have read and understand this office policy. I understand that by signing this agreement, I give my permission for the use and disclosure of my personal and health information in order to carry out treatment, payment activities, insurance claims, and healthcare operations. This office retains the right to revise the privacy policy.

Patient's Signature: ______________________________ **Date:** ________________

With Whom May We Discuss Your Account:

____

(Name & Relationship to Patient)