Piedmont Periodontics

Piedmont Periodontics
John W. Schaefer, DMD

PATIENT REGISTRATION INFORMATION

Welcome to our practice!
Thank you for selecting our dental healthcare team. Please fill out this form completely in ink. If you have any questions or concerns, please do not hesitate to ask for assistance – we will be happy to help!

Name_____
First *Middle* *Last*
Home Address_____ City_____ State_____ Zip_____
Birthdate _____ Age _____ Social Security # _____
Home Phone _____ Work Phone _____ Cell Phone_____
E-mail Address _____
Referred by _____

Responsible Party

Name of responsible party _____
First *Last* *Relationship*
Address (if different from above) _____ Home Phone _____
City, State, Zip _____ Birth date _____
Driver's License # _____ Social Security #_____
Employer _____ Work Phone _____

Insurance Information

Name of insured _____
First *Last* *Relationship*
Birth date _____ ID#_____ Social Security # _____
Employer _____ Work Phone _____
Insurance Company _____ Phone # _____
Subscriber ID #_____ Group #_____
Ins. Co Address _____ City _____ State _____ Zip _____
If you have dual insurance:
Subscriber Name _____ Social Security # _____
Employer _____ Work Phone # _____
Insurance Company _____ Group # _____
Ins. Co Address _____ City _____ State _____ Zip _____

Financial Arrangements

We will gladly bill your insurance for you and estimate your share at the time of treatment. Payment for your portion is due at time of service. For your convenience we offer the following methods of payment (Please circle the option you prefer): Cash Check AMEX Visa MasterCard Discover

A billing charge of 1.5% monthly is assessed on balances over 60 days

I acknowledge that I am financially responsible for all charges. If it becomes necessary to commence collections of any amount owed on this and subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I understand that missed or cancelled appointments without proper notification (see "our Policies") will result in a $50 per scheduled hour fee. I authorize the doctors of Piedmont Periodontics to bill my insurance. I release any information needed and assign benefits to Piedmont Periodontics.

In Case of Emergency

Name:_____ **Relationship:** _____
Phone No: _____ **Address:** _____

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Patient Dental History

What is the primary reason for your visit? (Chief Complaint)

_____

When was your last dental visit? _____ Your last deep cleaning? _____
Have your previous dental experiences been favorable? _____ If not, please explain _____
_____
_____
Name of your dentist and/or periodontist _____
Reason for change _____
When were your last x-rays/radiographs taken? _____ FMX _____ Panorex/3D Image_____
Please indicate with a check if you have had, or have any of the following?

_____ Teeth sensitive to _____ cold _____ heat _____ sweets _____ pressure
_____ Frequent toothache
_____ Habitual grinding or clenching of teeth*
_____ Clicking or popping of jaw joints
_____ Gum boils or abscesses
_____ Bleeding gums
_____ Gum Recession*
_____ Periodontal (gum) treatment*
_____ Frequent filling replacement
_____ Discolored teeth
_____ Orthodontic treatment (braces)
_____ Injury to face or jaw
_____ Wisdom tooth removal

*Type of periodontal treatment completed (please describe)?_____
_____

Patient Medical History

This information will help out in preventing serious medical complications or contagious disease. Any information given will be held in strictest confidence and will be released only with your written permission.
Name of Physician _____Date of last physical _____
What medications have you taken in the last three months? _____
_____
Are you under medical treatment? _____ If yes, describe _____
_____
Do you or did you use tobacco?_____ If so, what type and how often? _____
Do you use marijuana?_____ If so, what form and how often? _____
Do you use recreational drugs? _____If so, what and how often?_____
Allergies (Please List):_____

Is your general health good?	**Yes No**	Bleeding Problems	**Yes No**	Seizures	**Yes No**
Have there been changes in		Tuberculosis	**Yes No**	Herpes	**Yes No**
your health within the last year?	**Yes No**	Artificial Joint	**Yes No**	Asthma	**Yes No**
Hospitalizations, surgeries, or		Sleep Apnea	**Yes No**	Hepatitis	**Yes No**
serious illnesses in the last 3 years?	**Yes No**	Do you have or have you had:		Anemia	**Yes No**
Have you had or been treated for:		Diabetes	**Yes No**	Stroke	**Yes No**
Heart attack	**Yes No**	Psychiatric care	**Yes No**	Allergies	**Yes No**
Heart murmur	**Yes No**	Radiation treatment	**Yes No**	Cancer	**Yes No**
High blood pressure	**Yes No**	Chemotherapy	**Yes No**		
Rheumatic fever	**Yes No**	Prosthetic heart value	**Yes No**	Pregnant/Nursing?	
HIV Positive / AIDS	**Yes No**	Pacemaker	**Yes No**		**Yes No**
Are you taking Blood Thinners	**Yes No**	Osteoporosis	**Yes No**		

Has your medical doctor advised you to pre-medicate before dental procedures? **Yes No**

Your Signature _____ **Date** _____

Medical record reviewed by (To Be Completed by Piedmont Periodontics Staff):
Initials_____ Date_____

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PIEDMONT PERIODONTICS-OUR POLICIES

WELCOME to Piedmont Periodontics. It is our pleasure to have you as our patient. Our commitment is to provide you with the best possible dental care and to keep you informed of treatment recommendations and financial obligations.

-- If you have dental insurance, we will be glad to help you to receive your maximum allowable benefits.

The following is our policies and are established to serve your and our best interest. Please initial each policy.

- Payment is due at the time services are rendered. We accept Cash, Checks, MasterCard, Visa, American Express, and Discover. _____
- **If you are a patient with insurance, it is important to remember that your insurance plan is a contract between you, your employer, and the insurance company. The contract is in no way a binding obligation between the Dental Insurance Company and Piedmont Periodontics**. _____
- Our fees generally fall within the acceptable range of the maximum allowance determined by each insurance carrier. This applies only to companies, which pay a percentage of "Usual, Customary, and Reasonable (UCR)," rates. This does not apply to companies, which reimburse based on an arbitrary "schedule" of fees. _____
- After your initial exam you will receive a treatment plan which estimates your portion of payment. **If we estimate and collect your co-payment, and the insurance underpays or denies a benefit, you are responsible for the remaining balance.** _____
- We encourage a submitted insurance pre-determination be sent to your insurance company, this will determine which procedures might be covered and calculate your co-payment. A pre-determination does not guarantee payment from your insurance company. _____
- Not all services are covered in all insurance contracts. Insurance companies arbitrarily select certain procedures they do not cover, based upon the premium/contract arranged by your employer. Our office will comply with ADA standards in filing codes to your insurance company and will not allow insurance companies to dictate treatment. _____
- In order for us to help you process your insurance claim for your reimbursement, please bring all insurance information with you. Also, please call your dental insurance carrier to expedite claims if a claim is not paid within 30 days, as the law requires. _____
- Returned checks and outstanding balances over 60 days are subject to any collection fees. An interest rate of 1.5% will be assessed to your account monthly until the balance is paid in full. _____
- **Cancellation Policy** – in order to cancel or re-schedule an appointment, please adhere to the following formula to determine the acceptable amount of time needed to cancel or change an appointment: 1 business day per hour of scheduled time plus 2 business days, i.e. a 3 hour appointment would require 5 business days to cancel or change the appointment. Any appointment where this policy is not honored, a $100 charge per hour of appointment will be assessed to your account. If you neglect to contact us to cancel or change an appointment or are a no-show but wish to re-schedule the treatment that was missed, you will be required to pay 50% (non-refundable) of the fees for treatment in order to re-schedule. If you miss two scheduled appointments without notifying our office, you will be dismissed. Please remember that the staff sets aside a designated amount of time for your particular type of treatment. We appreciate your understanding of how important keeping your appointment is to the doctor and our other patients. _____
- **Deposits** – after initial consultation, any treatment scheduled WILL require a deposit or your estimated patient portion to be paid prior to scheduling the appointment. _____

We hope by presenting our policies to you in the beginning, we will avoid any misunderstandings and, therefore, have more time to dedicate to your dental care. If you have any questions regarding the above information or insurance coverage, please do not hesitate to ask …we are here to help!

Our financial policy is designed to keep our fees as low as possible. Our goal is to stay competitive and offer the best quality dental care to everyone. Please help us achieve our goal by a mutual respectful relationship. We look forward to a long happy relationship with you. Please do not hesitate to ask our staff for anything that might make your visit more enjoyable. We are all here for you, and welcome any constructive comments.

Sincerely,
John W. Schaefer, DMD

I have read and understand the above office financial policy.

Patient or responsible party signature **Date**

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ASSIGNMENT OF BENEFITS AGREEMENT

Piedmont Periodontics is pleased to accept your insurance assignment. We offer this service as a courtesy to our patients. It must be clearly understood that the "contract" is between the patient and the insurance company, the account thereby being the responsibility of the patient for any amount not paid by the insurance company. The following statements are our policies governing insurance claims.

- Although we are willing to complete insurance information forms and submit a claim on behalf of the patient, we do not accept responsibility—under any circumstance—for the outcome of the transaction. Completing insurance forms is a courtesy we extend to our patients in an effort to maximize their likelihood of obtaining insurance reimbursement. By having our office process insurance forms, the patient agrees to accept liability for those forms. Alternatively, a patient may fill out his/her own insurance forms and bill the insurance directly.
- We require our patients to sign an "authorization to Pay the Doctor" form (or any other necessary assignment documents required by your insurance company). By doing so, the insurance company will make payments directly to our office.
- The patient will pay the co-payment (the amount not covered by the insurance company) at the time services are rendered.
- Insurance payments ordinarily are received within 30 to 60 days from the time of billing. If a patient's insurance company has not made payment to our office within 60 days, we may request the patient to pay the balance due and then seek reimbursement from the insurance company when and if they pay.
- Our office does NOT guarantee that the patient's insurance company will pay. We will perform our routine insurance billing procedures upon verification of coverage. However, if for some reason the patient's claim is denied, the patient is then considered to be responsible for the full amount of the bill.
- Our office will not enter into a "dispute" with an insurance company over any claim, although we will work with the insurance company to sort out any confusions or questions which might arise. We will cooperate fully with the regulations and requests of the insurance companies. It will be, however, the responsibility of the patient to handle with the insurance company any type of dispute over payment by the company.

If you understand and agree to all of the above office policies, please sign your name below and we will accept your insurance assignment.

_____ _____

Signature of Patient/Legal Guardian **Date**

_____

Print name

See Separate Notice of Privacy Practices

Piedmont Periodontics

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

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

_____

Please print your name here

_____

Signature

_____

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

The patient refused to sign.

Due to an emergency situation it was not possible to obtain an acknowledgement.

We weren't able to communicate with the patient.

Other *(Please provide specific details)*

_____

_____

_____

_____ _____

Employee signature *Date*

CONSENT FOR USE / DISCLOSURE OF HEALTH INFORMATION

Patient' s Name:	
Patient's Date of Birth:	Patient's SSN:

Notice to Patient:
By signing this form, you grant us consent to use and disclose your protected health care information for the purposes of **treatment**, various activities associated with **payment** and **health care operations**. Our **Notice of Privacy Practices** provides more details on our treatment, payment activities and health care operations. If there is not a copy of the Notice accompanying this Consent form, please ask for one. We encourage you to read it since it provides details on how information about you may be used and/or disclosed and describes certain rights you have regarding your health care information.

As stated in our **Notice of Privacy Practices**, we reserve the right to change our privacy practices. If we should do so, we will issue a revised Notice. Since revisions may apply to your health care information, you have a right to receive a copy by contacting our Privacy Officer.

You have the right to **revoke** your Consent by giving written notice to our Privacy Officer. The revocation will not affect actions that were already taken in reliance upon this Consent. You should also understand that if you revoke this Consent we may decline to treat you.

You are entitled to a copy of this **Consent Form** after you have signed it.

(To Be Completed by Patient or Patient's Representative)

I,_____, have read the contents of this Consent Form and the Notice of Privacy Practices. I understand that I am giving you my consent to use and disclose my health care information to carry out treatment, payment activities and health care operations.

_____
Patient's Signature or Signature of Patient's Representative Date

_____
Printed Name of Patient's Representative Relationship to Patient

Our Privacy Officer can be contacted as follows:

Name of Privacy Officer: **Tracey Cater**		
Practice Address: **222 12th ST NE Suite 1B** **Atlanta, GA 30309**		
Phone: (**404) 815-4800**	Fax: **(404) 815-0002**	E-Mail: **appts@piedmontperiodontics.com**