

Welcome!

Thank you for selecting our dental health team.



Dentistry **in** BUCKHEAD
Peter A. Pate, DDS
Fellow, Academy of General Dentistry

Patient Info

Patient _____
Last name First Name MI Preferred Name

Address _____

City, State, Zip _____

Home phone _____ Work phone _____ Cell phone _____

E-mail _____ How would you like to receive courtesy notifications? Home # Cell # Work # E-mail

Sex: Male Female Age: _____ Date of birth _____ Marital status: Single Married Other

Social Security # _____ Driver's license # _____ State: _____

Employer: _____

Name of person responsible for account _____

If patient is a child, name of parent/guardian _____

How did you hear about our office? _____ Last dental visit? _____

Insurance

If you have dental insurance and have not yet provided this information, please complete this section.

Insurance company _____ Group Number _____

Policyholder's name _____ Relationship to patient _____

Policyholder's address _____

Policyholder's employer _____ Policyholder's work phone _____

Policyholder's SSN _____ Policyholder's date of birth _____

Emergency

In case of emergency, contact _____ Relationship to patient _____

Address _____ Phone # _____

City _____ State _____ Zip _____

Assignment/Release: I, the undersigned, assign directly to Peter A. Pate, DDS, LLC all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance. I hereby authorize Peter A. Pate, DDS, LLC to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Date: _____ Signature: _____

Minor/Child Consent: I, the parent or guardian of the patient listed above, do hereby request and authorize the dental team to perform necessary dental services for this patient, including but not limited to x-rays and the administration of fluoride, local anesthetics or nitrous oxide as deemed advisable by Dr. Pate, whether I am present at the actual appointment or not.

Date: _____ Signature: _____

Are you currently under the care of a physician? Yes No If yes, for what conditions? _____

Women: Pregnant? Yes No Due date _____ Taking birth control pills? Yes No Nursing? Yes No

Allergies

- Acrylic Anesthetics Aspirin Codeine Latex Metals Penicillin _____
 Other

Do you have, or have you had, any of the following?

Medical History

AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hay Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart ailments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Recreational drug use	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart valve/ vein replacement	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial joint	<input type="checkbox"/> Yes <input type="checkbox"/> No	High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bisphosphonate drugs (Fosamax / Actonel)	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV+	<input type="checkbox"/> Yes <input type="checkbox"/> No	Snoring/Sleep Apnea	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver problems/ hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	STD (venereal disease)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Malignancies	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emotional problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral valve prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid	<input type="checkbox"/> Yes <input type="checkbox"/> No
Excessive bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No	Neurological problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eye disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pregnancy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcer/Colitis	<input type="checkbox"/> Yes <input type="checkbox"/> No

Have you had any serious health issue not listed above? Yes No If yes, please explain _____

Are you taking any prescription or over the counter medications? Yes No If yes, please list _____

These questions relate to the need for antibiotics to prevent a potentially serious heart infection:

Have you ever been advised to take an antibiotic before routine dental appointments? Yes No

- Artificial Heart Valve Endocarditis Congenital Heart Defect Artificial joint Organ transplant

***** Do you have or have you had any of the above conditions? If yes, but you know that you are not required to premedicate, we will require a letter from your physician indicating that you do not need to premedicate.**

Do you have or do you use any of the following?

Dental History

Bad breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fluoride supplements	<input type="checkbox"/> Yes <input type="checkbox"/> No	Periodontal (gum) treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding gums	<input type="checkbox"/> Yes <input type="checkbox"/> No	Food caught between teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blisters --lips/mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Interdental stimulators	<input type="checkbox"/> Yes <input type="checkbox"/> No	Smokeless tobacco	<input type="checkbox"/> Yes <input type="checkbox"/> No
Burning of tongue	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth breathing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swelling/lumps	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cigarettes/pipe/cigar	<input type="checkbox"/> Yes <input type="checkbox"/> No	Oral habits (fingernail biting, cheek biting)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Unfavorable dental experience	<input type="checkbox"/> Yes <input type="checkbox"/> No
Clenching/grinding	<input type="checkbox"/> Yes <input type="checkbox"/> No	Orthodontic treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No	Unpleasant taste	<input type="checkbox"/> Yes <input type="checkbox"/> No
Complications from extractions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain around the ear	<input type="checkbox"/> Yes <input type="checkbox"/> No	Unusual sounds in ear while chewing	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dental floss	<input type="checkbox"/> Yes <input type="checkbox"/> No				

Do you have any specific concerns about your oral health? _____

I certify that the above information is accurate and complete to the best of my knowledge. I understand that any errors or omissions could harm my dental treatment and/or my overall health. I will not hold Dr. Peter A. Pate or his staff responsible for the results of any errors or omissions in the information I have provided.

Date: _____

Signature: _____

Office Policies and Financial Guidelines

To provide high quality dental care in a relaxed environment, we follow these guidelines.

Scheduling

Our practice was built on the philosophy that the patient is our most important concern. We manage our schedule to provide individualized attention to each patient. This means that your appointment time is reserved exclusively for you. We work hard to maintain our schedule so that all our patients can be treated promptly. Should you need to cancel or reschedule your appointment, we appreciate a 48 hour advance notice. In consideration of other patients, your appointment may not be extended if you arrive after your appointment time. Delayed arrival may result in the need to reschedule your appointment.

Insurance

If you have a dental benefit plan, we will make every effort to help you maximize your benefits. We will be happy to submit claim forms to your insurance company. However, please understand that we deal with many different insurance plans in an effort to accommodate our patients. It is impossible for our office staff to be aware of the unique requirements of every plan. For example, your plan may have limitations on the number of visits, x-rays, and number or types of procedures considered for payment. If you have any questions about whether a procedure will be considered for payment, please contact your insurance carrier before beginning treatment. Any outstanding balance not paid by insurance is the patient's responsibility.

Payments

We are committed to the success of your treatment, and our fees are usual and customary for the Atlanta market. Payment is expected at the time of service unless other arrangements have been made in advance. We accept cash, checks, and all major credit cards. We also offer favorable third-party financing options for our patients. If you are interested in financing options, please ask our front office team for details.

If your insurance does not pay within 45 days, the unpaid balance will become your responsibility.

In the rare event that it is necessary to turn your account over to our collections agency, you will be responsible for additional interest fees, late fees and collections fees.

I have read and understand the Office Policies and Financial Guidelines above, and all my questions have been answered to my satisfaction. I understand that payment is due at the time of service unless other arrangements have been made in advance. I will accept responsibility for all charges not paid by my dental benefit plan within 45 days of my visit.

Signature _____ Date _____



Dentistry ⁱⁿ BUCKHEAD
Peter A. Pate, DDS
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**ACKNOWLEDGEMENT 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.

 Please Print Name

 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
 - Communications barriers prohibited obtaining the acknowledgement
 - An emergency situation prevented us from obtaining acknowledgement
 - Other (Please Specify)
-
-



CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: Patient Giving Consent

Name: _____ Social Security Number: _____

Address: _____

Telephone: _____ E-mail: _____

Section B: To the Patient - Please Read the Following Statements Carefully

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Ann C. Moore 3833 Roswell Road • Suite 100 • Atlanta, GA 30342
 T: 404.266.9424 F: 404.261.4526 E-mail: ann@patedds.com

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____ have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If a personal representative on behalf of the patient signs this Consent, complete the following:

Personal Representative's Name: _____ Relationship to Patient: _____

REVOCAION OF CONSENT (Sign below ONLY if you intend to revoke consent)

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will affect any action you took in reliance on my Consent before you received this written Notice of Revocation, I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.