health • beauty • comfort • longevity

S. MICHAEL LODEN, DMD

• General & Restorative Dentistry •

Welcome

On behalf of Dr. S. Michael Loden and our dental team, we are pleased to welcome you to our practice. Please take a few minutes to provide us with the following information.

All information will be kept confidential.

Patient Information

Patient's Name: _____ Email: _____

Home #: _____ Work #: _____ Cell #: _____

Social Security #:_____ Date of Birth: _____ Age: _____

Gender: ____ Male ____ Female Marital Status: ____ Single ____ Married ____ Divorced ____ Widowed

Address: _____ City: _____ ZIP: _____

Employer: _____ Occupation: _____

Spouse's Name: _____ Spouse's Employer: _____

Emergency Contact Person: _____ Phone #: _____

Is the patient a student? _____ Full Time _____ Part Time

Responsible Party Information

Person responsible for Account: _____ Relationship to Patient: _____

Home Phone #: _____ Work or Cell #: _____

Address: _____ City: _____ ZIP: _____

Social Security #:_____Date of Birth: _____ Drivers License #: _____

Have you or any member of your family been a patient at this office before? _____ Yes _____ No

If YES, please give us their name: _____

Primary Dental Insurance Information

Insured's Name: _____

SS#: ___-___-___ DOB: _____

Insurance Carrier: _____

Group or Policy #: _____

Union/Group Name: _____

Local #: _____Date Employed: _____

Secondary Dental Insurance Information

Insured's Name: _____

SS#: ___-___-___ DOB: _____

Insurance Carrier: _____

Group or Policy #: _____

Union/Group Name: _____

Local #: _____Date Employed: _____

Who may we thank for recommending our office to you? _____

Otherwise, how did you learn about our practice?

_____ Internet _____ Office Website _____ Facebook _____Yellow Pages Other: _____

Dental History

What is the primary reason for your visit today? _____
Are you aware of any dental problem? If so, please explain: _____
Last Dental Visit: _____
Name of your previous Dentist and Dental Office: _____
City: _____ State: _____ Office Phone #: _____

Please share the following dates:
Your last dental examination and cleaning: _____
Your last complete series of x-rays: _____
Your last oral cancer screening: _____
Was there any dental treatment your last dentist recommended for you? If so, please describe:

_____

If your dental treatment was not completed, what prevented you from receiving it?
____ Time _____ Cost _____ Fear Other: _____
Why did you leave your last dentist? _____

Please check any of the following problems that apply to you:

____ Sensitivity (to hot, cold, sweets)
____ Tooth discomfort when chewing
____ Teeth or fillings breaking
____ Jaw Joint pain
____ Grinding / Clenching teeth
____ Bleeding, swollen or irritated gums
____ Loose, chipped or shifting teeth
____ Missing teeth
____ Bad breath and / or bad taste in your mouth
____ Dry mouth

Please indicate current / past dental treatments:

____ Dentures / Partial Dentures
____ Treatment for TMJ
____ Teeth extracted (adult teeth)
____ Braces
____ Wear a night guard / Splint
____ Deep cleanings / Periodontal Treatment
____ Dental Implants

What is the most important thing about your dental visit today?

_____

On a scale of 1-10, with 10 being the highest,
How important is your dental health to you? How would you rate your current dental health?

Please check any of the following that APPLIES TO THE PATIENT:

____ AIDS/HIV+
____ Seasonal allergies
____ Chemotherapy
____ Excessive bleeding
____ Hepatitis A/B/C
____ Mitral Valve Prolapse
____ Respiratory illness
____ Stroke
____ Allergies to antibiotics
____ Artificial Heart Valve
____ Cancer
____ Anemia
____ Asthma
____ Diabetes
____ Fainting
____ High Blood Pressure
____ Anxiety / Depression
____ Rheumatic fever
____ Thyroid disease
____ Tuberculosis
____ Emphysema
____ Heart Murmur
____ Arthritis
____ Blood Disease
____ Dizziness
____ Glaucoma
____ Low Blood Pressure
____ Pacemaker
____ Rheumatism
____ Phen-Fen (diet pills)
____ Kidney Disease
____ Radiation
____ Stomach Problems
____ Artificial Joints
____ Bruise easily
____ Drug addiction
____ Heart Conditions
____ Jaundice
____ Seizures
____ Osteoporosis
____ Liver Disease
____ Latex Allergy

other medical conditions: _____

Do you smoke or use chewing tobacco? ___ Yes ___ No How much? _____ How Long? _____
Do you drink alcoholic beverages? ___ Yes ___ No How much? _____ How Often? _____
Women only: Are you pregnant? ___ Yes ___ No # of Weeks: _____ Nursing? _____
What medical conditions are you currently being treated for? _____
Physician's Name and Office: _____ Phone#: _____
Please list any medications you are currently taking: _____

_____

Has any physician or previous dentist recommended that you take antibiotics prior to your dental appointment? _____
Please list any medications you are allergic to or have bad reactions to: _____

To the best of my knowledge, I have answered every question completely and accurately.
It is my responsibility to inform Dr. S. Michael Loden of any changes in my health and or in my medications.

Patient's Signature: _____ **Date:** _____ **Reviewed by:** _____

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Notice of Privacy Practices
Patient Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practice, containing a more complete description of the uses and disclosure s of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below 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. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

If you are not available, can we discuss your account with your spouse or anyone else? Yes or No

If so, please list their names and date of birth_____

_____

1267 Russell Parkway I Warner Robins, GA 31088
478.923.0253

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THREE IMPORTANT COMMITMENTS

We have three important commitments in our practice that we feel are valuable to share with you. We have put them in writing because we live by them and ask that all of our patients live by them as well. We have experienced that these three commitments may require actions that differ from what you may be accustomed to in the past, however, we believe they are very necessary. We ask that you read this page thoroughly.

1. **Commitment To Treatment**
   We believe that all treatment begun should be completed. Incomplete treatment leads to problems, complications, and misunderstandings. Incomplete treatment leads to loss of teeth and further disease. This policy states that all accepted treatment plans should be completed, once they are started. Some treatment plans, because of their design, take longer to complete. However, to begin staged treatment, your commitment to both starting and completing treatment is necessary.

2. **Commitment To Appointment**
   We reserve time for each patient in our practice. An appointment for you on our schedule is a commitment that we will be here to serve you and you will be present for that appointment. As a partner in your dental health, we value our appointment time with you. We request that you be present for all scheduled appointments. We do not appreciate cancellations or constant short notice changes. Our office policy in this regard is extremely firm. We believe in mutual respect for each other's time.

3. **Commitment To Financial Agreement**
   We believe we have a responsibility to use our best professional care, skill, and judgement in planning for your dental treatment. The benefits of treatment and liabilities of neglect are always explained by Dr. Loden in your Review of Findings.

   - All fees will be properly explained to you prior to treatment.
   - Acceptance of your treatment indicates your commitment to honor your financial obligations associated with that treatment.

Signed _____Date _____

Witness_____Date _____

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Office Policies

We are a team of health care professionals dedicated to improving the lives of our patients by establishing relationships based on trust, compassion, and commitment. Our goal is to become a partner with our patients to help them achieve and maintain optimum health, beauty, and comfort for a lifetime.

In order to provide this quality of dental care, we request all of our patients pay their estimated personal cost of treatment at the time of service. As a courtesy to our patients, we will file your dental insurance claims for treatment you receive. However, in the event the insurance company does not pay their estimated portion, the balance will become the patient's responsibility.

Please take the time to understand your insurance policy and benefits. The benefits you receive are based on the terms of the contract that were negotiated between your employer and the dental insurance company. Our goal is to help you achieve and maintain optimal dental health. Our office will do everything possible to help you understand and make the most of your dental insurance benefits and provide you with an estimate before any treatment is initiated. Please understand that estimates given are estimates, and may change depending on the individual insurance plan coverage.

All estimates for dental services will be valid for 90 days from the date of signed treatment agreement.

Policies for X-rays & Photographic records:

X-rays in conjunction with a clinical exam are necessary for a thorough and accurate diagnosis and dental treatment plan. Examination x-rays are generally taken once a year for adults and every six months for children. However the frequency at which x-rays are taken will be based upon individual dental need.

Dental models and photographs may be taken to document and analyze clinical treatment. These records may be used for educational and viewing purposes by the practice. At no time will the patient's identity be disclosed.

Appointment Policy:

We pride ourselves in providing adequate time for the personal attention each patient deserves. Your appointment time in this office will be reserved exclusively for you. We respect your time and make every effort to keep you from waiting. We request you provide us with at least 2 business days notice if you need to reschedule your appointment.

Patient Responsibility:

Below is a composite view of the different ways you may take care of your financial responsibilities in our office:

- Payment is expected at the time of services are rendered. Acceptable forms of payment are: cash, Check, and/or a valid Credit Card.
- For our patients who need extended credit terms to achieve their oral health goals, we will assist in arrangements with Care Credit, Springstone or Robins Federal Credit Union for those who are approved.

Past due payment policy:

A 1.5% interest fee will be charged to all accounts past due 30 days and 60 days. Accounts past due 90 days will be turned over to our Professional Partners (preferred Collection Agency) and are subject to a 30% recovery fee.

I have read and agree to the office policies stated above.

_____Date:_____

Signature of patient, parent or guardian

_____Date:_____

Signature of guarantor of payment / responsible party

Submit