Georgia Dental Medicine
1225 Johnson Ferry Road,
Suite 660
Marietta GA 30068

(770) 973-6494

New Patient Information

Welcome to the office of Georgia Dental Medicine. We are happy to have you as a patient. Please take a moment to enter or update your personal information to help us ensure the highest quality of care.

To minimize fraud, we will need to make a copy of your and/or the financially responsible party driver's license or legal identification card. Please make sure that you have this information available if this is your first visit.

We will also need to make a copy of any dental insurance card(s) you have.

This form is completed by new patients at their first visit, and infrequently by existing patients (so that we can keep our records up-to-date).

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Today's Date:

*

Chart #.
FOR OFFICE USE ONLY

Patient Name: Last First MI Preferred Name

Title: Mr/Ms/Mrs/etc Gender: ☐ Male ☐ Female Family Status: ☐ Married ☐ Single ☐ Child ☐ Other

Birth Date: SS #. Prev. Visit:

Email Address: Best time to call:

Phone: Home Work Ext Mobile Fax Other

Address: City State Zip Code

Whom may we thank for referring you to our practice?

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Financially Responsible Party Information:

The following is for: ☐ the patient's spouse ☐ the person responsible for payment ☐ neither-not applicable

Name: _____ (Last) _____ (First) ____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ☐ Male ☐ Female Family Status: ☐ Married ☐ Single ☐ Child ☐ Other

Birth Date: _____ Email Address: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) Best time to call: _____

Address: _____

_____ (City) ____ (State) _____ (Zip Code)

Employment Information:

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Phone: _____

Address: _____

_____ (City) ____ (State) _____ (Zip Code)

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Financial Policy at Georgia Dental Medicine

Thank you for choosing our office to provide you with dental care. We are committed to meeting your dental needs in a caring and service oriented environment. Our goal is to keep your insurance and other financial arrangements as simple as possible. In order to accomplish this in a cost-effective manner, we ask that you adhere to the following guidelines:

(1). Payment is due at the time of service.

(2). As a courtesy to you, we will file your insurance. Our office is not an approved provider in any "in network only" dental plans (such as DMO and HMO plans). You will be responsible for any and all services in excess of your insurance limits as well as all non-covered services. Insurance plans are different, so please review your benefits. If you have secondary insurance, we will provide all necessary forms for you to file your claim. When in doubt, we can help with pre-certification on large cases.

(3). Your estimated portion (that which insurance typically requires you to pay) is due at the time of service. It is important for you to realize that our services are rendered to you and not the insurance company. We will mail you a monthly statement for any outstanding balance after your insurance pays their portion.

(4). We reserve the right to charge for missed appointments. Please attempt to give us at least 2 business day's notice for cancellations. We understand that emergencies do occur. We also reserve the right to add interest changes and/or collection fees to payments not received when due. We accept cash, personal checks, and all major credit cards, with the exception of American Express.

(5). If financial arrangements are needed, please talk with our Office Manager regarding Care Credit(TM) or go to www.carecredit.com. Care Credit(TM) is essentially a "Dental/Medical Expenses Only" line of credit/credit card. In certain situations, Care Credit(TM) financing may be interest free.

(6). To provide additional clarification to the previous items: while Georgia Dental Medicine will do its best to keep track of the number of hygiene visits that you have previously completed within the calendar year, it is your (or the financial responsible person's) responsibility to make sure that you do not exceed any insurance company mandated yearly visitation limits. If these limits or any other financial limits are reached by your insurance policy, it is your (or financially responsible person's) responsibility to pay all expenses not covered by insurance. It is your responsibility to understand your insurance policy limits, restrictions and limitations BEFORE a dental procedure is performed.

Consent for Internet Communications

I grant my permission to Georgia Dental Medicine to upload and store confidential patient information (including account information, appointment information and clinical information) to any secure Internet site associated with this dental practice (e.g. secure cloud-based backups).

Note also that Georgia Dental Medicine may need to communicate with you via email. Any email that we send you that contains confidential patient information will be sent via a secure, encrypted method (which will require additional steps for you to decrypt the message). Patient appointment reminder emails are not sent encrypted since they do not contain confidential information.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to any secure Internet service on my behalf.

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Authorization

I hereby certify that I have accurately completed, to the best of my knowledge, the information provided above. I also certify that I have read and understand the previously provided information.

I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize Georgia Dental Medicine to release any necessary information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payers, and/or healthcare practitioners as part of dental treatment or payment for such treatment. For more details, see our "Notice of Privacy Practices" which is available at our office or online at www.dmdga.com

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any). I also understand the previous described Financial Policy.

If I ever have a change in my overall health or any change to my dental health, I will inform the Georgia Dental Medicine at or prior to my next dental appointment without fail.

I acknowledge that at any visit to Georgia Dental Medicine, I may be required to provide proof of identity. This is done to help prevent identity theft and fraud.

I also will inform Georgia Dental Medicine of any insurance changes when necessary, as soon as possible.

Via the signature below, I and/or the financially responsible party acknowledge an understanding of and fully accept the Financial Policy and all other policies, restrictions and limitations here in provided, and acknowledge that all of the preceding information is true, accurate and correct, to the best of my knowledge.

Signature of patient (if 18 or older) and parent/guardian/financially responsible party:

Signature: _____ Date: * _____

Relationship to Patient (if signature above is not the patient):

_____

Response Date: _____