Patient Registration Form

American Dental Association
www.ada.org

Email:			Today's Date:
Preferred Name: ❑ Miss ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr.		Referred by:	
Name: Last First Middle		Home Phone: *include area code* ( )	Cell Phone: *include area code* ( )
Address: Mailing address		City:	State: Zip:
SS#:		Date of Birth:	Sex: M F
Employer:			Business Phone: *include area code* ( )
Emergency Contact:	Relationship:	Home Phone: *include area code* ( )	Cell Phone: *include area code* ( )

College Student Status: ❑ Full Time ❑ Part Time Please provide school info:	School Name:_____
Employment Status: ❑ Full Time ❑ Part Time ❑ Retired	Address:_____
Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed	Address 2:_____
Pref. Pharmacy: Phone: ( )	City, State, Zip:_____

Dental Insurance Information

Primary Insurance Information

Name of Insured: _____	Relationship to Patient: ❑ Self ❑ Spouse ❑ Child ❑ Other
Insured Soc. Sec.: _____	Insured Birth Date: _____
Employer:_____	Ins. Company: _____
Address:_____	Address: _____
Address 2:_____	Address 2: _____
City, State, Zip:_____	City, State, Zip: _____
ID#: _____ Gr#:_____	

Secondary Insurance Information

Name of Insured: _____	Relationship to Patient: ❑ Self ❑ Spouse ❑ Child ❑ Other
Insured Soc. Sec.: _____	Insured Birth Date: _____
Employer:_____	Ins. Company: _____
Address:_____	Address: _____
Address 2:_____	Address 2: _____
City, State, Zip:_____	City, State, Zip: _____
ID#: _____ Gr#:_____	

Dental Information For the following questions, mark (X) your responses to the following questions.

	Yes	No	DK
Do your gums bleed when you brush or floss?	❑	❑	❑
Are your teeth sensitive to cold, hot, sweets or pressure?	❑	❑	❑
Is your mouth dry?	❑	❑	❑
Have you had any periodontal (gum) treatments?	❑	❑	❑
Have you ever had orthodontic (braces) treatments?	❑	❑	❑
Have you had any problems associated with previous dental treatment?	❑	❑	❑
Is your home water supply fluoridated?	❑	❑	❑
Do you drink bottled or filtered water?	❑	❑	❑
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY			
Are you currently experiencing dental pain or discomfort?	❑	❑	❑

	Yes	No	DK
Do you have earaches or neck pains?	❑	❑	❑
Do you have any clicking, popping or discomfort in the jaw?	❑	❑	❑
Do you brux or grind your teeth?	❑	❑	❑
Do you have sores or ulcers in your mouth?	❑	❑	❑
Do you wear dentures or partials?	❑	❑	❑
Do you participate in active recreational activities?	❑	❑	❑
Have you ever had a serious injury to your head or mouth?	❑	❑	❑

Date of your last dental exam:
What was done at that time?

Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

over

Medical Information

Please mark (X) your responses to indicate if you have or have not had any of the following diseases or problems.

(Check DK if you Don't Know the answer to the question) Yes No DK

Are you now under the care of a physician? ❑ ❑ ❑

Physician Name: _____

Phone: *include area code* (____) _____

Address/City/State/Zip: _____

_____

Are you in good health? ❑ ❑ ❑

Has there been any change in your general health within the past year? ❑ ❑ ❑

If yes, what condition was treated? _____

_____

Date of last physical exam: _____

Do you wear contact lenses? ❑ ❑ ❑

Are you taking, or have you taken, any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine) or fen-phen (fenfluramine-phentermine combination)? ❑ ❑ ❑

Are you taking or scheduled to begin taking either of the medications alendrontate (Fosamax®) or risendronate (Actonel®) for osteoporosis or Paget's disease? ❑ ❑ ❑

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastic cancer? ❑ ❑ ❑

Date Treatment Began: _____

Yes No DK

Have you had a serious illness, operation or been hospitalized in the past 5 years? ❑ ❑ ❑

If yes, what was the illness or problem? _____

Are you taking or have you recently taken any prescription or over the counter medicine(s)? ❑ ❑ ❑

If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements: _____

_____

_____

_____

Do you use controlled substances (drugs)? ❑ ❑ ❑

Do you use tobacco (smoking, snuff, chew, bidis)? ❑ ❑ ❑

If so, how interested are you in stopping?
Circle one: VERY / SOMEWHAT / NOT INTERESTED

Do you drink alcoholic beverages? ❑ ❑ ❑

If yes, how much alcohol did you drink in the last 24 hours? _____

If yes, how much do you typically drink in a week? _____

WOMEN ONLY Are you:

Pregnant? ❑ ❑ ❑

Number of weeks: _____

Taking birth control pills or hormone replacement? ❑ ❑ ❑

Nursing? ❑ ❑ ❑

Joint Replacement. Have you had an orthopedic total joint replacement (hip, knee, elbow, finger)? ❑ ❑ ❑

Date: _____ If yes, have you had any complications?

Allergies - Are you allergic to, or have you had a reaction to: Yes No DK

To all **yes** responses, specify type of reaction.

Local anesthetics _____ ❑ ❑ ❑

Aspirin _____ ❑ ❑ ❑

Penicillin or other antibiotics _____ ❑ ❑ ❑

Barbituates, sedatives, or sleeping pills _____ ❑ ❑ ❑

Sulfa drugs _____ ❑ ❑ ❑

Codeine or other narcotics _____ ❑ ❑ ❑

Metals _____ ❑ ❑ ❑

Latex (rubber) _____ ❑ ❑ ❑

Iodine _____ ❑ ❑ ❑

Hay fever / seasonal _____ ❑ ❑ ❑

Animals _____ ❑ ❑ ❑

Food _____ ❑ ❑ ❑

Other _____ ❑ ❑ ❑

	Yes	No	DK
Heart murmur	❑	❑	❑
Mitral valve prolapse	❑	❑	❑
Artificial heart valves	❑	❑	❑
Rheumatic fever	❑	❑	❑
Cardiovascular disease	❑	❑	❑
Angina	❑	❑	❑
Arteriosclerosis	❑	❑	❑
Congestive heart failure	❑	❑	❑
Coronary artery disease	❑	❑	❑
Damaged heart valves	❑	❑	❑
Heart attack	❑	❑	❑
Low blood pressure	❑	❑	❑
High blood pressure	❑	❑	❑
Congenital heart defects	❑	❑	❑
Pacemaker	❑	❑	❑
Rheumatic heart disease	❑	❑	❑
Abnormal bleeding	❑	❑	❑

	Yes	No	DK
Anemia	❑	❑	❑
Blood transfusion	❑	❑	❑
If yes, date: _____			
Hemophilia	❑	❑	❑
AIDS or HIV infection	❑	❑	❑
Arthritis	❑	❑	❑
Autoimmune disease	❑	❑	❑
Rheumatoid arthritis	❑	❑	❑
Systemic lupus erythematosus	❑	❑	❑
Asthma	❑	❑	❑
Bronchitis	❑	❑	❑
Emphysema	❑	❑	❑
Sinus trouble	❑	❑	❑
Tuberculosis	❑	❑	❑
Cancer/Chemotherapy/ Radiation treatment	❑	❑	❑

	Yes	No	DK
Chest pain upon exertion	❑	❑	❑
Chronic pain	❑	❑	❑
Diabetes Type I or II	❑	❑	❑
Eating disorder	❑	❑	❑
Malnutrition	❑	❑	❑
Gastrointestinal disease	❑	❑	❑
G.E. Reflux/Persistent heartburn	❑	❑	❑
Ulcers	❑	❑	❑
Thyroid problems	❑	❑	❑
Stroke	❑	❑	❑
Glaucoma	❑	❑	❑
Hepatitis, jaundice or liver disease	❑	❑	❑
Epilepsy	❑	❑	❑
Fainting spells or seizures	❑	❑	❑

	Yes	No	DK
Neurological disorders	❑	❑	❑
If yes, specify: _____			
Sleep disorder	❑	❑	❑
Mental health disorders	❑	❑	❑
If yes, specify: _____			
Recurrent infections	❑	❑	❑
Type of infection: _____			
Kidney problems	❑	❑	❑
Night sweats	❑	❑	❑
Osteoporosis	❑	❑	❑
Persistent swollen glands in neck	❑	❑	❑
Severe headaches/ Migraines	❑	❑	❑
Severe of rapid weight loss	❑	❑	❑
Sexually transmitted disease	❑	❑	❑
Excessive urination	❑	❑	❑

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ❑ ❑ ❑

Name of physician or dentist making recommendation: _____ Phone: (____) _____

Do you have any disease, condition, or problem not listed above that you think I should know about? ❑ ❑ ❑

Please explain: _____

NOTE: Both Doctor and patient are encouraged to discuss any and all relevent patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will reyl on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: _____ Date: _____

Powers Ferry Family Dentistry
6370 Powers Ferry Rd. NW Ste 103
Atlanta, GA 30339

GENERAL DENTISTRY INFORMED CONSENT FORM

TREATMENT PLAN
I understand that I may have the following work done but not limited to: Periodontal treatment, Crowns/Inlays/Onlays, Extractions, Root Canals, Dentures, X Rays, Surgery, Implants and or Other _____.

CHANGES IN TREATMENT PLAN
I understand that during treatment if may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during the examination. For example, root canal therapy following routine restorative procedures. I give permission to Dr. Kumar and Associates to make any changes and additions necessary.

DIAGNOSIS
I understand that diagnostic procedures can involve several appointments/ multiple radiographic images and in complex cases an additional specialist examination may be required to develop a comprehensive treatment plan.

DRUGS AND MEDICATIONS
I understand that antibiotics, analgesics and/or other medications can cause allergic reactions, redness, swelling,pain, itching, and/or anaphylactic shock. It is my responsibility to inform my treating practitioner about any possible allergies I may have.

LOCAL ANESTHESIA
I understand that local anesthesia is recommended for most of the procedures performed and its benefits far outweigh the potential risk,, however I am aware that it can result in allergic reaction and life threatening anaphylactic shock. Furthermore, it can result in permanent damage to the nerve, partial or complete permanent numbness lasting several days to months, bruising or formation of hematoma.

PREVENTATIAVE TREATMENT
I understand that my dentist may recommend alternative approaches for optimization of my dental/overall health, including but not limited to nutritional counseling/ tobacco counseling/ oral hygiene instructions/ fluoride treatment.

WHITENING TREATMENT
There may be sensitivity associated with the whitening procedures done in the office (zoom) and at home (trays, strips, pen). It is a common consequence of whitening. Patient is advised to take analgesics and treat the area with topical fluoride until sensitivity subsides.

PERIODONTAL CLEANING/SCALING AND ROOT PLANING
I understand that the most common complications are pain, bleeding, tissue (gum) laceration, sensitivity to temperature or foods, swelling, ulceration (infection), tooth fracture, breaking of fillings, dislodging of crowns or veneers. Reaction to fluoride treatment may cause nausea or vomiting.

PERIODONTAL LOSS (TISSUE AND BONE)
I understand that I may have a serious condition, causing gum inflammation, bone loss, and it can lead to loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, bone grafts, extractions, laser treatment and bacterial irrigation. Any dental procedures may have future adverse effects on my periodontal condition.

RESTORATIVE TREATMENT
I understand that the most common complications are pain, sensitivity to temperature, fracture of tooth, nerve damage, damage to other teeth, occlusal (bite) discrepancies, TMJ complications, reactions to drugs/ anesthesia. I understand that sometimes existing caries may cause inflammation of the nerve and subsequently fitting restoration may have further treated by a root canal therapy due to initial underlined inflammation of the nerve. Also I understand that once the tooth is restored with a filling material it is never going to feel the same natural tooth. It may be sore, temperature sensitive, pressure sensitive for several weeks the position of my teeth is dynamic condition therefore bite adjustments may required following the restorations.

CROWNS/INLAYS/ONLAYS/BRIDGES
I understand that sometimes is is not possible to match the color of artificial teeth exactly to natural teeth. Most of the time my dentist will give my an option of having the shade taken in the laboratory under the different light sources. I further understand that I may be wearing temporary crowns/ fillings that may come off easily and I must be careful to ensure that they are kept on until the permanent is delivered. I realize that the final opportunity make changes to my restoration (including shape., size, fit, and color) will be before cementation. It is also my responsibility to return for for permanent cementation within 20 days from the preparation date. Excessive delays may allow for tooth movement. This may necessitate a remake of the crown or bridge. I understand there will be an additional charge for remakes due to me delaying permanent cementation. I also understand that I may require root canal therapy after routine crown/inlay/onlay/bridge preparation. It will be determined by my health care provider at the time of presenting symptoms if further treatment with root canal therapy is required.

(Next Page)

Powers Ferry Family Dentistry
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GENERAL DENTISTRY INFORMED CONSENT FORM

ENDODONTIC TREATMENT (ROOT CANAL THERAPY)
I understand that there is no guarantee that root canal treatment will save my tooth, and the complications can occur from the treatment. Occasionally root canal filling material may extend through the tooth, which does not necessarily, affect the success of treatment. I understand the endodontic files and reamers are very fine instruments; stresses vented in their manufacture can cause them to separate or break during use. I understand that sometimes additional surgical procedures or re-treatment my be necessary following root canal treatment. I understand that the tooth may be lost in spite of all the efforts to save it. Root canal treated teeth must be covered by crowns or bridges and if I do not follow the post-operative instructions, it could lead to a fracture and failure of root canal treated tooth.

DENTURES AND PARTIALS
I understand that wearing dentures or partials may be difficult. Sore spots, altered speech and difficulty eating are some common problems. Immediate dentures (placed right after surgery/extractions) may be painful and may require considerable adjustments and several relines. Regular follow up is necessary to maintain soft tissue health and optimized healing. A permanent reline will be needed later. This is not included in the denture fee. I understand that this is my responsibility to return for delivery of dentures and follow up appointments. I understand that failure to keep my appointment may result in poor fitting dentures or partials. If a remake is required due to my delay of more than 30 days, there will be an additional charge.

ORTHODONTICS
Our doctors are experienced/trained in the provision of Invisalign orthodontic treatment. It is the patients responsibility to be 100% compliant with the instructions and home care for the treatment to be successful. I understand that additional fees may be applied if refinement of the treatment is needed. The cost of the retainers are not included in the initial treatment fee.

ACKNOWLEDEMENT
I certify that the answers to the health questionnaire are accurate and correct to the best of my knowledge. Since a change in medical conditions, pregnancy or medications can affect dental treatment. I understand the importance of and agree to notify Dr. Kumar and Associates of any subsequent appointment.

I understand that dentistry is not an exact science and therefore reputable practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment I have requested and authorized.

I hereby authorize Dr. Kumar and Associates and dental auxiliaries to proceed with and perform the dental procedures and treatments as had been explained to me. I understand this is only as estimate and subject to modification depending on unforeseen or undiagnosable circumstances that may arise during the course of treatment. I understand that regardless of any insurance coverage I may have. I am responsible for payment of dental fees. I agree to pay any attorney's fees, collection fees, or court cost that my incurred to satisfy obligation.

Patient Name (PRINT)	**Patient Signature**	**Date**

Powers Ferry Family Dentistry
6370 Powers Ferry Rd. NW Ste. 103
Atlanta, GA 30339
404-994-5650

In April of 2003, new federal requirements regarding privacy of information for health care patients take effect. H.I.P.A.A., the Health Insurance Portability Act requires that all medical providers, insurance companies and others put in place controls to ensure that your personal information is safe.

Powers Ferry Family Dentistry requires that each patient sign this consent for which allows us to share protected health information with other dental offices and insurance company. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent.

Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, parents or other to call and request of tests and procedures. Under the requirements for H.I.P.A.A. We are not allowed to give this information to anyone without the patients consent. If you wish to have your information released to family members, you must authorize and sign this form. Signing this form will only give consent to release laboratory and radiology results to the family members indicated below. The consent form will not allow Powers Ferry Family Dentistry to release any other information to these family members.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize Powers Ferry Family Dentistry to release my laboratory/radiology results and reports to the following individuals.

1. _____ Relation to Patient _____ Date _____

2. _____ Relation to Patient _____ Date _____

☐ **Authorize** ☐ **Not Authorized**

Authorization to Leave Messages with Household Members/Answering Machine

From time to time it is necessary for representatives of Powers Ferry Family Dentistry to leave messages for patients. The purpose of these messages is to remind patients that they have an appointment, to notify the patient that the staff would like to discuss lab or procedure results or to ask a patient to call the office regarding an issue or concern. At no time will a representative of Powers Ferry Family Dentistry discuss your medical circumstances or conditions without your consent. The purpose of this consent is to leave messages with members of your household or on your answering machine.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

☐ **Authorize** ☐ **Not Authorized**

Emailing X-Rays

In providing the best treatment for our patients, it might be necessary for us to email x-rays to other specialist or dentist. This allows other offices to have a better diagnostic tool available to them which will cost you less and permit you to have access to quicker services.

I understand that x-rays might need to be emailed to other specialist and dentists. I give my permission for this service.

☐ **Authorize** ☐ **Not Authorized**

Signature of Patient or Representative _____ **Date** _____

Powers Ferry Family Dentistry
6370 Powers Ferry Rd, NW, Ste 103
Atlanta, GA. 30339
404-994-5650 (office)
404-994-5651 (fax)

Photography Release

I hereby authorize Powers Ferry Family Dentistry to take photographs, slides and/or videos of my face, jaw, mouth and teeth.

I understand that the photographs, slides and/or videos will be used as a record of my care, and occasionally these may be used for Diagnostic purposes for consulting with other Dental or Health Professionals and/or Dental Laboratories. The photographs, slides and/or videos will not be shared on Social Media without my consent to the release.

I do not expect compensation, financial or otherwise, for the use of these photographs.

I further understand there is a video surveillance system and I consent to myself being recorded around the public areas of this office.

Print Name: _____

Signature: _____

Date: _____

Powers Ferry Family Dentistry
6370 Powers Ferry Rd, NW, Ste 103
Atlanta, GA, 30339
404-994-5650 (office)
404-994-5651 (fax)

We have a 2-BUSINESS DAY cancellation policy. If you need to change or reschedule your reserved time with us, please give us at least a 2-BUSINESS DAY notice so that we will be able to fill this time with others waiting for treatment. If your appointment time with us is on Monday, please confirm with us by Thursday, etc. If you cancel, fail to show for your confirmed appointment, or you arrive excessively late and treatment cannot be completed as planned, there will be an associated costs for the broken appointment in the amount of $50.00 or the cost of of broken/missed appointment as indicated by your in - network insurance company.

LATE ARRIVAL :If you are over 15 minutes late for your appointment, we reserve the right to reschedule your appointment for a later time. The Broken Appointment Fee of $50 will apply to this as well. Please understand that we strive to stay on time for your appointment as well as those patients that follow you. By signing below, you have read, and understand this agreement.

Patient Signature _____ Date _____

Guardian Signature _____ Date _____