COMPTON FAMILY DENTISTRY

215 Farrar Drive • Summerville, GA 30747 • 706.857.4850

Registration & Health History

Patient Name _____ **Date of Birth** _____

Present Age _____

Street Address _____

Single ☐
Married ☐
Widowed ☐
Divorced ☐
Separated ☐

City _____ State _____ Zip _____

Patient's Cell Phone # _____ Home Phone # _____

Patient's Social Security Number _____ E-Mail _____

Patient Employed By _____ Work Phone # _____ Ext. # _____

Spouse's Name _____ Spouse's Cell Phone # _____

Spouse Employed By _____ Spouse's Work Phone # _____

In case of emergency, whom do we notify? _____ Phone # _____

Whom may we thank for referring you to our office? _____

Last dental examination approximate date _____ Previous dentist _____

Please rate your anxiety with dental visits _____ O (no anxiety) — 5 (extreme anxiety)

Type of Dental Treatment Desired (Check one)

☐ **Emergency**-(Relief of pain / treatment of chief complaint) ☐ **Complete**-(Examination and necessary treatment)

What is the reason for your visit today?

Medical History

Your health is very important to us and has significant relevance to your dental treatment. Please provide accurate, up-to-date, and complete health history information—including ALL of your medications, medical conditions, hospitalizations, and surgeries—even if you do not believe this information is relevant to your dental treatment. If you cannot remember some of the details of your medical history or all of your medication, please make us aware so that we can contact your physician or pharmacy. Your signature at the end of Page 2 is an indication of accuracy.

Name of Family Physician _____ Date of last medical examination _____

Physician's Address _____ Phone # _____

Pharmacy Preference _____ Phone # _____

Please check ☑ Yes or ☑ No and provide complete and accurate information concerning your health

Yes No

☐ ☐ Are you now or have you recently been under the care of a physician? If so, why? _____

☐ ☐ Have you had surgery? If so, please list all surgeries you have had along with the approximate date of surgery.

Surgery _____ Date _____ Surgery _____ Date _____

☐ ☐ Have you recently been hospitalized? If so, why? _____

Yes No **For Women**

☐ ☐ Are you pregnant? Or, is there ANY chance you could be pregnant?
If you are at all uncertain as to the presence of a possible pregnancy, we have pregnancy tests available for your confidential use; it is very important to the health of the developing fetus that a pregnant woman not undergo sedation as sedative drugs may be extremely harmful to the fetus. When was your last menstruation period? _____

☐ ☐ Are you breastfeeding? *This is important for us to know when administering or prescribing medication.*

☐ ☐ Are you planning to become pregnant in the next 6 months?

☐ ☐ Are you taking birth control pills? *Some antibiotics may reduce or eliminate the effectiveness of birth control pills.*

☐ ☐ Do you want a pregnancy test?

☐ ☐ Have you entered menopause?

☐ ☐ Have you taken a Bisphosphonate medication for osteoporosis (bone density)? If so, what? _____

Yes No **Medical History**—*Continued from Page 1*

☐ ☐ Have you ever been sedated? If so, did you have any complications?_____

☐ ☐ Are you allergic to or do you have adverse effects or reactions to any of the following?

☐ Local anesthetic ☐ Penicillin/Amoxicillin ☐ Sulfa Drugs ☐ Barbiturates ☐ Sedatives ☐ Metals (nickel, mercury, etc.)

☐ Aspirin ☐ Iodine ☐ Latex Rubber ☐ Eggs/sulfites/soy ☐ Other Allergies:_____

☐ ☐ Are you currently taking any medication prescribed or self-administered? If so, please provide a complete list. We realize many of our patients take numerous medications. It is very important that we have a full and complete list of current medications, including over the counter medications and supplements. If you need help obtaining this information, please let us know and we will be happy to assist you by calling your physician or pharmacy.

Prescription Medications: (If more space is needed , let us know and please provide a complete list)

_____

Supplements or Substances: (Please circle or list any that you take. If more space is needed, please provide a list)
St. John's Wort, Kava-Kava, Dilantin, Tegretol, Cardizem (diltiazem) Calan, Isoptin (verapamil), Biaxin (clarithromycin), Erythromycin, Barbituates, Macrolide antibiotics, Cyclosporins, HIV medications/Protease Inhibitors, Systemic Antifungals (Diflucan/Fluconazole), Sporonax (itraconazole), or grapefruit/grapefruit juice.

_____

Please check ☑ Yes or ☑ No if you have or ever had any of the following:

Yes No **Cardiovascular**
- ☐ ☐ Abnormal EKG / ECG
- ☐ ☐ Anemia or blood disorder
- ☐ ☐ Angina (chest pain)
- ☐ ☐ Artificial heart valve
- ☐ ☐ Bleeding problems
- ☐ ☐ Blood thinners
- ☐ ☐ Congenital heart problem
- ☐ ☐ Congestive heart failure
- ☐ ☐ Excessive bleeding
- ☐ ☐ Heart surgery / procedure
- ☐ ☐ High blood pressure
- ☐ ☐ Implanted defibrillator
- ☐ ☐ Irregular heart beat or rhythm
- ☐ ☐ Low blood pressure
- ☐ ☐ Murmur
- ☐ ☐ Pacemaker
- ☐ ☐ Previous heart attack
- ☐ ☐ Sickle Cell disease / trait
- ☐ ☐ Stent
- ☐ ☐ Stroke
- ☐ ☐ Other:_____

Yes No **Bones/Joints**
- ☐ ☐ Arthritis
- ☐ ☐ Bisphosphonates (past or present) (Fosamax, Actonel, Aredia, Prolia, Someta, Reclast, Boniva)
- ☐ ☐ Hip or joint replacement
- ☐ ☐ Osteoporosis

Yes No **Endocrine**
- ☐ ☐ Diabetes Type I Age diagnosed:____
- ☐ ☐ Diabetes Type II Age diagnosed:____
- ☐ ☐ Diabetic complications (Nerve, eye, or kidney problems)
- ☐ ☐ Thyroid problems

Yes No **Other**
- ☐ ☐ Acute narrow angle glaucoma
- ☐ ☐ Cancer / Leukemia
  Chemotherapy completion date:_____
  Radiation completion date:_____
  Related surgeries/procedures:_____
- ☐ ☐ Dialysis
- ☐ ☐ Gastrointestinal problems
- ☐ ☐ GERD / Esophagus problems
- ☐ ☐ Hepatitis A, B, C (circle all that apply)
- ☐ ☐ HIV / AIDS—This will be held in strict confidence. Many drugs taken for this condition have a profound influence on sedation and can make the sedative drugs dangerously potent.
- ☐ ☐ Jaundice
- ☐ ☐ Kidney disease
- ☐ ☐ Liver disease
- ☐ ☐ Malignant hyperthermia (Self or Family History)
- ☐ ☐ Organ transplant
  Organ:_____Date:_____
- ☐ ☐ STD / Venereal disease

Yes No **Respiratory**
- ☐ ☐ Asthma
- ☐ ☐ COPD
- ☐ ☐ Easily winded
- ☐ ☐ Emphysema
- ☐ ☐ Lung disease
- ☐ ☐ Reactive airway
- ☐ ☐ Seasonal allergies
- ☐ ☐ Sleep apnea
- ☐ ☐ Tuberculosis
- ☐ ☐ Other:_____

Yes No **CNS**-Central Nervous System
- ☐ ☐ Alzheimers / dementia
- ☐ ☐ Fainting or dizzy spells
- ☐ ☐ Psychiatric diagnoses
- ☐ ☐ Seizure/epilepsy/convulsions
  What is your aura?_____
- ☐ ☐ Schizophrenia

List diagnos(es):_____

Yes No **Social History**
- ☐ ☐ Alcohol: Drinks per week _____
- ☐ ☐ Do you use recreational drugs? If so, which:_____
- ☐ ☐ Have you in the past or are you currently in treatment for any form of substance addition?
- ☐ ☐ Tobacco: Packs per day_____
- ☐ ☐ Vaping or Electronic cigarettes

I certify that I have read and understand the questions asked on this Registration & Health History, and that the questions have been answered accurately. I understand that providing incorrect information could be dangerous to my health. I authorize this dental practice to obtain previous medical or dental records from physicians or prior dentists. I also authorize this dental practice to release any information including the diagnosis and the records of any examination or treatment rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I agree to be responsible for payment for all services rendered on my behalf or my dependents. Permission is granted to contact me concerning the risk of not completing any necessary dental care.

Date_____ **Signature of Patient or Guardian** _____

Guardian, please print your name here:

(Office Use Only)

Date	Services Provided

Compton Family Dentistry

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HIPAA Acknowledgement & Patient Consent

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights to privacy regarding protected health information. A copy of the Notice of Privacy Practices, which provides information about how we may use disclose your information and also provides information about your rights as a patient, is posted in our main lobby for your review and a copy can be provided upon your request. You have the right to review this document before signing this acknowledgement.

You understand that your PHI (Protected Health Information) can and will be used in the following ways:

1. We may use this information to conduct, plan, and direct treatment and follow-up care among multiple healthcare entities such as other dentists, dental specialists, pharmacies, physicians, and any other healthcare entity who may be involved in the patient's care directly or indirectly.
2. We may use this information to obtain payment information from third party payers, and /or obtain uncollected payments with the assistance of collection agencies, courts, and attorneys.
3. We may use this information to conduct normal healthcare operations such as (but not limited to) quality assessments and licensing/training programs.
4. We may use this information to comply with requests in which the release of this information is mandated by law such as investigations into abuse or neglect, disclosures to law enforcement concerning crime investigation, in response to a subpoena, or in matters of national security.
5. We will use the provided phone numbers and mailing addresses to send information like appointment reminders and billing via phone (including leaving a message with another individual with minimal information if you are not available), voicemail, and postcards/letters. You have the right to restrict modes of communication or to request that we communicate with you about your health information by alternative means or to alternative locations; this r3equest must be made in writing and must specify the alternative means or location and provide satisfactory explanation as to how payments will be handles under the alternative means or location you request.
6. We may use this information in other limited situations in which the law allows or requires us to use or disclose your health information without your permission.

If you wish for persons other than those released under normal operations as indicated in the Notice of Privacy Practices to receive confidential information that is now protected under this law, please provide their information below. You may of course choose not to release your information to anyone. Parents or guardians of minor children do not need to be released.

By signing this form, you are acknowledging that Compton Family Dentistry has made our Notices of Privacy Practices available to you for review and that we have offered you a personal copy. You understand that your signature is voluntary, and that you may refuse to sign and that your treatment and/or payment obligations will not be affected. You understand that you may revoke this authorization at any time by written notification, but, if you do so, it will have no effect on uses or disclosures prior to the receipt of the revocation. You understand that this office may revise its Notice of Privacy Practices periodically; you may request and will be provided with a revised copy.

Name of Patient or Responsible Party: _____

Relationship to Patient: _____

Signature: _____ **Date:** _____

The following is an optional Authorization of Disclosure of Private Health Information:
I give authorization for details of my dental treatment, including fees and financial information, to be discussed with the following individuals:

Name: _____ Relationship: _____ Phone # _____

Name: _____ Relationship: _____ Phone # _____

Signature of Patient or Responsible Party: _____ Date: _____

Thank you for trusting Compton Family Dentistry with your dental care. Some important questions will be answered here, and we will be happy to answer any additional questions—just by asking.

FINANCIAL & Office Policies

Financial Arrangements:

Payment: Charges for dental services are due and payable at the time of treatment. We gladly accept Visa, MasterCard, Discover, American Express, and Care Credit as well as personal checks, money orders, and cash. A fee of $30.00 will be added to your account if your check is returned by your bank for any reason. Any account that is 90-days overdue is subject to being turned over to a collection agency, and you will be responsible for payment of the total balance along with the substantial collection agency fees and any legal fees incurred. Our business office team will make sure you are aware of fees, insurance estimated coverage, and financial arrangements for treatment. You can get answers to your questions—just by asking.

Insurance: If you have dental insurance, please complete our form "CONCERNING INSURANCE" giving us correct and necessary information to help us file insurance claims as a courtesy to you. Inform us about any changes in your insurance provider or coverage. Currently, we participate as an "in-network" provider with very few insurance companies, and will continue to terminate our participation when these companies place limitations on the quality of care we provide our patients through drastic reductions in coverage. You can still see us for your dentistry, and we will file claims for you as an "out-of-network" provider. Insurance does not guarantee payment for services provided.

Electronics/Cell Phone Use:

Out of respect for our team and patients, we do not permit photography or videotaping in the treatment areas. Earbuds or headphones must be used in all areas of the office during nontreatment times. For your safety, electronics, including cell phones, must remain off while your treatment is being actively performed.

Appointments:

We will do our best to reserve appointments at times that are best for you. It may not be possible to always accommodate your schedule. Please arrive on time for these appointments so we may treat you and other patients in a timely manner. Please contact us at least 24-48 hours in advance of your appointment time if you are unable to keep the appointment. Appointments cancelled with less than a 24-hour notice will be considered broken appointments.

Late Arrival: Please contact us if you are going to be late for an appointment. We will attempt to accommodate you, but may need to reschedule your appointment if adequate time does not remain to provide your treatment or if other patients will be affected by your late arrival.

Broken Appointments: At our discretion, multiple broken appointments may result in the following action: Charges for broken appointments; a change in your patient status to "emergency patient" or walk-in visits only; or dismissal from the practice. If you have additional necessary treatment that has not been completed, you will be responsible for any dental or medical loss that may occur due to the risk associated with not completing the necessary dental care.

Emergency Appointments: Emergency visits outside of our normal hours that are not related to recent treatment may incur an emergency fee in addition to fees charged for the emergency treatment provided. Patients who have not been seen for a complete dental evaluation are considered emergency patients. The responsibility for your continued dental health is completely in your hands. We hope you will reserve an appointment for a comprehensive dental evaluation.

Companions in the Treatment Area:

While we welcome one ***adult*** companion in the treatment area, we are not able to accommodate multiple family members and young minor companions. If one adult companion accompanies you, we ask that they do not move in and out of the treatment area and that they use headphones or earbuds while using electronic devices. If any companion becomes a distraction, we may request that they remain in the reception area during your treatment.

Copies of Dental Records/X-rays:

Dental records and x-rays created in our office are the property of Compton Family Dentistry. We will provide a dental or health care provider a copy of our dental records or x-rays, when a written request is provided by the patient or guardian. A minimum of a 24-hour notice is required. Additional time may be required during office closures or long weekends. This is generally a service that we provide our patients at no cost, but this policy could change at our discretion.

By signing below, you affirm that you have reviewed and understand the above policies and consent to the terms as described above. You also give permission for any pertinent health information to be shared with an outside collection agency in the event of nonpayment. At your request, we can provide you with a copy of these policies.

Patient or Guardian Signature:_____ Date:_____

COMPTON FAMILY
DENTISTRY
Sedation and Comprehensive Care
215 Farrar Drive • Summerville, GA 30747

CONCERNING INSURANCE

As a courtesy, we will assign a staff person to assist you in attempting to verify your dental insurance coverage, determine the limitations of your policy, identify your maximum dental insurance benefits, and assist you with filing the necessary forms, so that you receive the benefits to which you are entitled.

There is no guarantee of insurance coverage or payment. You should be aware that your dental insurance company does not guarantee payment, does not cover all procedures, and may not pay for any dental services provided.

By signing below, you acknowledge that you have been fully informed in advance of receiving treatment that your insurance may deny payment for some or all of the dental services that may be recommended and provided by Dr. Richard Compton, Dr. Melissa Compton, and other doctors or hygienists working with Compton Family Dentistry. You agree to be responsible for payment in full for charges, including "Covered Services" denied coverage by your insurance.

INSURANCE INFORMATION

Patient Name _____ Relationship to Policy Holder _____

Patient Date of Birth _____ Patient Social Security # _____

Policy Holder Name _____ Policy Holder Date of Birth _____

Policy Holder Social Security #_____ Employer _____

Insurance Company _____

Group #_____ ID #_____ Phone #_____

Insurance Company Address _____

City _____ State _____ Zip Code _____

❒ I authorize and request my insurance company to pay directly to Dr. Richard Compton, Dr. Melissa Compton, or Compton Family Dentistry unless otherwise payable to me. I understand that there is no guarantee of insurance coverage or payment and that my dental insurance carrier may deny payment or pay less than the actual bill for services. I agree to be responsible for payment for all services rendered on my behalf or my dependents. Initial_____

❒ I do not have dental insurance.

_____ _____
Signature of Patient or Guardian Date