SAVANNAH DENTAL
SOLUTIONS

On behalf of the entire team at Savannah Dental Solutions, let us welcome you to our practice. We are grateful to have the opportunity to serve you and that you have chosen us to meet your dental needs.

Patient Name: _____ _____
First Last MI Preferred Name

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

Birth Date: _____/_____/_____ **SSN**: _____ **Prev. Visit**: _____

Email Address: _____ **Best Time to Call**: _____

Phone: _____ _____ _____ _____
Home Work Ext Mobile

Address: _____

_____ _____ _____
City State Zip Code

Please provide us with an emergency name and phone number _____

How did you hear about our practice? _____

INSURANCE INFORMATION

Insurance Company: _____**ID#**: _____**Group#**: _____

Policy Holder: _____**SSN:** _____ **Date of Birth**: _____

Insurance Company Phone #_____ **Name of Employer**: _____ **Relationship to Patient**: _____

Insurance Disclaimer

1. Our practice is one of patient centered care, not insurance directed care. It is most important to us that we correctly diagnose and recommend the most appropriate treatment at the highest standard to care of each of our patients. We coordinate the proposed treatment plan to whatever insurance benefits may be available. While we completely recognize that dental insurance benefits are an important factor in the delivery of any care provided to our patients with dental insurance, we do not diagnose and provide oral health care based on insurance benefits.
2. We attempt to try to estimate what benefits may be available to better predict the out-of-pocket expense that may be expected after dental insurance benefits. Our estimates are not meant to be exact and cannot be interpreted as absolutes.
3. Information regarding changes to a patient's dental benefit must be provided before treatment and it is the responsibility of the patient to update Savannah Dental Solutions as applicable.

Signature: _____ Date: _____

Medical History

Indicate which of the following conditions you have or have had. By checking the box, it will indicate a "YES" response, leaving blank will indicate a "NO" response.

☐ Anemia	☐ Arthritis	☐ Artificial Joints
☐ Asthma	☐ Bisphosphoate Medications	☐ Blood Disease
☐ Blood Thinners	☐ Cancer	☐ Chemotherapy
☐ Cold Sores	☐ Diabetes	☐ Dizziness
☐ Epilepsy	☐ Excessive Bleeding	☐ Fainting
☐ Glaucoma	☐ Head Injuries	☐ Heart Disease
☐ Hepatitis	☐ High Blood Pressure	☐ High Cholesterol
☐ HIV	☐ Jaundice	☐ Kidney Disease
☐ Liver Disease	☐ Mental Disorder	☐ Nervousness Disorder
☐ Pace Maker	☐ Pain/Popping Jaw	☐ Pregnancy
☐ Radiation treatment	☐ Respiratory Problems	☐ Rheumatic Fever Rheumatism
☐ Stomach Problems	☐ Stroke	☐ Ulcers
☐ Thyroid Disease	☐ Tuberculosis	☐ Tumors

☐ Ever been hospitalized (illness or injury)
☐ Subject to frequent headaches
☐ Currently being treated for any other illnesses
☐ Tobacco/Alcohol/Controlled Substance Use

Please check the box if you are allergic to any of the following medications:

☐ Amoxicillin	☐ Aspirin	☐ Dental Anesthetic
☐ Codeine	☐ Sulfa	☐ Erythromycin
☐ Latex	☐ Penicillin	☐ Seasonal Allergies
☐ Other: _____		

Females

☐ Taking birth control pills
☐ Hormone Replacement
☐ Pregnant
☐ Breast Feeding

If any conditions or alerts selected above need further clarification, please describe below:

_____

Are you required to take a pre-medication for dental work? If yes, please explain. _____

_____

What is your estimate of your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Name of your physician and phone number:

_____

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

_____

List all medications (prescription and non-prescription) including regular doses of aspirin:

_____

_____ _____

Patient or Guardian Signature Date

Dental Information

How would you rate the condition of your mouth?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist Name and Phone Number:

_____

Date of most recent dental exam and dental x-rays:

I routinely see my dentist every:

☐ 3 Mon☐s 4 Mon☐s 6 Mon☐s 12 Mo☐hs Not routinely

What is your immediate concern?

_____

Do you have dental anxiety / phobia? ☐ Yes ☐ No

What would you like to change about your smile?

☐Color ☐Bite ☐Chipped Teeth ☐Spaces ☐Crowding ☐Smile Makeover ☐Missing Teeth ☐Whiter Smile

Check all that apply:

- ☐ Had complications from past dental treatment
- ☐ Had trouble getting numb
- ☐ Had any reactions to local anesthetic
- ☐ Had/have braces
- ☐ You experience dry mouth
- ☐ Any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth
- ☐ Food gets trapped between any teeth
- ☐ Have you ever whitened or bleached your teeth
- ☐ Have you experienced popping and/or clicking of your jaw joint

By signing below, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical/ dental conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any further changes.

_____ _____

Patient or Guardian Signature Date

Photo Release Consent

____ I give Savannah Dental Solutions permission to use "Before and After" photos of my cosmetic procedure(s) for the following pu

1. Internet/Website smile galleries
2. Photographs to be used in advertisements
3. Display in office smile gallery albums

_____I give Savannah Dental Solutions permission to use only pictures of my smile and/or teeth, while my name and full-face characteristics will be kept confidential.

_____ I do **NOT** give Savannah Dental Solutions permission to use any of my "Before and After" photos for a smile gallery.

Consent for Treatment

I understand that my agreement to accept the dental services of Savannah Dental Solutions and that includes any routine procedure(s) or treatment(s) examinations, X-rays, use of local anesthesia and other treatment you, the patient, has agreed upon.

_____ _____

Patient or Guardian Signature Date

Missed Appointment Policy

Savannah Dental Solutions will implement a *$50 missed appointment fee per hour reserved* for any appointments changed or no-showed without 1 business days' notice. If you miss your reserved time, this fee must be paid prior to reserving any additional dates/times. As a courtesy, our staff will attempt to remind all patients of future appointments; however, you are responsible for any appointments you make with our office.

_____ _____

Patient, Parent or Guardian Signature Date

Late Arrival

When we reserve time for you, we require all of that time to provide you with the best quality work possible. When you are late it decreases our ability to accomplish this. ***If you arrive more than 15 minutes late, your appointment may be rescheduled in order to meet the needs of those who are on time for their pre-reserved visit.***

_____ _____

Patient, Parent or Guardian Signature Date

Financial Agreement

Please be informed that Savannah Dental Solutions collects all known co-pays, co-insurances or deductibles at the time of your visit. Savannah Dental Solutions does not check Insurance benefits. We require our patients to verify that they have dental benefits with their insurance. By signing this form, you agree to pay for dental services in the event that they are not covered by your insurance. Please be advised that you will be charged a day of cancellation fee of $50.00 per hour of service reserved. Thank you.

_____ _____

Patient, Parent or Guardian Signature Date

ACKNOWLEDGEMENT OF RECEIPT ON 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 acknowledgment could not be obtained because:

_____ Individual refused to sign

_____ Communication barriers prohibited the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgment

_____ Other (Please Specify)