BUCKHEAD ESTHETIC DENTISTRY
Family and Cosmetic Dentistry

Dr. Jolanda M. Warren
3098 Piedmont Road.,Suite 100
Atlanta, GA 30305

Patient Information

Name: _____ Preferred Name: _____ Date: _____

Phone Numbers: Home: _____ Work: _____ Cell: _____

Address: _____City: _____Zip Code:_____

E-Mail: _____ Employer: _____

Gender: Male _____ Female _____ Marital Status: Single _____ Married _____

Social Security Number: _____ Date of Birth: _____

Who may we thank for referring you to our practice? _____

Please list any family members that are current patients here: _____

Insurance Information

Insurance Carrier: _____ Phone Number: _____

Carrier Address: _____

Employer: _____ Group Number: _____

If insured different from patient:

Subscriber Name: _____ Date of Birth: _____

Social Security Number: _____ ID Number: _____

Patient relationship to insured: Spouse: _____ Child: _____ Other: _____

Photo Release:

I hereby authorize Dr. Jolanda Warren to use any and all models, casts, photographs, radiographs of me and my treatment for the purpose of dental education. This includes, but is not limited to, case presentations to other dentists, lectures illustrating specific treatment modalities, case outcomes and examples to other patients. These may be used for educational and promotional purposes for Buckhead Esthetic Dentistry.

Patient/legal guardian signature: _____ Date_____

Printed name_____

Office Policies

Thank you for choosing our practice. Our goal is to provide excellent care and superior patient service. Our policies are intended to accomplish that goal in a cost-effective manner. *Your agreement to the following policies will help us serve you well.*

Appointments:

Appointment times are reserved for you. So that we may assure you and other patients of uninterrupted treatment it is necessary for all patients to accept and adhere to a definite arrangement of appointment times and fees. As a courtesy, we make every effort to reach you to remind you of your appointment. However, we do expect that you will accept responsibility to provide us with **48 hours'** notice should the need to change or cancel your appointed time with us arise. Failure to do so will result in a $50.00 cancellation charge or the necessity to require a deposit or advanced payment to reserve future appointments. Please be aware that we are closed on Fridays and need notice before 5:00 PM Thursday to change Monday appointments. We value the time you take for your dental needs; therefore, we want to make sure you are seen in a timely and efficient manner. We also appreciate you respecting our time and our schedule we have reserved for you as well as for other patients.

Payments/Insurance:

- As a condition of your treatment by our office, payment is due in full at the time services are rendered.
- *If you do not have insurance, or it can not be verified, total payment for your visit is due at the time of service.
- We will file claims to your insurance carrier and accept payment directly from them. We must have your complete and current demographic and insurance information to do this. It is your responsibility to let us know about any changes in your insurance coverage and contact information. If we submit with the information you provide us and the claim is denied due to incorrect or missing information, we will bill you for the full amount and you may file for reimbursement from you insurance company. Our Insurance coordinator wants to help you in every way with filing your insurance. Please help her do so in an efficient manner.
- Since insurance benefits are unique to each patient's insurance coverage, it is your responsibility to know your insurance benefits PRIOR to services being rendered. Many routine dental services are not covered by insurance carriers. It is imperative that the patient understand that this office does not have access to all insurance company records. Most plans tell their insured that they will be covered "up to 80% or up to 100%", but do not specify the plan fee schedule allowance annual maximum, or any limitations such as pre-existing conditions. We are not responsible for unpaid amounts as a result of deductibles or denials from you insurance company.
- You may receive a letter from your insurance company stating that our fees are higher than the usual and customary. An insurance company surveys a geographic area, finds the average fee, and then takes 90% of that fee and considers it customary. Included in the fee survey are discount clinics which will further bring down the average. Any dentist in private practice will have fees that are considered higher than average.

Treatment Plan Estimates:

Treatment plan estimates are just that. We will make every attempt to plan accurately, but unanticipated situations do arise and can effect previously planned treatment. Patients will be notified of applicable fees before services are rendered. A fee estimate is effective for 90 days.

Cosmetic and Elective Services:

Full payment is required at the time of service. Cosmetic and elective procedures may require a deposit or payment in full to hold the appointment. Please be aware that a missed appointment can result in loss of some or all of your deposit.

Fees: Returned check fee: A $30 fee will be due for any check returned from the bank for non-payment.

Health Insurance Portability and Accountability ACT (HIPPA): Patient copy available upon request

Patient Permission: I grant my permission to Dr. Jolanda M. Warren, DMD, PC, or her assignee, to telephone me at home or my place of employment to discuss matters related to this form.

I have read, understand and agree to the terns of the office and financial policy as well as the $50.00 cancellation fee.
I acknowledge that I have read a copy of this office's Notice of Privacy Practices.
I authorize and request my insurance company to pay directly to the dentist otherwise payable to me.
I agree to be responsible for payment of all services rendered on my behalf or my dependents.
In consideration for the professional services rendered to me, or at my request, by Dr. Jolanda Warren, DMD, PC, I agree to pay the fee for said services to Dr. Jolanda M. Warren, DMD, PC (Buckhead Esthetic Dentistry) or her assignee at the time services are rendered. I understand that I am responsible for all charges for myself and my dependents whether or not covered by insurance

.

Signature of Patient or Responsible Party: _____ **DATE:** _____

Print Name: _____

Emergency Contact: Name: _____ Phone Number: _____

I give Dr. Jolanda Warren permission to discuss my case and/or financial arrangements with the above contact person.

Signature: _____ Date: _____

Dental History

One of the goals in our office is to consistently understand and meet the needs of our patients. We are committed to making each visit an exceptional experience. The comfort and quality of care you receive here is one of our highest priorities. We are asking for the following information because we want to get to know you and serve you consistently each time we see you. Please answer the following questions to the best of your ability. We welcome you to our office and your new dental home.

What brought you in to see us today? **What chief problems or concerns can we help you with?**

_____

Date of last dental exam _____What was done?_____
How often do you brush your teeth? _____How often do you floss your teeth?_____
Have you had problems with prior dental treatment? _____
What dental concerns do you have? _____
Are you in pain now? _____
Does hot temperature bother your teeth? _____ What area of the mouth? _____
Does cold temperature bother your teeth? _____What area of the mouth? _____
Are any of your teeth sensitive to biting or chewing? _____What area of the mouth? _____
_____
Do your gums bleed when you brush or floss? _____
How do you feel about the appearance of your teeth? _____
Would you change anything about their appearance or function? _____

Have you ever experienced any of the following? Please reply "Y" or "N" after each question and any remarks:

Grinding or clenching of your teeth? _____
Popping in front of your ears? _____
Tenderness or tightness in the muscles that work your jaw? _____
Pain in the jaw joints? _____ Right or Left side? _____When did you first notice pain? _____
Locking of your jaw? _____Frequency? _____
Frequent headaches? _____When did these headaches start? _____
Difficulty chewing your food? _____
Do you feel your bite is off? _____
Have you been treated for TMJ or headaches or joint problems? _____
Have you had jaw problems following dental treatment in the past? _____
Problems associated with any previous dental work? _____
Problems with your bite or tooth sensitivity in the past? _____
Do you currently wear a night time appliance?_____

Have you been treated for periodontal or gum problems in the past?_____ If so:

Have you had Root Planing or a Deep Cleaning? _____ When: _____
Have you had Gum Surgery? _____When: _____
Are you currently under the care of a Periodontist (Gum Specialist)? _____ Who? _____

Have you had Orthodontic (braces) treatment in the past or currently under treatment? _____

By whom? _____
If you have not had orthodontic treatment, was it ever recommended? Y / N

Have you bleached your teeth in the past? Y / N. If yes, did you get the results you expected?_____
Are you considering bleaching your teeth now? Y / N

I am interested in learning more about: (Circle all that apply)

Cosmetic Dentistry	Alternatives to bridges or partials
Facial Esthetics	Straighter Teeth
Smile enhancement/Improving your smile	Porcelain Veneers/Lumineers
Improved Dental/Oral Health	Oral Cancer
Silver or Mercury Filling Removal	Dental Implant
Cosmetic Posterior Restorations	Sleep Apnea/Snoring
Smile Whitening	Dentures/Partials
Improved denture stability	Invisible Braces - Invisalign
Ideal, Comprehensive Dentistry	Teeth Grinding and Wear / Bruxism / Fractured Teeth

MEDICAL HISTORY

PATIENT NAME _____ Birth Date_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? Yes No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____
in the last ***5 years***?
Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____
Are you taking any medications, pills, or drugs? Yes No If yes, please list: _____
Do you take, or have you taken, Phen-Fen or Redux? Yes No If yes, please explain: _____
Have you ever taken Fosamax,Boniva, Actonel or any Yes No If yes, please explain: _____
other medications containing bisphosphonates?
Are you on a special diet? Yes No
Do you use tobacco? Yes No If yes, type and frequency:_____
Do you use controlled substances? Yes No
Women: Are you Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other If yes, please explain:_____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Renal Dialysis	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A,B,or C	Yes	No	Rheumatic Fever	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Herpes	Yes	No	Rheumatism	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	High Blood Pressure	Yes	No	Scarlet Fever	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Cholesterol	Yes	No	Shingles	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	Hives or Rash	Yes	No	Sickle Cell Disease	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hypoglycemia	Yes	No	Sinus Trouble	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Irregular Heartbeat	Yes	No	Spina Bifida	Yes	No
Asthma	Yes	No	Fainting Spells/Dizziness	Yes	No	Kidney Problems	Yes	No	Stomach/Intestinal Disease	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Leukemia	Yes	No	Stroke	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Liver Disease	Yes	No	Swelling of Limbs	Yes	No
Breathing Problem	Yes	No	Frequent Headaches	Yes	No	Low Blood Pressure	Yes	No	Thyroid Disease	Yes	No
Bruise Easily	Yes	No	Genital Herpes	Yes	No	Lung Disease	Yes	No	Tonsillitis	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No	Mitral Valve Prolapse	Yes	No	Tuberculosis	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Pain in Jaw Joints	Yes	No	Tumors or Growths	Yes	No
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Murmur	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disorder	Yes	No	Heart Pace Maker	Yes	No	Radiation Treatments	Yes	No	Yellow Jaundice	Yes	No
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Recent Weight Loss	Yes	No			

Have you ever had any serious illness not listed above? Yes No If yes, please explain:_____

_____

_____

Comments:_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____