ALPHARETTA OFFICE
3450 Old Milton Pkwy # 110
Alpharetta, GA 30005
Ph: (678) 562-1555, Fax: (678) 562-1556
Email: frontdesk@acefamilydental.com

NORCROSS OFFICE
3985, Steve Reynolds Blvd,
Suite K101, Norcross, GA 30093
Ph: (770) 806-1255, Fax: (770) 806-1254
Email: norcross@acefamilydental.com

LILBURN OFFICE
3993, Lawrenceville Hwy,
#100, Lilburn, GA 30047
Ph: (770) 279-2020, Fax: (770) 279-1222
Email: frontdesk@theaffordabledental.com

ACE FAMILY DENTAL CARE NEW PATIENT FORM

PATIENT DETAILS

Name : ______ Last Name ______ First Name ______ Middle Name ______ Title

Preferred Name : ______ ○ Male ○ Female

Address : ______ City : ______ State : ______ Zip : ______

SSN : ______ Date of Birth : ______

Home Phone : ______ Work Phone : ______

Cell Phone : ______ Email Address : ______

Employer : ______ Occupation : ______

Marital Status : ○ Domestic Partner ○ Single ○ Married ○ Divorced ○ Widowed ○ Separated

How did you hear about our office? ______

NOTE: We will contact you by Email and/or by Phone for appointment confirmation.

INSURANCE - Primary

Subscriber Name : ______ Relationship to Patient : ______ Subscriber DOB: ______

Subscriber SSN / ID : ______ Subscriber Employer : ______

Insurance Co. Name : ______

Insurance Co. Address : ______

Insurance Co. Phone : ______ Group Number : ______

INSURANCE - Secondary

Subscriber Name : ______ Relationship to Patient : ______ Subscriber DOB: ______

Subscriber SSN / ID : ______ Subscriber Employer : ______

Insurance Co. Name : ______

Insurance Co. Address : ______

Insurance Co. Phone : ______ Group Number : ______

ASSIGNMENT & RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to **Ace Family Dental Care** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the Dentist to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature :

Relationship : ______ Date : ______

CONSENT

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

Patient / Guardian Signature : ______

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Patient Name : ______________________ Date of Birth : ____________

MEDICAL HISTORY

Do you have a personal physician? ○ Yes ○ No

Physician's Name: Physician's Phone: ____________ Date of Last Visit: ____________

Your current physical health is: ○ Good ○ Fair ○ Poor

Are you currently under the care of a physician? ○ Yes ○ No

Please Explain ______________________

Do you use tobacco in any form? ○ Yes ○ No

Have you had any metal rods, pins or implants placed? ○ Yes ○ No

Are you taking any medications? ○ Yes ○ No

Please list each one ______________________

Have you ever had any surgical procedures? ○ Yes ○ No

Please list each one ______________________

Women: Are you taking Birth Control Pills? ○ Yes ○ No | Are you pregnant? ○ Yes ○ No If so, # of Weeks ____________ | Are you are Nursing? ○ Yes ○ No

Are you allergic to any of the following? ○ Aspirin ○ Penicillin ○ Codeine ○ Dental Anesthetics ○ Erythromycin ○ Jewelry ○ Latex ○ Metals ○ Tetracycline

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

○ Abnormal Bleeding	○ Fainting Spells	○ Psychiatric Problems
○ Alcohol Abuse	○ Fever Blisters	○ Radiation Therapy
○ Allergies	○ Frequent Headaches	○ Rheumatic Fever
○ Anemia	○ Glaucoma	○ Seizures
○ Angina Pectoris	○ HIV + AIDS	○ Sexually Transmitted
○ Arthritis	○ Heart Attack	○ Shingles
○ Artificial Heart Valve	○ Heart Murmur	○ Sickle Cell Disease
○ Asthma	○ Heart Surgery	○ Sinus Problems
○ Blood Transfusion	○ Hemophilia	○ Thyroid Problems
○ Cancer	○ Hepatitis A	○ Tuberculosis
○ Chemotherapy	○ Hepatitis B	○ Ulcers
○ Colitis	○ Hepatitis C	
○ Congenital Heart Defect	○ High Blood Pressure	
○ Diabetes	○ Joint Replacement	
○ Difficulty Breathing	○ Kidney Problems	
○ Drug Abuse	○ Liver Disease	
○ Emphysema	○ Low Blood Pressure	
○ Epilepsy	○ Mitral Valve Prolapse	
○ Facial Surgery	○ Pace Maker	

Nearest relative not living with you:

Name : ______________________ Relationship: ____________

Address: ______________________ Phone : ____________

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature ______________________ Date: ____________

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Patient Name : ______________________ Date of Birth : ____________

DENTAL HISTORY

How may we help you today? ______________________

Your current dental health is:	○ Good	○ Fair	○ Poor
Do you require antibiotics before dental treatment?		○ Yes	○ No
Are you currently in pain		○ Yes	○ No
Have you ever had gum treatment?		○ Yes	○ No
Do you now or have you had any pain/discomfort in your jaw joint? (TMJ)		○ Yes	○ No
Are you under stress? (New job, Moving, Relationships)		○ Yes	○ No
Do you like your smile?		○ Yes	○ No
Is there anything you would like to change about your smile?		○ Yes	○ No
Are you happy with the color of your teeth?		○ Yes	○ No
Do your gums bleed?		○ Yes	○ No

How many times a do you: Floss / Week? ________ Brush / Day? ________

Have you lost any teeth?	○ Yes	○ No
Have you ever had a serious/difficult problem with any previous dental work?	○ Yes	○ No
Have you ever had any unfavorable dental experiences?	○ Yes	○ No

When was your last dental cleaning? ______________________

When was your last dental visit? ______________________

Why did you leave your previous dentist? ______________________

How can we accommodate you better during your dental visit? ______________________

Here at **Ace Family Dental Care**, we offer a wide variety of services to enhance and keep your smile healthy and beautiful. Please select any services below you would like our friendly staff to discuss with you during your visit.

☐ In House Teeth Whitening	☐ Veneers / Lumineers	☐ Invisalign
☐ Six Month Smiles Cosmetic Braces	☐ Smile Makeover	☐ Bonding
☐ Sealants	☐ Crown and Bridge	☐ Implant / Implant Crowns
☐ Partials / Dentures	☐ Night / Sport Guards	☐ Snap-On Smile

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Patient Name : ______________________ Date of Birth : ______________

FINANCIAL AGREEMENT

- For my convenience, this office may release my information to my insurance company and receive payment directly from them.
- I understand that I am responsible for my estimated portion of the treatment fees at the time that treatment is delivered.
- I understand that my dental insurance benefits are one form of payment that I am providing to this dental practice and that payment for the total cost of services delivered to me is ultimately my responsibility. This practice will make efforts to help me secure optimal reimbursement from my insurance plan. However, if the insurance carrier does not pay as expected, I am ultimately responsible for all fees charged.
- I understand that, due to the complexity of dental diagnosis, treatment plans sometimes change. I will be responsible for payment for the care that is actually delivered to me.
- In the case of returned checks or any other reversal of payment methods that I have provided to the practice, my account will be subject to a **$30** processing fee.
- If I allow my account to become severely delinquent in payments, causing the practice to enlist the assistance of a collections agency, I agree to pay all related fees and court costs.
- Accounts not paid within **90 days** are subject to a **1.5%** monthly finance charge.
- Any unpaid insurance balance is assumed to be patient financial responsibility.

Signature : ____ Date : ____________________

NOTICE OF PRIVACY POLICIES

I have had full opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that I am giving my permission to your use and disclosure of my protected health information in order to carry out treatment, payment activities and healthcare operations. I also understand that I have the right to revoke permission.

Signature : ____ Date : ____________________

MISSED APPOINTMENTS

I understand that this practice requires at least **48 hours** advance notice to cancel or reschedule my appointment. I also understand that, in the case that I miss an appointment, providing no or late (failing to inform the office at least **48 hours** in advance) cancellation, my account will be subject to a **$25** charge.

Signature : ____ Date : ____________________

CONSENT OF SERVICES

I understand that the information that I have given is correct to the best of my knowledge. I hereby authorize the Dentist or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize the Dentist to perform all recommended treatment mutually agreed upon and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications. I agree to be responsible for payment of all services rendered to me or my dependents. I understand payment is due at the time of service. I give permission for my information to be shared between the offices mentioned in this form for my optimal patient care.

Signature : ____ Date : ____________________

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COVID-19 Dental Treatment Consent Form

Patient Name: ____
Date: ____

I knowingly and willingly consent to have emergency dental treatment completed during the COVID-19 pandemic.

I understand the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms and still be highly contagious. It is impossible to determine who has it and who does not given the current limits in virus testing.

Dental procedures create water spray which is how the disease is spread. The ultra-fine nature of the spray can linger in the air for minutes to sometimes hours, which can transmit the COVID-19 virus.

- I understand that due to the frequency of visits of other dental patients, the characteristics of the virus, and the characteristics of dental procedures, that I have an elevated risk of contracting the virus simply by being in a dental office.
- I have been made aware of the CDC and ADA guidelines that under the current pandemic all non-urgent dental care is not recommended. Dental visits should be limited to the treatment of pain, infection, conditions that significantly inhibit normal operation of teeth and mouth, and issues that may cause anything listed above within the next 3-6 months.
- I confirm I am seeking treatment for a condition that meets these criteria.

I confirm that I am not presenting any of the following symptoms of COVOID-19 listed below:

- Fever
- Shortness of Breath
- Dry Cough
- Runny Nose
- Sore Throat

- ___________ (Initial)

I understand that air travel significantly increases my risk of contracting and transmitting the COVID-19 virus. And the CDC recommends social distancing of at least 6 feet for a period of 14 days to anyone who has, and this is not possible with dentistry.

- I verify that I have not traveled outside the United States in the past 14 days to countries that have been affected by COVID-19.
- I verify that I have not traveled domestically within the United States by commercial airline, bus, or train within the past 14 days.

Patient (or Legal Guardian) Signature: ____
Date: ____