Adult Patient Registration

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive, or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not discriminate.

Patient Name Home phone: Work phone: Cell Phone:

Last_____ First_____ Middle_____ (___) _____ (___) _____ (___) _____

Physical Address_____ City_____ State_____ Zip_____

Mailing Address_____ City_____ State_____ Zip_____

Email Address:_____ Date of Birth_____ SS#____-____-____ Sex___M___F____

Responsible Party_____ Relationship to patient_____ Daytime phone number_____

Emergency Contact:_____ Relationship to patient:_____ Phone_____ Cell Phone_____

How did you hear about our office?_____

Do you have any of the following diseases or problems?

	Yes	No	Dk (don't know)
Active Tuberculosis.....	□	□	□
Persistent cough for over 3 weeks	□	□	□
Cough that produces blood.....	□	□	□
Exposed to someone with tuberculosis ...	□	□	□

*****If you answer yes to any of the 4 items above, please stop and return this form to the receptionist**

Dental Insurance Information

Policy Holder_____ Date of Birth_____

S.S. # of policyholder_____ Relationship to Patient_____

Name of Employer_____ Work phone_____

Insurance Company_____ Group #_____

Address_____ City_____ Zip_____

Insurance Company phone number_____

Dental History NEW patients ONLY

For the following questions, please mark (X) your responses to the following. Mark "Dk" if you do not

Former Dentist_____ Phone:_____ Date of last x-rays_____ Professional cleaning?_____

Reason for today's visit_____

How important is it to you to keep your teeth for a lifetime?_____

Do your gums bleed when you brush or floss? _____ How often do you brush?_____ How often do you floss?_____

	Yes	No	Dk
Do your gums bleed when you brush or floss?	□	□	□
Are your teeth sensitive to cold, hot, pressure?	□	□	□
Does food or floss catch between your teeth?	□	□	□
Is your mouth dry?	□	□	□
Have you had any periodontal (gum) treatment? ...	□	□	□
Have you ever had orthodontic treatment?	□	□	□
Have you had any problems associated with previous dental treatment?.....	□	□	□
Is your home water supply fluoridated?	□	□	□

Are you currently experiencing dental discomfort? _____

Please explain:_____

	Yes	No	Dk
Do you have earaches or neck pain?	□	□	□
Do you have popping, 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?.....	□	□	□
Do you drink filtered or bottled water.....	□	□	□

Date of your last dental examination: _____

What was done at that time? _____

If YES how often? DAILY/ WEEKLY OCCASIONALLY

If you could change anything about your smile, what would it be?

_____

_____

Medical History

For the following questions, please mark (X) your responses to the following. Mark "Dk" if you do not know

Allergies: Are you allergic to or haveyou had a reaction to the following: To all "yes "answers specify type of reaction.	Yes	No	Dk
Local Anesthetics_____	□	□	□
Aspirin_____	□	□	□
Penicillin or other antibiotics_____	□	□	□
Barbiturates, sedatives, or sleeping pills_____	□	□	□
Sulfa Drugs_____	□	□	□
Codeine_____	□	□	□
Other Narcotics, please list_____	□	□	□

Physician_____ **Phone:**_____

Date of last visit_____

Have you been hospitalized within the last 12 months? □ **YES** □ **NO**

Please list all prescription medications, vitamins, natural or herbal preparations and/ or diet supplements you are currently taking:

_____

_____

_____

_____

Medical Information

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems. Mark Dk" if you do not know.

	Yes	No	Dk
Do you wear contact lenses?	□	□	□

Joint Replacement: Have you had an orthopedic total joint (hip, knee, elbow, or finger) replacement? □ □ □
Date

Are you taking or scheduled to begin taking Any medications for bone pain , hypercalcemia, or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer ?..... □ □ □

Allergies:

Metals.....	□	□	□
Latex (rubber).....	□	□	□
Avocado, bananas, Kiwi?.....	□	□	□
Iodine?.....	□	□	□
Hay fever/seasonal?.....	□	□	□
Animals.....	□	□	□

Other_____

	Yes	No	Dk
Do you use controlled substances?.....	□	□	□
Do you drink alcoholic beverages?.....	□	□	□

If so, how much alcohol did you drink in the last 24 hours?_____
If yes, how much do you typically drink in a week?_____

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

How interested are you in stopping? (circle one)
VERY INTERESTED MILDLY INTERESTED NOT INTERESTED

Please mark (X) your response to indicate if you have or have not had any of the following diseases:

	Yes	No	Dk
Artificial (prosthetic) heart valve.....	□	□	□
Previous infective endocarditis.....	□	□	□
Damaged valves in transplanted heart.....	□	□	□
Congenital heart disease (CHD).....	□	□	□
Unrepaired cyanotic CHD	□	□	□
Repaired (completely) in last 6 months.....	□	□	□
Repaired CHD with residual defects.....	□	□	□

**Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

Has a physician recommended that you take antibiotics prior to dental visits?
Name_____ Phone_____

	Yes	No	DK
Cardiovascular disease ...	□	□	□
Angina.....	□	□	□
Arteriosclerosis.....	□	□	□
Congestive heart failure.....	□	□	□
Damaged heart valve.....	□	□	□
Heart Attack.....	□	□	□
Heart Murmur.....	□	□	□
Low blood pressure.....	□	□	□
High blood pressure.....	□	□	□
Other congenital heart defects.....	□	□	□

	Yes	No	Dk
Mitral valve prolapse	□	□	□
Pacemaker.....	□	□	□
Rheumatic fever.....	□	□	□
Rheumatic heart disease.....	□	□	□
Abnormal bleeding.....	□	□	□
Anemia.....	□	□	□
Blood Transfusion.....	□	□	□
If yes, date_____			
Hemophilia.....	□	□	□
AIDS or HIV disease...../..	□	□	□
Arthritis.....	□	□	□

	Yes	No	Dk
Autoimmune disease.....	□	□	□
Rheumatoid arthritis	□	□	□
Systemic Lupus	□	□	□
Asthma.....	□	□	□
Bronchitis.....	□	□	□
Emphysema.....	□	□	□
Sinus trouble.....	□	□	□
Tuberculosis.....	□	□	□
Cancer/Chemotherapy.....	□	□	□
Radiation treatment.....	□	□	□
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.....	□	□	□
High Cholesterol.....	□	□	□

	Yes	No	Dk
Hepatitis, jaundice, liver disease	□	□	□
Epilepsy.....	□	□	□
Fainting spells or seizures.....	□	□	□
Neurological disorder.....	□	□	□
If yes, specify_____			
Sleep disorder.....	□	□	□
Mental health disorder.....	□	□	□
Specify:_____			
Recurrent infections.....	□	□	□
Type of infection_____			
Kidney problems	□	□	□
Night sweats.....	□	□	□
Osteoporosis.....	□	□	□
Persistent swollen glands in the neck.....	□	□	□
Severe or rapid weight loss.....	□	□	□
Severe headaches/migraines.....	□	□	□
Sexually transmitted disease.....	□	□	□
Excessive urination.....	□	□	□

WOMEN ONLY: Are you:

	Yes	No	Dk
Pregnant	□	□	□
Number of weeks_____			
Birth control?	□	□	□
Taking Hormones?	□	□	□
Nursing?	□	□	□

FOR COMPLETION BY DENTIST

_____

_____

_____

_____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services . I understand that dental treatment is a partnership and that appointments are reserved exclusively for me. In the event of a failed appointment where there is less than 24 hours notice there may be a fee charged. Further, I understand that accounts overdue by 60 days are subject to an interest fee of 18% APR and/or late fees.

X_____ _____

SIGNATURE OF PATIENT (or parent if a minor) **Date**

Financial Options

Our commitment is to provide quality dental care to the entire family through exceptional service and the utilization of advanced technology

Methods of payment

- Cash, Check, or Credit card (MasterCard, Visa, American Express, and Discover)
- Dental Insurance (described below)
- Care Credit –a credit card specifically designed for healthcare use (application available)
- Dental Fee plan (flexible monthly payment option) **call 1-800-204-3332 or www.dentalfeeplan.com**

Dental Insurance:

- We are pleased you have dental insurance, and our office will assist you in obtaining the maximum benefits specified in your contract. However, your insurance contract is between you, your employer, and the insurance company.
- ***We consider the patient responsible for the payment of the account.***
- If your insurance company agrees to make payment directly to the doctor, we will accept insurance assignment. ***We ask that your estimated co-payment and deductible be paid at the time of service.*** Not all services are a covered benefit in all contracts. ***Some insurance companies arbitrarily select certain services they will cover. Many plans have exclusions and limitations, which will affect your out-of-pocket expense.***
- Whenever possible, we will submit an estimate to your insurance company for an outline of benefits for which you may be entitled.

Billing:

- We estimate your co-payment portion based on information given to us by your insurance carrier. Payment of your portion is expected at the time you are in our office for dental care. ***However, sometimes there is a need to send a statement for the portion insurance has not paid, and this is due upon receipt***
- Accounts over 60 days are considered past due and are subject to a service fee of 1.75% per month (annual percentage rate of 21%).
- For patients requiring extensive treatment, we offer ***short-term payment plans***. For patients who desire a longer period of time to make payment, an application to Dental Fee Plan or Care Credit may be an option for you.

Related Information:

- Returned checks are subject to additional collection fees.
- In the event that the account is not paid and we refer the account to collection, you will be responsible for all fees incurred for collection of the bill (i.e. , attorney fees, court costs, and collection agency fees).
- ***Your appointment has been reserved exclusively for you***. Any change in your appointment affects many patients***. 24 hours notice is needed to avoid a charge***.

I have read and understand the above information. I understand I am responsible (regardless of my insurance) for any charges incurred from services rendered. I authorize the payment of dental benefits, otherwise payable to me ,directly to Robert A. Foster, Jr., DMD PC. I further authorize Robert A Foster Jr DMD PC and all of its independent contractors, business associates, agents, and/or any affiliates to contact me through the use of any dialing equipment or an artificial voice or prerecorded voice, at any telephone number associated with my account including cellular/wireless telephone numbers that may result in charges to me for the call. I expressly consent to such calls both dire4ct and automated to my home, cellular, or other associated numbers and with such consent, I specifically waive any claims I may have against all parties authorized to make such calls.

Name *(Please print)*_____

(parent/guardian if patient is under 21)

Signature_____ ***Date***_____

Robert A. Foster, Jr., DMD PC

1230 Johnson Ferry Road, Suite C-10
Marietta, GA 30068
(770) 971-5119

Recommended Standard of Dental Care for Children

- Professional cleanings and complete examinations by a dentist are generally recommended every six- (6) months. Children who are particularly cavity prone may need to have more frequent visits.

- Radiographs for detection of hidden decay (cavity detecting x-rays) are recommended on at least a six- (6) month interval.

- A full mouth x-ray that shows facial bones and the formation of permanent teeth is recommended every 3 years unless otherwise indicated by unusual circumstances.

- Professional application of fluoride is generally recommended every six- (6) months. Fluoride strengthens teeth in its battle with plaque, the precursor to decay. A child with a high decay rate may require additional treatments.

- Application of sealant material to all chewing surfaces of permanent molars and premolars is recommended as soon as the teeth are completely present and unobstructed by soft tissue. SEALANTS MAY BE RECOMMENDED ON PRIMARY TEETH if a child is particularly prone to cavities at a very early stage in life.

- Give your child fluoridated water. TYPICALLY, BOTTLED WATER DOES NOT CONTAIN FLUORIDE. Read the label. You may want to consider a water purifier connected to your tap. The purifier will not remove fluoride.

- Avoid rewarding your child with sticky, chewy, sugary foods without making sure they are able to brush their teeth right after the snack. Instead offer a snack from the vegetable or fruit groups.

- Acquiring good dental hygiene habits at home will require parental supervision. The skills of brushing and flossing are hard at first. Your child will need your guidance. Be available and patient with them. And, best of all; let them learn by your good example.