Welcome!

Please take a few minutes to answer the following questions so we can better assist you with you dental needs.

Patient Information

Date_____ Soc. Sec.#_____ Date of Birth_____

Name _____
Last name First name Initial

Address_____ Home Phone _____

City _____ State_____ Zip_____
Sex: Male___Female___Minor____Single____Married____Divorced____Widowed___
Employer_____ Business Phone _____
Business Address_____Occupation_____
Who should we thank for referring you? _____
In case of emergency, who should we contact? _____
Home phone_____ Work Phone _____

Insurance

Person Responsible for Account_____
Last name First name Initial
Relationship to Patient _____ Birthdate _____ S.S. _____
Address_____Home Phone _____
City _____ State _____ Zip _____
Responsible Party Employed By _____ Business Phone _____
Business Address _____ Occupation _____
Insurance Company _____ Phone # _____
Insurance Company Address _____
Subscriber I.D. #_____ Group # _____

Dental History

How would you explain your current dental problem? _____
Date of your last dental exam _____ Former Dentist _____
Date of your last dental x-rays_____
Was all proposed treatment completed?_____
How do you feel about the appearance of your teeth? _____
Have you had a serious/difficult problem associated with any previous dental treatment? If so, please explain_____

Medical History

1. Are you now, or have you been under a physician's care during the past two years? If so, please explain _____
2. Have you been in the hospital during the past two years? If so, please explain _____
3. Are you subject to fainting, dizziness, nervous disorders, convulsions or epilepsy? _____
4. Have you ever had breathing difficulties such as asthma, bronchitis, emphysema, or tuberculosis? _____
5. Do you smoke?_____
6. Are you pregnant? _____ Nursing? _____Taking birth control pills?_____
7. Do you have allergies or sensitivities to drugs such as Penicillin, Novacaine, Codeine, Aspirin, etc.? _____ Latex? _____
8. Have you ever had excessive bleeding requiring special treatment? If so, please explain _____
9. Please list all medication that you are currently taking:_____ _____
10. Have you ever had any of the following problems? Please circle Yes or No:

    - Angina (chest pain) or heart attack _____ Yes No
    - Rheumatic fever or Rheumatic heart disease _____ Yes No
    - High blood pressure (HTN) _____ Yes No
    - Heart murmur of Mitral valve prolapse _____ Yes No
    - Hepatits / Liver disease _____ Yes No
    - Kidney problem _____ Yes No
    - Ulcers _____ Yes No
    - Artificial joint or Valve replacement _____ Yes No
    - Stroke _____ Yes No
    - Diabetes _____ Yes No
    - Anemia _____ Yes No
    - Thyroid disease _____ Yes No

    Other / Medical condition not listed: _____ _____

Assignment and Release

I hereby authorize payment directly to Dr. Russell L. Boyd, DMD, PC for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by the insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and / or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ Date_____

Russell L. Boyd, DMD, PC
Family Dentistry
1150 Hammond Drive
Bldg. C, Suite #3100
Atlanta, GA 30328
(770) 351-9222

Please read and sign this statement before we agree to accept assignment directly from your insurance company. This avoids any misunderstandings and facilitates processing of your insurance claim. If you have any questions, please ask us. Thank you.

I understand and agree that I am responsible for the payment of all treatment fees on my account. If my insurance company fails to make payment within 90 days, I will be responsible for the full amount owed to Dr. Russell L. Boyd, D.M.D.

As a courtesy we will try to verify your benefits by phone and estimate the amount not paid by the insurance company. We cannot be responsible for exact verbal verification. Therefore I understand and agree that I am responsible for the amount not paid by the insurance company.

I understand that after the insurance company pays Dr. Russell L. Boyd, D.M.D., there could be a balance remaining, for which I am responsible.

I understand and agree that if upon payment by the insurance company, there is a remaining balance, I am responsible for the amount in full at that time.

_____
Date

_____
Signature of responsible party

_____
Office Manager

Dr. Russell L. Boyd, DMD, PC
Family Dentistry
PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for the staff of Dr. Russell L. Boyd, DMD, PC to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Dr. Russell L. Boyd, DMD, PC's Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Dr. Russell L. Boyd, DMD, PC reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the office.

With this consent, the office staff may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care.

By signing this form, I am consenting to Dr. Russell L. Boyd, DMD, PC's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign the consent, or later revoke it, Dr. Russell L. Boyd, DMD, PC may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Patient's Name Date