Belvedere Plaza Dental

3521 Memorial Dr, Ste A, Decatur, GA 30032 | 404.567.8485

PLEASE COMPLETE ALL INFORMATION THAT APPLIES TO YOU - THANK YOU

PATIENT LAST NAME: _____ **FIRST:** _____ **INITIAL:** _____

How do you wish to be addressed? _____ DOB _____

(❑ Single ❑ Married ❑ Divorced) (❑ Male ❑ Female) Full time Student? ❑ Yes ❑ No School _____

Address _____

City _____ State _____ Zip _____

Telephone (Home) _____ (Work) _____ (Mobile) _____

Email _____

Employer _____ Occupation _____

Soc. Sec. No. _____ Dental Insurance Co. _____ Group _____

Is patient covered by another dental insurance? ❑ Yes ❑ No Insurance Co. _____

How did you hear about our practice? Whom may we thank for your referral? _____

HUSBAND, FATHER OR RESPONSIBLE PARTY (IF OTHER THAN PARENT)

Last Name _____ First _____ Initial _____

Address _____ DOB _____

City _____ State _____ Zip _____

Telephone (Home) _____ (Work) _____ (Mobile) _____

Email _____

Employer _____ Occupation _____

Soc. Sec. No. _____ Dental Insurance Co. _____ Group _____

WIFE, MOTHER OR RESPONSIBLE PARTY (IF OTHER THAN PARENT)

Last Name _____ First _____ Initial _____

Address _____ DOB _____

City _____ State _____ Zip _____

Telephone (Home) _____ (Work) _____ (Mobile) _____

Email _____

Employer _____ Occupation _____

Soc. Sec. No. _____ Dental Insurance Co. _____ Group _____

NEAREST RELATIVE

Last Name _____ First _____ Initial _____

Address _____

City _____ State _____ Zip _____ E-Mail _____

Telephone (Home) _____ (Work) _____ (Mobile) _____

AUTHORIZATION

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize the release of any information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I authorize the release of any information concerning my (or my child's) health care, advice and treatment to another dentist.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me. I understand that my dental care insurance carrier or payer of my dental benefits **may pay less** than the actual bill for services. I understand **I am financially responsible** for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payments of services not paid, in whole or in part by my dental care payer.

I attest to the accuracy of the information on this page.

Signature _____ Date _____

Patient Registration

Belvedere Plaza Dental

3521 Memorial Drive, Ste A, Decatur, GA 30023 | 404.567.8485

DENTAL INSURANCE VERIFICATION FORM

Use this form as a template for documenting dental benefits when calling Customer Service for a dental benefit quote.

Date: _____

PATIENT/SUBSCRIBER INFORMATION

Patient Information

Patient Name: _____
Date of Birth: ____/____/_____ Age: _____
SSN#: _____

Subscriber Information

Subscriber Name: _____
Date of Birth: ____/____/_____
Subscriber ID#: _____
Plan/Group#: _____
Employer Name: _____

Insurance Information

Insurance Name: _____
Insurance Address: _____
Insurance Phone: _____ Payor ID: _____
Insurance Effective Date: ____/____/_____
Standard COB: Y / N
Waiting Period: Y / N

Year Type: Calendar / Plan
Individual Deductible: $_____ Met to date: $_____
Family Deductible: $_____ Met to date $_____
Deductible applies to: Preventive / Basic / Major
Dental Maximum: $_____
Crowns Paid on Seat Date: Y / N

DENTAL BENEFITS

Class I: Preventive_____%

Routine oral exam - Frequency: _____
Routine prophylaxis - Frequency: _____
Bitewings - Frequency: _____
Panoramic/FMX - Frequency: _____
Fluoride - Frequency: _____ Age Limit: _____
Sealant - Frequency: _____ Age Limit: _____
(Sealants limited to Permanent Teeth Only)

Class II: Basic_____%

Fillings - Frequency: _____
Posterior composites reduced on 2nd or 3rd molars: Y / N
Simple extractions
Periodontal maintenance - Frequency: _____

Class III: Major_____%

Crowns, inlays, onlays, labial veneers, bridge, dentures
Prosthetic Replacement Limitation: _____
Missing Tooth Clause: _____
Implants Benefits: Y / N

Allowable under Basic or Major:

Endodontic: Basic / Major
Perio Scaling: Basic / Major - Frequency: _____
Osseous Surgery: Basic / Major - Frequency: _____
Surgical Extractions: Basic / Major
Oral Surgery: Basic / Major
Nightguards (Bruxism): Basic / Major - Frequency:_____

Orthodontia: _____%

Orthodontia Lifetime Deductible: $_____ Orthodontia Lifetime Deductible Met to date: $_____
Diagnostic & Banding Maximum (applies to Orthodontia Lifetime Max): $_____
Lifetime Orthodontia Maximum: $_____ Age Limit: _____

Notes:

Belvedere Plaza Dental

3521 Memorial Dr, Ste A, Decatur, GA 30032 | 404.567.8485

PLEASE COMPLETE ALL INFORMATION – THANK YOU

PATIENT LAST NAME: _____ **PATIENT FIRST NAME:** _____

DENTAL HISTORY

Reason for today's visit _____ Date of last dental visit _____

Former dentist _____ Date of last dental cleaning _____

Please check if you have/had:	Yes	No		Yes	No
Bad breath	❑	❑	Head, neck, jaw pain, or aches	❑	❑
Blisters on lips or mouth	❑	❑	Lip or cheek biting	❑	❑
Burning sensation on tongue	❑	❑	Loose teeth or broken fillings	❑	❑
Chew on one side of mouth	❑	❑	Mouth breathing	❑	❑
Cigarette, pipe, or cigar smoking	❑	❑	Orthodontic treatment	❑	❑
Smokeless tobacco	❑	❑	Nitrous Oxide	❑	❑
Dry mouth	❑	❑	Periodontal treatment	❑	❑
Food collection between teeth	❑	❑	Sensitivity to pressure or irritants	❑	❑
Clench or grind teeth	❑	❑	(cold, heat, sweets)		
Growths or sore spots in your mouth	❑	❑	How often do you floss? _____		
Gums swollen, tender or bleeding	❑	❑	How often do you brush? _____		

Have you ever had an allergic reaction to Novocaine, local, or general anesthetics? ❑Yes ❑No

If Yes, please explain _____

Have you ever had trouble from previous dental care?

❑Yes ❑No If Yes, please explain _____

MEDICAL HISTORY

Physician's name _____ Date of last visit _____

Physician's address _____ Blood Pressure _____

Have you had any serious illnesses or operations Yes ❑ No ❑ If yes, please describe _____

List any medical condition you have/had that is not listed below _____

(Women) Are you pregnant? Yes ❑ No ❑ Due date _____ Nursing? Yes ❑ No ❑ Taking birth control pills? Yes ❑ No ❑

Please check if you have/had:	Yes	No		Yes	No		Yes	No
Allergies, hay fever, sinusitis	❑	❑	Headaches	❑	❑	Slow healing wounds	❑	❑
Anemia	❑	❑	Heart murmur	❑	❑	Stroke	❑	❑
Arthritis, Rheumatism	❑	❑	Heart problems	❑	❑	Swelling of feet or ankles	❑	❑
Artificial heart valves	❑	❑	Hepatitis type _____	❑	❑	Thyroid problems	❑	❑
Artificial joints	❑	❑	Herpes	❑	❑	Tonsilitis	❑	❑
Asthma	❑	❑	High blood pressure	❑	❑	Tuberculosis	❑	❑
Required Hospitalization	❑	❑	Any immune deficiency	❑	❑	Tumor or growth on head/neck	❑	❑
Have you used steroids	❑	❑	Jaundice	❑	❑	Ulcer	❑	❑
Date of last episode _____	❑	❑	Kidney disease	❑	❑	Venereal disease	❑	❑
Bleeding abnormally with operations or surgery	❑	❑	Low blood pressure	❑	❑	Weight loss, unexplained	❑	❑
Blood disease, clotting disorders	❑	❑	Mitral valve prolapse	❑	❑	Do you wear contact lenses?	❑	❑
Cancer	❑	❑	Osteoporosis	❑	❑	Do you consume alcoholic beverages?	❑	❑
Chemical dependency	❑	❑	Osteopenia	❑	❑	Are you currently under the care of a Physician?	❑	❑
Chemotherapy	❑	❑	Pacemaker	❑	❑	Are you allergic/sensitive to Latex?	❑	❑
Circulatory problems	❑	❑	Radiation treatments	❑	❑	Allergic to Penicillin, Aspirin, or other drugs?	❑	❑
Cortisone treatments	❑	❑	Respiratory disease	❑	❑	*If Yes, please specify* _____		
Cough, persistent or bloody	❑	❑	Rheumatic fever	❑	❑			
Diabetes	❑	❑	Scarlet fever	❑	❑			
Emphysema	❑	❑	Shortness of breath	❑	❑	List any medications that you are taking:		
Epilepsy	❑	❑	Sinus trouble	❑	❑			
Fainting	❑	❑	Sickle cell anemia	❑	❑			
Glaucoma	❑	❑	Skin rash	❑	❑			

AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowledge.

Patient/Guardian Signature _____ Date _____

Reviewed by: _____ Date _____

Dental & Medical Health History

Belvedere Plaza Dental

3521 Memorial Drive, Ste A, Decatur, GA 30032 | 404.567.8485

SECTION A: PATIENT GIVING CONSENT

Patient Name: _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Officer:	**Abbas Haider, DDS**
Telephone:	**404-567-8485**
Address:	**3521 Memorial Drive, Suite A, Decatur, GA 30032**

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation.

SECTION C: SIGNATURE

I, _____ have had full opportunity to read and consider the contents of this Consent form and and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and heath care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative (parent/guardian) on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

SECTION D: FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ❑ Individual refused to sign
- ❑ Communication barriers prohibited obtaining the acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Other (please specify) _____

Signature: _____ Date: _____

You are entitled to a copy of this consent after you sign it.

SECTION E: REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

If this Revocation of Consent is signed by a personal representative (parent/guardian) on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

SECTION F: RESTRICTION OF PROTECTED HEALTH INFORMATION (PHI)

I request Dr. Abbas Haider restrict the disclosure of my PHI to those specified below:

Name: _____

Name: _____

Signature: _____ Date: _____

If this Restriction of PHI is signed by a personal representative (parent/guardian) on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

Practice Policies

Abbas Haider, DDS Belvedere Plaza Dental 3521 Memorial Drive, Suite A Decatur, GA 30032

Patient Name: _____ Date_____

Refund Policy

There are absolutely no refunds, guarantees or warranties. It is your mouth and we cannot control factors that effect products we seat/deliver. Once any work has been started, the total fee is due, even if you change your mind. So, please make sure you want to do the work before we begin work. All Pertinent Consent forms must be signed prior to beginning any Dental work.

Insurance Policy

Our office participates with most dental insurance plans. As a courtesy, we will verify your benefits and file your insurance for you. Your insurance company has developed maximum and allowable fee schedules for dental services performed within the area. Any insurance estimation quoted to you for treatment is a guestimate of what your insurance carrier **may** pay for services. **Please be advised that you are responsible for the total charges for services rendered.** If you do not feel your insurance company has made adequate payment on your account, please contact them directly or your Human Resources Manager to discuss this matter.

Payment Policy

We accept Cash, Check, or most Major Credit Cards as methods of payment. We also offer Third-Party Financing. **It is expected that all payments be paid at the time of service**, unless prior financial arrangements have been made with the Practice Manager. All accounts over 90 days will incur a 2% finance charge on unpaid balances per month. Returned checks incur a $75 fee. If for any reason there are chargebacks to credit cards and it is reversed, you will be charged a $250 Office Visit fee payable immediately.

Hygiene Policy

We pride ourselves on the extent of communication and education we provide our patients. We strive to place restorations that yield Function, Longevity and Esthetics. We teach our patients how their overall dental health can be maintained for a lifetime by complying with regular Hygiene visits and by utilization of a Home Hygiene Maintenance System. We need you to value your Reserved Hygiene Appointment. It is not simply a "cleaning." As the Doctor/Hygienist will tell you, you can 'clean' your teeth at home. The reason you visit Dental Professionals is to clean those areas in your mouth that cannot be cleaned with home care techniques. Please reserve your Hygiene visit upon check-out today. We consider your Hygiene Reservation confirmed and will call/email you as a courtesy reminder when the time comes.

Scheduling Policy

Please provide us 48 hours notice to reschedule or cancel your reserved appointment time. If you cancel, no-show or reschedule an appointment without the required notice, you may be charged a $50 Office Visit fee for Hygiene appointments and a $150 Office Visit fee for Treatment appointments. After 2 missed appointments, regardless of the reason, we will inactivate your file and you will be considered an "emergency-only" patient. You will also forfeit any future Saturday appointments.

We use Patient Activator to help remind you of your Appointed times. Please reply to texts or emails to confirm your Reserved Time. **Please show up 15 minutes prior to your Appointment time to update paperwork.** If you don't do this, your appointment may be rescheduled at our discretion.

By signing below, I attest that I have read and understood the above Practice Policies. All my questions regarding the above policies have been answered and I promise to abide by the Practice Policies.

Patient/Guardian Signature: _____

Patient Consent for Electronic Communication

You have requested that our office communicate with you electronically. By utilizing our practice's electronic services, you agree that Belvedere Plaza Dental, Dr. Abbas Haider and any Associates, Affiliates and/or Employees may send to you communication that can be sent through the Internet or Text Message or Automated Phone Calls to an email address or phone number you designate.

Consent and Acknowledgement

I_____, in the presence of my dentist or the dental practice's privacy official, agree that the practice may electronically communicate with me at the following email address and phone number.

Email Address_____

Phone_____

I acknowledge that the practice may send the following to my email or phone via call or text. Check each that apply, and then provide your initials at the end of each item selected.

- ☐ Information about my invoice or accounts payable. _____(initials)
- ☐ Information about a specific dental visit or appointment. _____ (initials)
- ☐ Information about <u>any</u> dental visit. _____ (initials)
- ☐ Advertisements regarding specials being ran at the office. _____ (initials)

Acknowledgement

By signing below, you acknowledge understand regarding the above information and also the following information before we can send communications electronically.

- I am responsible for providing the dental practice any updates to my email address and/or phone number.
- I am able to receive information electronically and store it securely away from any public computer.
- I can withdraw my consent to electronic communications by calling (404) 567-8485.

Patient's Signature_____Date_____