

# Vinings Family Dentistry

## Demographic Information

LAST NAME: \_\_\_\_\_ FIRST \_\_\_\_\_ M.I. \_\_\_\_\_

ADDRESS: \_\_\_\_\_ APT# \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

BIRTHDATE: \_\_\_\_/\_\_\_\_/\_\_\_\_ SOCIAL SECURITY \_\_\_\_/\_\_\_\_/\_\_\_\_

HOME PHONE: \_\_\_\_\_ E-MAIL: \_\_\_\_\_

MARITAL STATUS (M / S) SPOUSE'S NAME: \_\_\_\_\_

WHO REFERRED YOU? \_\_\_\_\_

**For our records the person with the dental insurance must also be the person responsible for the account. Please enter the insurance subscriber's information in FULL if you wish to assign benefits to our office.**

## SUBSCRIBER'S INFORMATION IF DIFFERENT FROM ABOVE

SUBSCRIBER'S NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

EMPLOYED BY: \_\_\_\_\_

INSURANCE COMPANY NAME AND ADDRESS: \_\_\_\_\_

\_\_\_\_\_

INSURANCE COMPANY'S PHONE #: \_\_\_\_\_

GROUP POLICY NUMBER: \_\_\_\_\_

EMPLOYEE ID: \_\_\_\_\_

REALTIONSHIP TO PATIENT: \_\_\_\_\_

SUBSCRIBER'S BRITHDATE: \_\_\_\_\_ SSN: \_\_\_\_\_

# Vinings Family Dentistry

## Medical Health Questionnaire

**Please circle the appropriate response. Since a complete physical examination is not a part of our oral examination it is important that you inform the doctor of present medical conditions, and all the medications you are taking.**

Yes No Are you under  
The care of a physician? \_\_\_\_\_

Yes No Do you have a serious  
Or chronic illness? \_\_\_\_\_

Yes No Do you have serious  
or chronic injuries? \_\_\_\_\_

Yes No Have you had  
hospital admissions? \_\_\_\_\_

Yes No Operations? \_\_\_\_\_

Yes No Blood transfusion? \_\_\_\_\_

### **Cardiovascular**

Yes No Angina Pectoris?

Yes No Myocardial Infarction?

Yes No Congenial Heart Defect?

Yes No Rheumatic Fever?

Yes No Rheumatic Heart Disease?

Yes No Heart Murmur?

Yes No Hypertension?

Yes No Stroke?

### **Respiratory**

Yes No Tuberculosis?

Yes No Emphysema?

Yes No Asthma?

Yes No Shortness of Breath?

Yes No Edema?

### **Musculoskeletal**

Yes No Arthritis?

Yes No Bone disorders? \_\_\_\_\_

Yes No Muscle disorders? \_\_\_\_\_

### **Genitourinary**

Yes No Kidney problems? \_\_\_\_\_

Yes No Venereal Disease? \_\_\_\_\_

### **Endocrine**

Yes No Diabetes? \_\_\_\_\_

Yes No Adrenal disorders?

Yes No Thyroid disorders?

Yes No Parathyroid disorders?

Yes No Are you taking Steroids?

### **Hematopoetic**

Yes No Anemia?

Yes No Bleeding disorders?

Yes No Anticoagulants? \_\_\_\_\_

Yes No Leukemia? \_\_\_\_\_

### **Neurologic**

Yes No Paralysis? \_\_\_\_\_

Yes No Epilepsy?

Yes No Convulsions?

Yes No Psychiatric Treatment?

Yes No Fainting/ Spells?

Yes No Tranquilizers or Mood  
Elevating Medications?

### **Gastrointestinal**

Yes No Ulcers?

Yes No Bleeding?

Yes No Hepatitis? \_\_\_\_\_

Yes No Jaundice? \_\_\_\_\_

Yes No Cirrhosis?

Yes No OTHER? \_\_\_\_\_

### **General**

Yes No Present Medications? \_\_\_\_\_

\_\_\_\_\_

Yes No Allergies? \_\_\_\_\_

\_\_\_\_\_

Yes No Past Pregnancy?

Yes No Current Pregnancy?

Yes No Illicit Drugs? \_\_\_\_\_

Yes No Alcohol? \_\_\_\_\_

Yes No Tobacco? \_\_\_\_\_

ANY OTHER CONDITIONS? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# Vinings Family Dentistry

## Dental Health Questionnaire

Date of your last teeth cleaning appointment: \_\_\_\_\_

Yes No Do you have a complaint today? Please explain: \_\_\_\_\_

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- Yes No Are you satisfied with the appearance of your teeth?  
Yes No Would you like to have whiter teeth?  
Yes No Do you brush more than once a day?  
Yes No Do you use dental floss?  
Yes No Are your teeth stained?  
Yes No Does calculus (tartar) form rapidly?  
Yes No Do you usually have your teeth cleaned twice a year?  
Yes No Do you frequently consume food or beverages between meals?  
Yes No Are your gums shrinking away from your teeth?  
Yes No Do your teeth seem to be shifting in position?  
Yes No Do you notice a popping, clicking, or soreness of your jaws?  
Yes No Do you have teeth that seem to be loose?  
Yes No Do your gums bleed when you brush or floss?  
Yes No Do you clench or grind your teeth?  
Yes No Are you conscious of the way your teeth come together?  
Yes No Have you ever had an injury to your jaw or your face?  
Yes No Were teeth extracted because of decay?  
Yes No Were teeth extracted due to periodontal disease?  
Yes No Does food frequently wedge between your teeth?  
Yes No Have you had braces?  
Yes No Are you having dental pain?  
Yes No Are your teeth sensitive to hot, cold, or sweets?  
Yes No Do you think you have decayed teeth?  
Yes No Do you have difficulty chewing food?  
Yes No Are your gums frequently sore or tender?  
Yes No Do you have missing teeth?  
Yes No Would you like your missing teeth replaced?

I, the undersigned understand, and agree that all the information on these forms is true and correct. I give my informed consent for treatment. This chart, and any diagnostic films, or casts are the property of Dr. Guy F. McMaster. Any charges incurred are my sole responsibility.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
Patient or Guardian

Signature \_\_\_\_\_ Date \_\_\_\_\_  
Treating Doctor

# Vinings Family Dentistry

## Dental Anxiety Questionnaire

Please answer the following as completely as possible. Your comfort is very important to us. Remember: **WE CATER TO COWARDS!**

Please scale your responses from 1 to 10. (one, being completely comfortable, and ten being completely uncomfortable.)

Anticipating your appointment . . . . . \_\_\_\_\_

Waiting your turn to see the dentist . . . . . \_\_\_\_\_

Waiting your turn to see the hygienist . . . . . \_\_\_\_\_

Sitting in the dental chair . . . . . \_\_\_\_\_

Having your teeth filled . . . . . \_\_\_\_\_

Having your teeth cleaned . . . . . \_\_\_\_\_

The sounds of the dental instruments . . . . . \_\_\_\_\_

OTHER, PLEASE EXPLAIN:

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Our office staff will meet your comfort requirements through techniques from simple TLC (tender loving care) to pharmacological sedation. A request for any of the following is strictly a personal preference, and every attempt will be made to comply with your wishes.

Please check any that apply:

Don't tell me anything; just do what you have to.

Inform me of anything that may cause discomfort so that it needs not be anticipated.

Music through headphones helps to distract me and drown out the noises during treatment.

Nitrous oxide (laughing gas) has helped me in the past, and I would like to have it during treatment.

I have had terrible experiences with the dentist in the recent, past, or as a child and would like to have some form of sedative medicine to help me through my treatment.

\*\*Other, please explain:

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Notes:

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# Vinings Family Dentistry

## Office Payment Policy

**\* To avoid charges, you may pay for services at the time of rendering. \***

### **Insurance:**

Please be aware that your insurance company is only one of thousands. Every insurance company has their own **USUAL, CUSTOMARY, AND REASONABLE (UCR)** fees. The calculation of which will not be divulged to us. Therefore; we ask that you understand your policy's exclusions and peculiarities. Our office staff will make every reasonable effort to assist with your reimbursement for covered services. **It is our office policy to pursue your insurances benefit for 60 days at no cost to you.** Thereafter, the unpaid "insurance" balance will be transferred to the "patient" balance where compounded interest will accrue at **1.5%** per month, or **\$2.00** per monthly billing period (**whichever is greater**). Balances over 90 days will be placed with our collections agent. I agree to pay any fees incurred by Dr. McMaster for the recovery of any funds owed. All fees quoted will be honored for a three-month period from the delivery of a treatment plan.

### **Co-payment:**

An estimate of your co-payment is due and payable at the time of the initiation of your treatment!

I agree to pay using:

CASH: \_\_\_\_\_ CHECK: \_\_\_\_\_ CREDIT CARD: \_\_\_\_\_

### **Missed appointments:**

Our office strives to respect your time, and does the extra things required to be one time. We will call to confirm your appointment the day before you are scheduled. If you use voicemail or an answering machine, our message will be your confirmation. We will not overbook our schedule in fear of no-shows. The treatment room is reserved for you. In return we ask that you respect our effort, and expense before the appointed services are rendered. A minimum fee of **\$75.00** will be assessed for a cancellation of less than **24** hours notice or a missed appointment.

### **Senior Citizen's Discount:**

Our office offers a 10% discount to seniors 65 years of age and over.

### **Assignment of Benefits:**

Our office will accept an assignment of benefits as a promise of payment by the patient or their guardian.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**ACKNOWLEDGEMENT  
OF  
RECIPT OF NOTICE OF PRIVACY PRACTICES**

**Vinings Family Dentistry  
Guy F. McMaster, D.M.D.  
2931 Paces Ferry Rd  
Suite 10  
Atlanta, GA. 30339  
(770) 432-8516**

My signature confirms that I have been informed of my rights to privacy regarding my protected health information under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information is used to:

- \*Provide and coordinate my treatment among a number of healthcare providers who may be involved in that treatment directly and indirectly.**
- \*Obtain payment from third-party payers for my health care services.**
- \*Conduct normal health care operations such as quality assessment and improvement activities.**

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may use this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree you are bound to abide by such restrictions.

Patient name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_ Signature: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Other Persons authorized to access my

Information: \_\_\_\_\_

For office use only:

We were unable to obtain the patients written acknowledgment of our Notice of Privacy Practices due to: ( refusal to sign, communication barriers, emergency situation, Other):

\_\_\_\_\_