PiedmontDental

Benjamin L. Areheart DMD

Patient Full Name: _____Preferred Name: _____

Parent or Guardian Name(s)(if patient is a minor – 18 & under):_____

Date of Birth:_____ Social Security Number: _____-_____-_____

Mailing Address : _____

Home Phone: _____Cell Phone:_____Work Phone: _____

Email Address: _____

Marital Status: (Married/Divorced/Widow/Single) Employer: _____

Who may we thank for referring you to our office? _____

Primary Dental Insurance Information (Leave blank if there is no dental insurance to file)

Insurance Company Name: _____

Name of Subscriber (Person who carries the insurance): _____

Subscriber's Social Security Number: _____-____-_____ Subscriber's DOB: _____

Subscriber's ID Number: _____ Group Number: _____

Subscriber's Employer: _____

Policy for Filing Insurance

Our office has never been in network with any dental insurance providers, however as a courtesy we will file your claim. You will be responsible for any chargers your insurance does not pay. If for any reason your insurance company has not paid within 60 days of treatment the balance will be your responsibility and you will need to re-file with your insurance company. The patient's estimated portion will be due at the time of service.

Payment Services

If you are a self-pay patient with no dental coverage all financial responsibility must be paid at the time of service. In the event you do have insurance but are unable to provide us with the insurance card you may be asked to pay in full at the time of service. When insurance is provided we give an estimate to the best of our knowledge. In the event insurance does not pay in full you are responsible for the balance. All balances on accounts must be paid within 30 days. All delinquent accounts will be subject to being turned over to a collection agency.

By signing below, I attest that the above information is correct to the best of my knowledge. I also understand that payment is due when services are rendered and that I will be responsible for any amount that insurance does not cover.

Responsible Party Signature: _____ Date: _____

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HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION OR FINANCIAL INFORMATION

Patient Name of Patient: _____Date of Birth: _____

PHI DISCLOSURE TO FAMILY MEMBERS

You may authorize us to contact a family member regarding your medical and/or financial matters. This is to acknowledge that you authorize Piedmont Dental to disclose your private health information to the following individuals.

Name: _____ Relationship to patient: _____

Telephone: _____

Name: _____ Relationship to patient: _____

Telephone: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Piedmont Dental is committed to protecting your privacy. We will not release any information about you or your treatment without your consent. Only the people you list will be authorized to receive your information. I acknowledge that a copy of this office's Notice of Privacy Practices is available to me upon request.

Patient or Responsible Party: _____ Date: _____

BROKEN APPOINTMENT AND CANCELLATION POLICY

We hold appointment times especially for you in good faith that you will be here. When patients do not show up or cancel at the last minute (regardless of the reason) we cannot fill the open slot. This results in nonproductive time with results in increased fees for everyone. We appreciate your understanding. There will be a $50 charge for ALL missed appointments and cancellations with less than 48 business hours prior to the scheduled appointment time.

Patient or Responsible Party: _____ Date:_____

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HEALTH HISTORY

1. Are you currently under the care of a physician? Yes No
   If yes, who_____
2. Have you had any operation or been hospitalized in the past five years? Yes No
   If yes, when _____
3. Do you have a prosthetic or a joint replacement, if so are you required to premedicate prior to dental treatment? Yes No
4. Are you currently on any blood thinner or medication that makes you bleed easily? Yes No
   If yes, what _____
5. Have you ever taken bisphosphonates or a bone density medication? Yes No
6. Have you had any serious medical trouble associated with any dental experiences? Yes No
   If yes, explain: _____
7. Have you ever received head/neck radiation for cancer? Yes No
8. Have you had a serious illness, operation, or hospitalized within the last year? Yes No
   If yes, explain: _____
9. Do you smoke and/or vape? Yes No
   If yes, how often? _____
10. Do you participate in recreational drugs or have a history of drug dependence/alcohol dependence? Yes No
    If yes, how often? _____
11. Do you have any known allergies? Yes No
    If yes, please list: _____
    _____

WOMEN: Are you pregnant, nursing, or taking birth control? _____

Do you **currently** take any medications? (Please provide a list to be scanned if you have one)

_____ _____

_____ _____

_____ _____

Preferred Pharmacy: _____

Pharmacy Address: _____

Have you ever had any of the following diseases or medical problems? (Circle all that apply)

Alcohol/Drug Abuse
Anemia
Anxiety/Depression
Artificial Joints/Bones/Valves
Autoimmune disorder
Asthma
Blood transfusion
Bruise easily
Cancer/chemotherapy
Colitis
Congenital heart defect
Diabetes (Type I or Type II)
Difficulty breathing
Emphysema
Fainting spells
Frequent headaches
Glaucoma
Heart attack
Heart surgery
Hemophilia
Ulcers
Hepatitis (A, B, C, or D)
Herpes/fever blisters
High blood pressure
HIV/AIDS
Kidney problems
Liver problems
Low blood pressure
Lung problems
Mental health disorder
Mitral valve pro lapse
Osteoporosis/Paget's Disease
Pacemaker
Pain in jaws when eating
Pain management
Parkinson's Disease
Radiation
Seizures/Epilepsy
Sleep apnea
Sinus problems
Stroke

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. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Print name of patient: _____ Date: _____

Signature of patient or responsible party: _____Date: _____

Doctor Initials: _____ Date: _____

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CONSENT FOR INTERNET COMMUNICATIONS

I grant my permission to Piedmont Dental to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the Piedmont Dental practice.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand that Piedmont Dental will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that Piedmont Dental has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand that Piedmont Dental will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand that Piedmont Dental CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR THE MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

☐ I have read the information above regarding the secured uploading of patient information to the web site for Piedmont Dental, and grant Piedmont Dental permission to securely upload my patient information to the website. *