Welcome!

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

Patient Information

Date________________ Soc. Sec. #__________________________ Date of Birth____________

Name____
Last Name First Name Initial

Married_____ Single______

Address______________________________ City______________ State_____ Zip_______

Home Phone ( )______________ Work ( )________________ Cell ( )___________

Email Address___________________ Sex: Male________ Female___________

Employer_________________________ Address_____________________________________

Who should we thank for referring you? _______________________________________

Emergency Contact: ___________________ Home#: ______________ Work#:__________

Insurance

Person Responsible for Account:____
Last Name First Name Initial

Relationship_________________ Birthdate_____________ S.S.___________________

Address_____________________________ City________________ State_____ Zip_______

Home Phone ( )____________ Work Phone ( )______________ Cell ( )_____________

Employer_____________________ Address____

Insurance Company______________________________ Phone#: ( )_________________

Insurance Address ____

Subscriber ID#: ____________________________ Group#: ______________________

I hereby authorize payment directly to Dr. Russell 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, provider, or any 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 ______________________

Dental History

Former Dentist_______________________ Phone#: ( )_______________________
Date of last dental exam____________________ Dental x-rays ____________________
Was all proposed treatment completed? ________________________________
Have you had a serious/difficult problem associated with any 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. Women only: Pregnant? _______Nursing? ______ Taking birth control pills? _______
6. Have you ever had excessive bleeding requiring special treatment? If so, explain____
7. Do you have allergies or sensitivities to drugs such as Penicillin, Novacaine, Codeine, Aspirin, ect? ____________________________Latex allergy? ______________
8. Please list all medication that you are currently taking:
   ____
   ____
9. Have you ever had any of the following problems? Please circle yes or no:

Angina (Chest pain):	Yes No	Heart Attack:	Yes No
Rheumatic fever	Yes No	Rheumatic heart disease:	Yes No
High Blood Pressure	Yes No	Stroke:	Yes No
Heart Murmur:	Yes No	Mitral valve prolapsed	Yes No
Hepatitis:	Yes No	Liver disease:	Yes No
Kidney problem;	Yes No	Ulcers:	Yes No
Artificial Joint:	Yes No	Valve replacement:	Yes No
Diabetes:	Yes No	Anemia:	Yes No
Thyroid disease:	Yes No	Other: ______________________	

I certify that I have read and understand the above information to the best of my knowledge. These questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize Dr. Russell L. Boyd, DMD, PC to release any information including the diagnosis and records of in treatment or examination rendered to me or my dependents during the period of such dental care payors and/or healthcare providers.

Signature of Responsible Party: ______________________________**Date**______________________

Russell L. Boyd, DMD, PC

Traditional Family Dentistry

Member: American Dental Association • Georgia Dental Association
Northern District Dental Society of Georgia • The Hinman Dental Society of Atlanta

Please read and sign this statement before we agree to accept assignment directly from your insurance company. This avoids any misunderstanding 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 Manger

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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