TIME 10:35 AM DATE 10/6/2020

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Time 11:06 AM | Heritage Family Dentistry | Date 11/19/2020

Eaglesoft Medical History

Patient Name: | Birth Date: | Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Are you under a physician's care now?	◯ Yes ◯ No	If yes	
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes	
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes	
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes	
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes	
Are you on a special diet?	◯ Yes ◯ No		
Do you use tobacco?	◯ Yes ◯ No		
Do you use controlled substances?	◯ Yes ◯ No	If yes	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Other? ☐ If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Easily Winded	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Angina	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Excessive Thirst	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No
Blood Transfusion	◯ Yes ◯ No	Frequent Diarrhea	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No
Breathing Problems	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Genital Herpes	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No
Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Convulsions	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No
						Yellow Jaundice	◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____

HERITAGE
FAMILY DENTISTRY

Our Standards of Care: In Service of Your Health

Welcome to Heritage Family Dentistry! We are happy that you have chosen us to be your dental care providers and we look forward to having a relationship with you. Our ultimate goal for all of our patients is health. We want to improve and optimize both your oral and systemic health. In order to meet this goal for our patients, we have a standard of dental care that we feel is necessary to provide and is recommended by the American Dental Association. We would like to share this with you ahead of time.

Radiographs (x-rays):

Our first visit with an adult patient is a comprehensive exam. Dr. Pickwick will take the time to get to know you and your dental history. There are two kinds of radiographs (or x-rays) that are necessary for this exam—bitewing and panoramic. The bitewing x-rays are a more focused set that will allow us to see bone levels around each tooth and cavities between the teeth up close. The panoramic is a broader view radiograph which shows the entire mouth and surrounding structures— nasal and sinus cavities, temporomandibular joints (TMJ: the joint that opens and closes mouth/jaw). This is the x-ray professionals commonly use to evaluate wisdom teeth. It is also important because it can capture tumors, cysts, impacted teeth, fractures and infections. This panoramic x-ray can even spot calcifications or clogs in the carotid artery, before you may experience symptoms of an impending heart attack or stroke. Heritage Family Dentistry follows the current American Dental Association guidelines to update the bitewing x-rays once per year and the panoramic x-ray once every three years. We will work hard to stick to your insurance guidelines so that you will get maximum coverage for your x-rays. It is also important to realize that most insurance companies require specific kinds of x-rays to pay on many of the dental services we perform. These x-rays, combined with a thorough investigation of the inside of your mouth, will help determine necessary dental treatment, such as implants, crowns, bridges, cavity fillings, removable partial dentures or tooth wear appliances/nightguards. During your comprehensive exam, Dr. Pickwick will also do a thorough gum measuring exam in order to ascertain the health of the gums and bone around your teeth. Healthy gums and bone are the foundation of tooth health.

Dental Cleanings:

Heritage Family Dentistry follows the current American Dental Association standard of preventive care when a patient has healthy gum and bone levels—a prophylaxis dental cleaning and routine doctor exam every 6 months. When there is active gum and bone disease, deeper cleanings and more frequent visits will be necessary to establish health.

Scheduling:

At Heritage Family Dentistry, it is not customary that we "double book" patients. We value the time we set aside just for you and we do our absolute best to be respectful of your time. Considering this, we may not be able to honor the appointment if a patient is more than 15 minutes late. We want to ensure that we are able to thoroughly perform the services we have intended for you, but also respect the patients that are appointed after your time. Please call us immediately to discuss if you are running behind. We also require at least 24 hour notice of your appointed time if a cancellation is necessary. When you are booked for our most requested scheduled time which is either 8:00 a.m. or a 4:00 p.m. we require confirmation of your appointment 24 hours in advance if not, your appointment will be rescheduled. Otherwise, you will be subject to a broken appointment fee depending on how much time was saved for you and we may ask that you hold your time for future visits with a deposit. We understand that life happens and things come up. If you have any questions or concerns, please don't hesitate to ask us! I have been informed of the Standard of Care for Heritage Family Dentistry:

Printed name_____ Date_____

Signature_____

Financial Policy

On behalf of our staff, we want to welcome you to our office. We are pleased that you have selected us to care for your dental needs and we look forward to your initial visit. We want you to know that we are committed to provide you with the highest quality of oral health care in the most gentle, efficient, and enthusiastic manner possible.

We accept cash, check, Visa, MasterCard, AMEX, Discover, Care Credit, and Wells Fargo.

Please also note that fees quoted over the phone are only an estimate, and we require payment in full at the time of service for anything not covered by your insurance. A service charge of 1.5% per month and a $10.00 rebilling fee will also be added to any unpaid balance over 60 days from the time of service. Returned checks will receive a charge of $25.00 per check.

We appreciate the value of your time, and except for emergency situations, you can expect us to be on time for you as you are for us. We expect at least 48-hour advance notice for appointment cancellation to allow us to schedule your reserved time to another patient in need. Improper notice will result in a $50.00 cancellation charge for cleanings and 25% charge on appointments with Dr. Pickwick.

If you have dental insurance, please bring your insurance card and your dental breakdown if one has been distributed. If a card is not available please have all insurance information, such as provider name, address, subscriber ID number, etc. We will file to your company as a courtesy to you. We HIGHLY recommend that you call your insurance company before treatment, so that you know exactly what they will cover during your visit. Your contract is between you and your insurance company, and the payment for services is your responsibility. Should your insurance pay more than estimated, we would be happy to issue you a refund or credit your account.

If necessary, a collection agency, attorney or small claims court will take over a delinquent account. If your account is placed with any of the above listed agencies, you will be responsible for all collection cost and attorney's fees, in addition to the cost of services rendered.

If your insurance company's policy is to send the check to the subscriber (Patient) instead of our office, you will be responsible for your charges in full at the time of service.

"I hereby authorize payment of benefits, otherwise payable to me directly to Heritage Family Dentistry".

"I understand that I must cancel my appointment 48-hours in advance in order to avoid being charged a cancellation fee."

"I have been informed of all office policies. I agree that I am responsible for all charges for services and materials not paid for by my insurance. I have read and understand the statements outlined above in the financial/ insurance portions."

Signed (Patient/Guardian) _____ Date_____

Dr. Erin Pickwick, DMD
2023 Grayson Hwy, Suite 203
Grayson, Ga 30017

NOTICE OF PRIVACY PRACTICES

Our Legal Duty
We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003 and will remain in effect until we replace it. This notice was revised September 18, 2018.

We reserve the right to change our privacy practices and the terms of this Notice any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health insurance information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices or any additional copies of this Notice, please contact us using the information listed at the end of this notice.

Uses and Disclosures of Health Information
We use and disclose health information about you for treatment, payment and healthcare operations. For example:

Treatment: We may use or disclose your health information in providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include crowns, fillings, teeth cleaning services, etc. to a physician or other healthcare provider providing treatment for you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you, such as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your dental plan for your dental services

Healthcare Operations: We may use and disclose your health information in connection with your healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing and credentialing activities.

Your Authorization: In addition to our use for your healthcare information for treatment, payment or healthcare operations, you may give us written authorization to use your healthcare information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so
.
Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating a family member), your personal representative or other person responsible for your care, of your location, your general condition or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment, disclosing only health information that is directly relative to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays or other similar forms of health information.

Marketing Health Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence, or the possible victim of other crimes. We may disclose your health information

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

- You May Refuse To Sign This Acknowledgement

I, _____ have received a copy of this office's Notice Of Privacy Practices.

_____
Please print name

_____
Signature

_____
Date

FOR OFFICE USE ONLY

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

_____Individual refused to sign

_____Communications barriers prohibited obtaining the acknowledgement

_____An emergency situation prevented us from obtaining acknowledgement

_____Other (Please Specify)
_____
_____
_____

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This form is educational only and does not contain any legal advice, and covers only federal, not state law (August 14,2002)

HERITAGE
FAMILY DENTISTRY

Records Release Authorization to Heritage Family Dentistry

I, _____respectfully request the release of all my records (treatment, progress notes and radiographs) that you have on file to the office of Heritage Family Dentistry from the office listed below. Please forward any digital images in jpeg format by email to Heritage Family Dentistry (**info@graysonheritagedental.com**)

Patient Name _____

Date of Birth _____

Address_____

_____

Telephone number_____

Records released from the office of:

Dentist_____

Address_____

_____

Telephone_____

Thank you for releasing my records to Heritage Family Dentistry

Signature_____Date_____