Robert Simmons Jr. D.D.S., P.C.

And

Associates

PERSONAL AND CONFIDENTIAL INFORMATION

(PLEASE PRINT)

DENTAL REGISTRATION AND HISTORY

PATIENT INFORMATION

Date_____

SSN_____Age_____

Patient Last Name_____

First Name_____ Middle Initial_____

Address_____

City_____State_____Zip_____

Sex ☐ M ☐ F Birthdate_____

☐Married ☐Widowed ☐Single

☐Minor ☐Separated ☐Divorced

Employer/School_____

Spouse's Name_____

Birthdate_____SSN_____

Spouse's Employer_____

If Patient is a Minor:

Mother's Name_____

SSN_____ Birthdate_____

Employer_____

Father's Name_____

SSN_____ Birthdate_____

Employer_____

Whom may we thank for referring you?_____

DENTAL INSURANCE

Who is responsible for this account?_____

Relationship to Patient_____

Insurance Co._____

Subscriber's Name_____

Group#_____ ID#_____

Is patient covered by additional insurance? ☐Yes ☐No

Insurance Company_____

Subscriber's Name_____

Group#_____ ID#_____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance with

_____and assign directly to
Name of Insurance Company(ies)

Dr._____ all insurance benefits, if any, otherwise payable to me services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent/Legal Guardian or Personal Representative

_____
Printed Name

_____ _____
Date Relationship to Patient

PHONE NUMBERS

Home (____) _____ Work (____) _____ Ext____ Cell Phone (____) _____

Spouse's Work (____) _____ Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship_____

Home Phone (____) _____ Work Phone (____) _____

HEALTH HISTORY

Patient's Name _____ Date _____ _____

Have you ever taken any of the drugs in the group collectively referred to as "fen-phen?" These include combinations of lonimin, Adipex, Fastin, (brand names of phentermine), Pondimin (fonfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you have any of the following:

ADD or ADHD	☐Yes ☐No	Cortisone Treatments	☐Yes ☐No	Respiratory Disease	☐Yes ☐No
AIDS/HIV	☐Yes ☐No	Cough, persistent or bloody	☐Yes ☐No	Type_____	
Anemia	☐Yes ☐No	Diabetes	☐Yes ☐No	Rheumatic Fever	☐Yes ☐No
Arthritis, Rheumatism	☐Yes ☐No	Epilepsy	☐Yes ☐No	Scarlet Fever	☐Yes ☐No
Artificial Heart Valves	☐Yes ☐No	Fainting or dizziness	☐Yes ☐No	Shortness of Breath	☐Yes ☐No
Artificial Joints/Breast Implants/	☐Yes ☐No	Glaucoma	☐Yes ☐No	Sinus Trouble	☐Yes ☐No
Screws/Plates Date_____		Headaches	☐Yes ☐No	Skin Rash	☐Yes ☐No
Asthma	☐Yes ☐No	Heart Murmur	☐Yes ☐No	Special Diet	☐Yes ☐No
Autism	☐Yes ☐No	Heart Problems	☐Yes ☐No	Stroke Date_____	☐Yes ☐No
Back Problems	☐Yes ☐No	Type_____		Swollen Feet or Ankle	☐Yes ☐No
Behavioral Conditions	☐Yes ☐No	Hepatitis Type_____	☐Yes ☐No	Thyroid Problems	☐Yes ☐No
Bleeding Abnormally, with	☐Yes ☐No	Herpes	☐Yes ☐No	Tobacco Habit	☐Yes ☐No
Extractions or surgery		High Blood Pressure	☐Yes ☐No	Tuberculosis/Chest X-ray	☐Yes ☐No
Blood Disease	☐Yes ☐No	Jaw Pain	☐Yes ☐No	Diagnosed Date_____	
Cancer	☐Yes ☐No	Kidney Disease	☐Yes ☐No	Tumor or growth on head or neck	☐Yes ☐No
Date_____ Type_____		Liver Disease	☐Yes ☐No	Ulcer	☐Yes ☐No
Chemical Dependency	☐Yes ☐No	Mitral Valve Prolapse	☐Yes ☐No	Venereal Disease	☐Yes ☐No
Chemotherapy/Radiation	☐Yes ☐No	Nervous Problems	☐Yes ☐No	Weight Loss, unexplained	☐Yes ☐No
Date_____		Pacemaker	☐Yes ☐No	Medication for Osteoporosis	☐Yes ☐No
Circulatory Problems	☐Yes ☐No	Psychiatric Care	☐Yes ☐No	or bone loss	

Are you wearing partials or dentures? ☐Yes ☐No Year they were made _____
Do you wear contact lenses? ☐Yes ☐ No
Problems with anesthesia (getting numb)? ☐Yes ☐No
Have you ever had any surgeries? ☐Yes ☐No
Types of surgeries/hospitalizations and dates: _____

Are you pregnant? ☐Yes ☐No Due Date _____
Are you nursing? ☐Yes ☐No Taking Birth Control ☐Yes ☐No

Do you have any medical conditions not listed on this form? ☐Yes ☐No
If so, please explain_____

Primary Care Physician_____ Phone_____ Date Last Seen_____

Dentist Signature:_____ Date_____

MEDICATIONS

Are you currently taking any medications? ☐Yes ☐No
Please list all medications you are taking and the correlating diagnosis:

Pharmacy Name _____
Phone (___) _____

ALLERGIES

☐ **Aspirin** ☐ **Penicillin**
☐ **Barbiturates (sleeping pills)**
☐ **Codeine** ☐ **Sulfa**
☐ **Iodine** ☐ **Other_____**
☐ **Latex** _____
☐ **Local Anesthetic** ☐ **None**

Signature_____ Relationship to Patient_____ Date _____

Robert Simmons Jr. D.D.S., P.C.

And

Associates

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

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

Printed Name_____Signature_____Date_____

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

☐ Emergency Situation ☐ Other_____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Name_____Telephone_____

Address_____

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 out 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:
Terrie Nolan Telephone (912) 368-3333 Fax: (912) 368-6009

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, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Signature

I, _____, have had full opportunity to read and consider the contents of this Consent form 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_____ Relationship to Patient_____
YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT. STOP HERE TO GIVE CONSENT.

REVOCATION OF CONSENT

I revoke my consent for your use and disclosure of my protected health information for treatment, payment activities, and health care operations. I understand that revocation of my consent will not affect any action taken 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.

ONLY TO REVOKE CONSENT

Signature_____ Date_____

Robert Simmons Jr. D.D.S., P.C.

And

Associates

RECORDS RELEASE

I, _____ give Dr. Robert Simmons Jr. permission to release my dental records and medical records relevant to dental treatment, or copies of such to:

Name_____

Address_____

Phone Number_____

Signature_____

Relationship to Patient_____

Date_____

Witness_____

Witness_____

Robert Simmons Jr. D.D.S., P.C.

And

Associates

WRITTEN FINANCIAL POLICY

Thank you for choosing Robert Simmons Jr D.D.S. P.C. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options

You can choose to pay by:

- Cash
- Check
- Visa, MasterCard, American Express, or Discover Card
    - We offer a 5% courtesy discount to patient who pay for their treatment with cash prior to completion of care for treatment of $1000 or more
- Convenient Monthly Payment Options from CareCredit[1] Healthcare Credit Card
    - Allows you to pay over time
    - No annual fees or pre-payment penalties

Please note:

Robert Simmons D.D.S. P.C. requires payment at the beginning of treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.

For plans requiring more than 1 appointment, alternative payment arrangements may be provided. There is a $25 nonrefundable reserved appointment retainer fee to secure all appointments that are 90 minutes or longer.

For patients with dental insurance, we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.[2]

Robert Simmons D.D.S. P.C. charges $30 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want and need.

Signature_____Relationship to Patient_____

Printed Name_____Date_____

[1] Subject to credit approval

[2] If we do not receive payment from your insurance carrier within 90 days, you will be responsible for payment for treatment and collection of your benefits directly from your insurance carrier.

OFFICE SCHEDULING AND CANCELLATION POLICY

In an attempt to provide high quality dental care in a timely fashion to as many patients as possible, we request 24 hours' notice for any cancellation. If this is not done, you are required to pay for your next visit in advance.

This time is especially reserved for you. We will give you a courtesy call, text and/or email two days in advance. Verbal confirmation of appointments is required. You must call or come in to the office to confirm every appointment. If we do not hear from you within 24 hours of your appointment, you will be removed from our schedule and will need to contact our office for a new appointment.

After three broken appointments, you may be dismissed from the practice.

DUPLICATION OF X-RAYS AND RECORDS

Any patient requesting a copy of x-rays or records will be responsible for a duplicating charge of $9.00 per patient. This fee is non-negotiable and is the responsibility of each patient, regardless of transferring locally or out of state.

Signature_____ Relationship to Patient_____

Printed Name_____ Date_____