PARRISH | CHILDS
Grady Parrish, DDS | Chris Childs, DMD

Please Complete and Return to the Business Office

Personal Information

Name: Last First Middle

Address: Street or P.O. Box # City State Zip code

Phone Number:
Home:
Work:

Pager#: Cell Phone: Email Address:

Age: Yrs. Birth Date: Mo. Day Year Birthplace:

( )Married
( )Unmarried
( )Separated

Social Security No: (if child, parents) Driver's License No:

Occupation: Employer: How long employed? Address & Phone No:

Person responsible for bill: Age: Address: Relationship: Social Security No:

Driver's License No:

Occupation: Employer: How long Employed?

Employer Address & Phone No:

Insurance Information

Insured Person's Full Name Date of Birth

Social Security Number Relationship to Patient Work Phone

Insurance Company Name Group or Union Name Group or Local Numbers

Employer's Name Full Address of Employer

Getting to Know You

1. Why did you select our practice? _____
2. Whom may we thank for referring you? _____
3. Is another member of your family or relative a patient in our practice? _____
4. Person to contact for emergency: _____
   Phone: _____
5. When was your last dental visit? _____
6. When was the last time you had complete dental radiographs taken? _____
   Name and Address of last Dentist: _____
7. Have you ever had any teeth removed? _____
   How long have these teeth been missing? _____
   Have these teeth been replaced? _____
   How? ❒Bridge ❒Partial ❒Denture ❒Implants

Payment Alternatives

Please check appropriate box:

❒ 1. As a special service to you, we offer a cash courtesy if you pay for your entire treatment plan in full, in advance.

❒ 2. Cash and personal checks are accepted as your treatments are provided.

❒ 3. If you have dental insurance, we want you to receive the full benefit of it. Our office team can assist you in completing your insurance forms and verifying the coverage that your particular program provides. We accept assignment of your insurance payment, another service to you. This means that you are responsible for your deductible and the portion the insurance does not cover. Remember, however that you are responsible for the account if the insurance company, for any reason, does not honor their commitment to you and to us.

❒ 4. MasterCard, Visa and Discover

❒ 5. For long term or extended payments, we offer a healthcare financing program, which once you are extended a line of credit will allow small monthly payments for the treatment received.

FOR ALL PATIENTS

I hereby authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with the dental care of the patient above and further authorize and consent that the doctor chooses and employs such assistance as he or she deems fit. I also understand that previous to treatment, full explanation of the procedure(s) involved will be given by the doctor and/or team. I agree to pay for all services rendered by this office.

Signature of Responsible Party Relationship Date

MEDICAL HISTORY

1. How do you feel about getting and maintaining a healthy mouth?_____
2. How do you feel about the appearance of your teeth?_____
3. If you could change anything about your smile, what would you change?_____
4. Are you having dental problems at this time?……❒Yes ❒No
5. Do your gums bleed at any time?……❒Yes ❒No
6. Do you feel very nervous about having dental treatment?……❒Yes ❒No
7. Have you ever had a bad experience in the dental office?……❒Yes ❒No
8. Have you been under the care of a medical doctor during the past two years?……❒Yes ❒No
   If yes: for what reason?_____
   Please provide the name, address, and telephone number of your physician.
9. Have you been a patient in the hospital during the past two years?……❒Yes ❒No
   If yes: for what reason?_____
10. Have you taken any medicine or drugs during the past two years? If yes, please list:……❒Yes ❒No
11. Are you allergic to (i.e., itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, latex, aspirin, codeine, or any other drugs or medicines? If yes, please list:……❒Yes ❒No
12. Have you ever had excessive bleeding requiring special treatment?……❒Yes ❒No
13. Do you use any tobacco products?……❒Yes ❒No
14. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired?……❒Yes ❒No
15. Do your ankles swell during the day?……❒Yes ❒No
16. Have you lost or gained more than 10 pounds in the last year?……❒Yes ❒No
17. Do you use more than 2 pillows to sleep?……❒Yes ❒No
18. Do you ever wake up from sleep short of breath?……❒Yes ❒No
19. Are you on a special diet?……❒Yes ❒No
20. Check any of the following which apply in either past or present:

❒Heart Valve Prolapse
❒ Heart Failure
❒ Heart Disease or Attack
❒ Family History of Cardiovascular Disease
❒ Angina Pectoris (chest pain)
❒ Rheumatic Fever
❒ Congenital Heart Lesions
❒ Scarlet Fever
❒ Artificial Heart Valve
❒ Heart Pacemaker
❒ Heart Surgery
❒ Artificial Joint of Any Type
❒ Diet Medication: Name_____
❒ Heart Murmur
❒ Bruise Easily
❒ Blood Transfusion
❒ Hemophilia
❒ Sickle Cell Disease

❒ High Blood Pressure
❒ Anemia
❒ Asthma
❒ Emphysema
❒ Shortness of Breath
❒ Hay Fever
❒ Allergies or Hives
❒ Fainting or Dizzy Spells
❒ Epilepsy or Seizures
❒ Nervousness
❒ Psychiatric Treatment
❒ Any Form of Eating Disorder
❒ Recreational Drug Use
❒ Drug Addiction/Alcoholism
❒ Tuberculosis (TB)
❒ Any Form of Hepatitis
❒ Liver Disease
❒ Rheumatism

❒ Cortisone Medication
❒ Arthritis
❒ Pain in Jaw Joints
❒ X-Ray or Cobalt Treatment
❒ Cancer or Tumors
❒ Chemotherapy (Cancer, Leukemia)
❒ Thyroid Disease
❒ Glaucoma
❒ HIV Positive (AIDS)
❒ Venereal Disease
❒ Cold Sores or Fever Blisters
❒ Genital Herpes
❒ Kidney Trouble
❒ Diabetes
❒ Ulcers
❒ Stroke
❒ Birth Control Medication
❒ Pregnant – Due Date_____

21. Do you have any disease, condition or problem not listed? If so, please list……❒Yes ❒No

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1283 Sims Street
Gainesville, GA 30501
(770) 536-0581
www.ParrishChildsDental.com

Consent for Use and Disclosure of Health Information

Section A: Patient Giving Consent

Name: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Patient #: _____ Social Security #: _____

Section B: To the Patient – 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 our 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:

Contact Person: _____

Telephone: _____ Fax: _____

Email: _____

Address: _____

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 look 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 health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLEDTO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

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Acknowledgement of Receipt of Notice of Privacy Practices

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

_____
Name (Please Print)

_____
Signature

_____
Date

FOR OFFICE USE ONLY

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
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

_____