Dental Care of Flowery Branch
5900 Spout Springs Rd, U21
Flowery Branch, GA 30542
(P)770-967-1850 (F) 770-967-1858
flowerybranchdental@gmail.com

PATIENT REGISTRATION AND HEALTH HISTORY

PLEASE COMPLETE ALL FORMS OF THE FOLLOWING CONFIDENTIAL INFORMATION

OUR OFFICE IS COMMITTED TO MEETING OR EXCEEDING THE STANDARDS OF INFECTION CONTROL MANDATED BY OSHA, THE CDC, AND THE ADA.

TODAY'S DATE: ____________________.

NAME: ______________________ NAME I LIKE TO BE CALLED: ______________

MAILING ADDRESS: ______________________ CITY: ______________ ZIP: ________

STREET ADDRESS: ______________________ CITY: ______________ ZIP: ________

BIRTHDAY: __________ MARITAL STATUS: __________ SS#: ____________ EMAIL: ______________

HOME #: (____)____________ WORK#:(____)______________ EXT:____ CELL#: (____)__________

OCCUPATION: ______________________ EMPLOYER: ______________________

SPOUSE'S OR PARENT'S NAME: ________________ BIRTHDAY: ____________ SS#: __________

SPOUSE'S/PARENT'S OCCUPATION: ______________ SPOUSE'S/PARENT'S EMPLOYER: ______________

BEST CONTACT PHONE #: ______________________

PERSON RESPONSIBLE FOR ACCOUNT

□ CHECK IF SAME AS ABOVE; PROCEED TO NEXT SECTION

NAME: ______________________________ SS#: ______________________

ADDRESS: ______________________ CITY: ________________ ZIP: __________

RELATIONSHIP TO PATIENT: ______________________ BIRTHDATE: ______________

EMPLOYER: ______________________________ WORK #: (____)______________

DENTAL INSURANCE

EMPLOYEE NAME: ________________ MEM ID#: ______________ BIRTHDATE: ____________

INSURANCE COMPANY: ____________________ INSURANCE: (____)______________

EMPLOYER: ______________________________ GROUP#: ______________________

GETTING TO KNOW YOU

PLEASE LIST THE MEMBERS OF YOUR FAMILY THAT ARE PATIENTS IN OUR OFFICE: ______________

____

HOW DID YOU HEAR ABOUT OUR OFFICE? □YELLOW PAGES □WEBSITE □FRIEND: ______________

□NEWSPAPER □SIGN □TV □BILLBOARD □MAILER □MAGAZINE □FACEBOOK □GOOGLE

OTHER: ____

PERSON TO CONTACT IN CASE OF EMERGENCY (NOT LIVING WITH YOU):

NAME: ______________________________ PHONE: (_____)______________

ADDRESS: ______________________ CITY: ______________ STATE: ________ ZIP: __________

HEALTH HISTORY - ANSWER ALL QUESTIONS

NAME: ______________________

Are you currently under the care of a physician?- Y N

Physician's Name:______________________Phone:______________________

Are you taking ANY prescriptions or over-the-counter medications? **(IF YES, PLEASE LIST ALL MEDICATIONS)** Y N

List:______________________

Are you allergic to any medications or substances (including latex)?- Y N

If yes, explain: ______________________

Is there any history of alcohol or chemical dependency that may affect the care we provide for you? - - - - - - - - - - - Y N

If yes, explain: ______________________

Are you taking or have you ever taken Bisphosphonates for osteoporosis or any other medical conditions?- - - - - - - - Y N

If yes, circle all that apply: Fosamax Actonel Boniva Skelid Didronel Aredia Zometa

Have you ever been or are you currently being treated for a mental illness?- Y N

If yes, explain: ______________________

HEART DISEASE - - - - - - - - - - - - - - - - - - Y N If yes, explain: ______________________

LUNG DISEASE- - - - - - - - - - - - - - - - - - - Y N If yes, explain: ______________________

BLEEDING OR BLOOD DISORDER- - - - - - - - - Y N If yes, explain: ______________________

DIABETES- Y N If yes: Type I Type II Last HBA1C :______________________

LIVER DISEASE- - - - - - - - - - - - - - - - - - - Y N If yes, explain: ______________________

ARTIFICIAL JOINT/IMPLANT - - - - - - - - - - - Y N If yes, explain: ______________________

SMOKE/VAPE/CHEW TOBACCO- - - - - - - - - - Y N If yes, how much per day ______________________

RECREATIONAL DRUGS- - - - - - - - - - - - - - Y N If yes, explain: ______________________

SEIZURES/EPILEPSY- - - - - - - - - - - - - - - - Y N

HIGH BLOOD PRESSURE - - - - - - - - - - - - - Y N RADIATION OR CHEMOTHERAPY- - - - - - - - - - - - - - - - - Y N

SINUS OR NASAL PROBLEM - - - - - - - - - - - Y N HIV POSITIVE- Y N

KIDNEY DISEASE - - - - - - - - - - - - - - - - - - Y N STOMACH ULCERS OR COLITIS- - - - - - - - - - - - - - - - - - Y N

GLAUCOMA - Y N ARTHRITIS- Y N

SLEEP APNEA - Y N THYROID DISEASE - Y N

Do you have any other disease, condition, or problem not listed that you think the doctor should know about?- - - - - - - - Y N

If yes, explain: ______________________

FOR WOMEN ONLY

Are you on any form of birth control?- - - - - - - - Y N Are you pregnant or nursing?- Y N

DENTAL HISTORY

Are you having pain or discomfort at this time?- - - - - - - - Y N Explain: ______________________

Have you ever had a bad dental experience?- - - - - - - - Y N Explain: ______________________

Are you happy with the appearance of your smile?- - - - - Y N Explain: ______________________

Is there anything else about going to the dentist that bothers you ? ______________________

Please rate your level of dental anxiety: HIGH AVERAGE LOW NONE

I affirm that the above information is correct to the best of my knowledge. If I have any changes in my health history, or if my medicines change, I will inform my dentist at the next appointment without fail. I authorize the doctor/assistant to take x-rays, study models, photographs, or any other diagnostic aid deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the doctor to perform all recommended treatment, appropriate medications, and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that the doctor choose to employ assistance as deemed fit to provide recommended treatment.

Patient (or Guardian) Signature: ______________________ **Date:** ______________________

FINANCIAL AGREEMENT

Dr. Jason Lue Yen's goal is to help you establish excellent oral health. He is committed to helping you determine the most appropriate treatment for your dental needs and desires. Should you have questions concerning your treatment, treatment sequence or fees for services, please ask for clarification before treatment begins.

Our financial policy is as follows:

1. **We accept cash and most major credit cards (MasterCard, Visa and Discover)**
2. **Payment is due at the time of service.**
3. **Payment plans for certain procedures are available through Care Credit with payment options available for up to 6 months with no interest**
4. **At first office visits that are Emergency Visits, we will collect $99 regardless of insurance benefits, unless prior arrangements have been approved.**
5. **Extended treatment plans will be outlined so that appropriate payments may be made as each phase of treatment progresses.**
6. **You agree that we may contact you by telephone at any telephone number associated with your account. This includes wireless telephone numbers, which could result in charges to you.**

Please remember that you are responsible for timely payment of your account. Should it become necessary to refer your account to an agency or attorney for collection, you will also be responsible for all costs associated with the collection, including attorney's fees and court costs.

By signing below, you agree to the terms listed above.

Patient Signature: ______________________________ Date: ________________

DENTAL CARE
OF FLOWERY BRANCH

Missed Appointment Policy

At Dental Care of Flowery Branch, your time is valued. Our doctors, hygienists and staff strive to see patients in a timely manner. We respect your time and ask you to respect our time and other patients' needs by keeping your appointment. Each appointment time slot is important and cannot be recovered if a patient chooses not to keep their appointment. When appropriate, we collect missed appointment fees to ensure that our doctors can continue to see patients. Please keep in mind that each skipped/ missed appointment is not just time lost, but also time when other patients cannot be seen.

- ***It is your responsibility to provide us with a working telephone number and/or email address to allow us to communicate important information and provide reminders of scheduled appointments. Having a valid telephone number and/or email address is truly important- please help us to maintain your records.***
- ***Each missed appointment will be flagged and you will receive a notice by phone, email or text that you have missed your appointment.***
- ***Accounts that accumulate 3 missed appointments may be dismissed from the practice.***
- ***A $50 missed appointment fee may be charged at the office's discretion. Please note that the fee will not be billed to your insurance.***
- ***Any cancellation not made at least 1 business day (Monday's appointments must be cancelled before the end of the day on the Friday prior to your appointment) before the scheduled appointment is considered a missed appointment and subject to the terms above.***
- ***If you arrive late and the time remaining in your appointment does not allow us to complete your scheduled treatment, this will be considered a missed appointment. Please remember that communication with our office is critical to providing you with quality dental care.***
- ***We understand that circumstances occur that do not allow you to keep your scheduled appointment. If this is the case, please call and discuss this with the office staff as soon as possible. We will waive the cancellation fee for this appointment as long as you do not have a history of cancellations. Our schedule fills up quickly, and this will allow other patients to fill those openings.***
- ***We make every effort to make certain that you are able to be seen promptly at your appointment time. However, due to patient emergencies or other unexpected incidents, our schedule may occasionally fall behind. If this is the case, we will let you know the status of our schedule as soon as possible, as we value your time.***

By signing below, you agree to the terms listed above.

Patient Signature: ______________________________ Date: ________________

DENTAL

5900 Spout Springs Rd. Flowery Branch, GA
770-967-1850

With whom may we discuss your dental care?

We can not discuss any aspect of your care or treatment with anyone other than you unless their name has been listed below. Please indicate any family members, relatives and/ or friends with whom we can discuss your care.

No One But Myself (check here): ________

Name: __________________________ Relation: __________________ Phone #: _______________

Name: __________________________ Relation: __________________ Phone #: _______________

Name: __________________________ Relation: __________________ Phone #: _______________

How may we contact you regarding your insurance, payments, treatment, account balances and other account- related inquiries (write Y or N)?

Cell Phone: ___________ May we leave a message? _______

Work Phone: ___________ May we leave a message? _______

Home Phone: ___________ May we leave a message? _______

Email: ___________

US Mail: _____________

DENTAL

5900 Spout Springs Rd.

Flowery Branch, GA 770-967-1850

Notice of Privacy Practices

I, ____, have had the time to read and review a copy of this office's Notice of Privacy Practices. I have been provided a copy when requested.

Signature: ____ Date: ________________

For Office Use Only

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

_____ The Individual Refused to Sign

_____ Communication Barriers Prohibited Obtaining Acknowledgement

_____ An Emergency Situation Prevented Obtaining Acknowledgement