BRUCE EDELSTEIN DDS, PC

WELCOME TO OUR OFFICE

ABOUT YOU

Today's Date:__________________

Name: ______________________________

I prefer to be called:______________________________

Home Address: ______________________________

____

Home Phone: (____)______________________________

Work Phone: (____)________________________Ext:___________

Email Address: ______________________________

Social Security Number: ______________________________

Birthdate: ______________________________

Single Married Divorced Widowed Separated

Male Female

Whom may we thank for referring you? ______________________________

Previous/Present Dentist: ______________________________

Last Visit Date: ______________________________

Other family members seen by us: ______________________________

Employer: ______________________________

Occupation: ______________________________

Employer's Address: ______________________________

____

SPOUSE OR SIGNIFICANT OTHER INFORMATION (if applicable)

Spouse's name: ______________________________

Spouse's Employer: ______________________________

Work Phone: (____)________________________Ext:___________

Spouse's Social Security Number: ______________________________

Spouse's Birthdate: ______________________________

ACCOUNT INFORMATION

Person Responsible for Account: ______________________________

Relation: _________________S.S.# ______________________________

Home Phone: (____)______________________________

Work Phone: (____)________________________Ext:___________

Billing Address: ______________________________

____

Employer: ______________________________

Fill in below if you need our assistance in maximizing your insurance benefits.

PRIMARY DENTAL INSURANCE (if applicable)

Insurance Company Name: ______________________________

Phone Number: (____)______________________________

Insurance Co. Address: ______________________________

____

Group Number: ______________________________

Insured's Name: ______________________________

Relation: ______________________________

Insured's Birthdate: ______________________________

Insured's Insurance ID Number:______________________________

Insured's Social Security Number: ______________________________

Insured's Employer: ______________________________

SECONDARY DENTAL INSURANCE (if applicable)

Insurance Company Name: ______________________________

Phone Number:______________________________

Insurance Co. Address______________________________

Group Number: ______________________________

Insured's Name: ______________________________

Relation: ______________________________

Insured's Birthdate: ______________________________

Insured's Social Security Number: ______________________________

Insured's Employer: ______________________________

MEDICAL INSURANCE (if applicable)

Insurance Company Name: ______________________________

Phone Number:______________________________

Insurance Co. Address______________________________

Group Number: ______________________________

Insured's Name: ______________________________

Relation: ______________________________

Insured's Birthdate: ______________________________

Insured's Social Security Number: ______________________________

Insured's Employer: ______________________________

MEDICAL HISTORY

Your current physical health is: ☐Good ☐Fair ☐Poor

Are you currently under the care of a physician? ☐Yes ☐No

Please explain: ______________________________

Are you taking any prescription/over the counter drugs? Please list each one: ______________________________

____

____

Do you have a personal physician? ☐Yes ☐No

Physician's Name:______________________

Phone Number: ______________Date of last visit: __________

HAVE YOU EVER HAD ANY OF THE FOLLOWING: (circle)

Y	N	Asthma/Arthritis	Y	N	Kidney Problems
Y	N	Anemia/Radiation	Y	N	High/Low Blood Pressure
Y	N	Blood Transfusion	Y	N	Psychiatric Problems
Y	N	Cancer/Chemotherapy	Y	N	Severe/Frequent Headaches
Y	N	Congenital Heart Defect	Y	N	Shingles
Y	N	Diabetes	Y	N	Sinus Problems
Y	N	Difficulty Breathing	Y	N	Stroke
Y	N	Drug/Alcohol Abuse	Y	N	Tuberculosis (TB)
Y	N	Emphysema	Y	N	Venereal Disease
Y	N	Epilepsy/Seizure	Y	N	Artificial Bone/Joints
Y	N	Fever Blisters/Herpes	Y	N	Artificial Valves
Y	N	Glaucoma	Y	N	Heart Attack
Y	N	Hemophilia/Abnormal bleeding	Y	N	Heart Murmur
Y	N	Hepatitis	Y	N	Heart surgery/pacemaker
Y	N	HIV+/AIDS	Y	N	Mitral Valve Prolapse
Y	N	Hospitalized for any Reason	Y	N	Rheumatic/Scarlet Fever

Please list any other medical condition(s) that you have had: ____________

____

____

Are you allergic to any of the following?

☐Aspirin ☐Latex

☐Codeine ☐Penicillin

☐Dental Anesthetics ☐Tetracycline

☐Erythromycin ☐Other__________________

FOR WOMEN:

Are you taking birth control pills? ☐Yes ☐No

Type of birth control:______________________________

Are you pregnant? ☐Yes ☐No

Week #:____________________

Are you nursing? ☐Yes ☐No

DENTAL HISTORY

Why have you come to the dentist today?

____

Are you currently in pain? ☐Yes ☐No

Have you ever had any serious/difficult problems associated with any previous dental work? ☐Yes ☐No

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? ☐Yes ☐No

Your current dental health is: ☐Yes ☐No

Do you like to smile? ☐Yes ☐No

Do your gums ever bleed? ☐Yes ☐No

How many times a week do you floss? __________

How many times a day do you brush? __________

Have you had previous periodontal treatment? ☐Yes ☐No

If so, when and what? ______________________________

IN THE EVENT OF AN EMERGENCY, WHO MAY WE CONTACT?

Name:____________________ Relation:________________

Work#: ________________Home #: ________________

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

____

Signature (If patient is under 18, parent or guardian) Date

Payment is due in full at the time of treatment unless prior arrangements have been approved.

– OFFICE USE ONLY –

I have verbally reviewed the medical/dental information above with the patient named herein.

Signature:______________________________Date__________

Comments:______________________________

Signature:______________________________Date__________

Comments:______________________________

Signature:______________________________Date__________

Comments:______________________________

Signature:______________________________Date__________

Comments:______________________________

Signature:______________________________Date__________

Comments:______________________________

Bruce A. Edelstein, DDS, PC

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

See Chart

Name: ______________________________

Address: ______________________________

Telephone: _______________ E-mail: _______________

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: Dr. Bruce A. Edelstein, DDS, PC

Telephone: 404-352-1911 Fax: 404-352-3661

E-mail: drbruce@baegumdoc.com

Address: 2045 Peachtree Road, NE Suite 416, Atlanta, GA 30309

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 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 ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Include completed Consent in the patient's chart.