sweet city smiles

RUBY TRUONG, DMD
JONATHAN CHANG, DMD

WWW.SWEETCITYSMILES.COM
Tel: (470) 655-6888

5019 W. BROAD ST. SUITE M213
SUGAR HILL, GA 30518

PATIENT INFORMATION

Patient: _____
LAST FIRST MI PREFERRED TITLE

☐MALE ☐FEMALE ☐CHILD* ☐STUDENT** ☐SINGLE ☐MARRIED ☐DIVORCED ☐WIDOWED

*IF CHILD, PROVIDE PARENT/GUARDIAN NAME(S):

Patient Date of Birth: _____ Patient SSN: _____

Address: _____
ADDRESS LINE 1

_____ HOME: _____
ADDRESS LINE 2 CELL: _____

_____
CITY ST ZIP CODE

E-Mail: _____

How did you hear about us? _____

EMERGENCY INFORMATION

In case of emergency, please provide information for the designated contact person:

_____ Tel: _____
NAME RELATIONSHIP

EMPLOYMENT INFORMATION

Employer: _____ Occupation: _____

DENTAL HISTORY

Reason for today's visit:

Date of last dental visit:
Date of last dental x-rays:

PLEASE CHECK IF YOU HAVE/HAD: ☐ NONE

☐INJURIES TO MOUTH/TEETH/HEAD ☐CLENCH OR GRIND TEETH ☐PAIN BITING OR CHEWING
☐BLISTERS ON LIPS OR MOUTH ☐GROWTHS OR SORE SPOTS IN MOUTH ☐ORTHODONTIC TREATMENT
☐BURNING SENSATION ON TONGUE ☐SWOLLEN, TENDER, OR BLEEDING GUMS ☐NITROUS OXIDE

☐ DOES ANY TYPE OF DENTAL TREATMENT MAKE YOU NERVOUS? IF YES, PLEASE EXPLAIN BELOW:

CHILD/MINOR PATIENTS: PLEASE ANSWER THE FOLLOWING QUESTIONS:

☐ ANY MOUTH HABITS? (THUMB SUCKING, NAIL BITING, MOUTH BREATHING, NURSING/BOTTLE HABITS, PACIFIER, ETC.)

_____

☐ ANY UNUSUAL SPEECH HABITS? IF YES, PLEASE EXPLAIN:

_____

☐ DOES THE PATIENT RECEIVE ASSISTANCE WITH BRUSHING AND FLOSSING? HOW OFTEN?

By signing below, I certify that the information above is accurate and complete to the best of my knowledge. I consent to receiving HIPAA-compliant electronic communications, such as email or text messages regarding treatment, payment, and healthcare operations. I understand that there is no obligation to receive these electronic communications. Message/data rates may apply, and I may opt-out of receiving electronic communications at any time through a written request.

Signature:_____ **Date:**_____

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MEDICAL HISTORY

GENERAL HEALTH: ☐EXCELLENT ☐GOOD ☐FAIR ☐POOR

☐Y☐N Under a physician's care now?
☐Y☐N Any hospitalization in the past 5 years?
☐Y☐N Any serious illnesses/surgeries?
☐Y☐N Use tobacco in any form? If Yes, Type:
☐Y☐N Is pre-medication required before dental visits due to heart condition or artificial joint?
☐Y☐N Taking any prescription or daily OTC medications/drugs? *If yes, list details in the Medication Section.*

FEMALE PATIENTS: ☐Y☐N Currently nursing? ☐Y☐N Currently pregnant? Due Date:

Do you know of any reason why routine dental procedures might pose a risk to you, our staff, or other patients? ☐Y☐N
If yes, please describe:

Is there anything important about your medical condition we have not asked? ☐Y☐N If yes, please describe:

ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐NONE

☐ACID REFLUX	☐BULIMIA	☐HEARING PROBLEMS	☐PSYCHIATRIC TREATMENT
☐ADHD	☐CANCER/MALIGNANCY	☐HEART ATTACK	☐RADIATION/CHEMO
☐AIDS/HIV	☐CEREBRAL PALSY	☐HEART DISEASE	☐RESPIRATORY DISEASE
☐ANEMIA	☐CHEMICAL DEPENDENCY	☐HEART MURMUR	☐RHEUMATIC FEVER
☐ANOREXIA	☐CHICKEN POX	☐HEPATITIS	☐SINUS PROBLEMS
☐ANXIETY	☐CONVULSIONS	☐HIGH BLOOD PRESSURE	☐STROKE
☐ARTIFICIAL HEART VALVE	☐DEPRESSION	☐KIDNEY DISEASE	☐THYROID CONDITION
☐ARTIFICIAL JOINTS	☐DIABETES	☐LIVER PROBLEMS	☐TUBERCULOSIS
☐ARTHRITIS	☐DIZZINESS/FAINTING	☐MITRAL VALVE PROLAPSE	☐ULCERS
☐ASTHMA	☐EPILEPSY/SEIZURES	☐MONONUCLEOSIS	☐VENEREAL DISEASE
☐AUTISM/ASPERGER'S	☐FREQUENT EAR INFECTIONS	☐PACEMAKER	
☐BLEEDING DISORDER	☐ FREQUENT HEADACHES	☐OTHER – PLEASE LIST:	

ALL PATIENTS: ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD ANY REACTION TO THE FOLLOWING? (CHECK ALL THAT APPLY):

☐ASPIRIN	☐CODEINE	☐LACTOSE INTOLERANCE	☐SLEEPING PILLS	☐NONE
☐ANESTHETIC – LOCAL	☐DAIRY	☐METAL SENSITIVITY	☐SULFA DRUGS	
☐BARBITURATES	☐LATEX	☐NITROUS OXIDE SEDATION	☐PENICILLIN/OTHER ANTIBIOTICS	
☐OTHER – PLEASE LIST:				

MEDICATION INFORMATION

ALL PATIENTS: ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐NONE

☐ANTIBIOTICS/SULFA DRUGS	☐ANTIHISTAMINES/ALLERGY	☐DAILY ASPIRIN	☐BLOOD PRESSURE MEDICATIONS
☐BLOOD THINNERS	☐CANCER/CHEMO MEDICATIONS	☐CORTISONE/STEROIDS	☐HEART MEDICATION/DIGITALIS
☐INSULIN	☐NITROGLYCERIN	☐ORAL CONTRACEPTIVES	☐OSTEOPOROSIS MEDICATIONS
☐OTHER DIABETIC MEDICATIONS	☐RECREATIONAL DRUGS	☐THYROID MEDICATIONS	☐TRANQUILIZERS
☐OTHER (PLEASE LIST BELOW)			

DRUG NAME	DOSAGE	REASON PRESCRIBED

By signing below, I certify that the information above is accurate and complete to the best of my knowledge.

Signature:_____ **Date:** _____

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Financial Guidelines

We are committed to providing you with the best care possible to achieve total oral health. In order to achieve these goals, we need your assistance and your understanding of our financial guidelines.

Insurance

- **Sweet City Smiles provides insurance company billing as a courtesy to our patients.** The patient portion of particular dental services is estimated and due at the time of service. This amount may be subject to adjustment when the dental service claims are adjudicated by the insurance company. In addition, certain insurance companies have annual limitations for the amount of dental services that can be reimbursed within each plan year. If you or your family exceed these annual limitations in any plan year, you will be responsible for the full amount of dental services that exceed the particular plan's limitations. The patient is responsible for monitoring the amount of his/her remaining benefits for any annual benefit period. The patient may not rely upon any information provided by Sweet City Smiles staff regarding his/her remaining benefit in any such benefit period.
- **The claims we submit to insurance companies indicate that you have assigned those benefits to Sweet City Smiles.** However, if the insurance company sends payment to you directly instead of to Sweet City Smiles, you then become responsible for the total account balance and payment would be expected immediately.
- **You as a patient are always responsible for any charges that are not covered by your insurance.**

Payments

- **Patient portion or patient co-pay is due at the time services are rendered** – unless prior financial arrangements have been made.
    - All major credit cards are accepted (Visa, MasterCard, Discover)
    - Various financing options with CareCredit®
    - Checks (please note that a $50 charge will be applied in the event of a returned check payment)
- **Balances left over 60 days will incur $30 billing fee.** Failure to pay overdue amounts may result in your account being placed with a collection agency. In the event that your account is further referred to an attorney, all collection and attorney fees are your responsibility.
- **Minors must be accompanied by a parent or legal guardian**. If the parents are separated or divorced, the person accompanying the minor will be responsible for copayment at the time of service.

Short Cancelled/ Missed Appointments

- **Please give 48 hours notice** if you are unable to keep your reserved time. Unless an emergency occurs, we expect to run on time for your appointments as we do not double book, and we appreciate the same courtesy from you.
- **For appointments scheduled for 1 hour or longer**, you will be required to make a reservation deposit of 20% the estimated appointment copayment or fee, which will be applied to your out of pocket expense for the appointment. This reservation deposit is non-refundable, and will be forfeited if you do not show up or give 48 hours' notice to cancel or reschedule.
- **In absence of a reservation deposit being charged,** a $50 cancellation fee may apply if you do not provide 48 hours' notice of cancellation or rescheduling.

By signing below I acknowledge I have read, understand, and agree to the guidelines above.

Signature: _____ Date: _____

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SECTION A: 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 the 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 singing 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 visiting:

https://www.hhs.gov/hipaa/for-profesionals/index.html

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.

SECTION B: SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and the 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 healthcare operations.

Signature:_____ Date: _____

If this Consent is signed by a personal representative (parent/guardian) on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

SECTION C: PATIENT/RELATIVE HIPAA CONSENT

I, _____, understand that by signing this Consent form, I am giving my consent to Sweet City Smiles to disclose and discuss my protected health information to carry out treatment, payment activities, and healthcare operations with the following designated contact person:

Designated Contact and Relationship to Patient: _____

Designated Contact's Phone Number: _____

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation.

Signature:_____ Date: _____

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Assumption of the Risk and Waiver of Liability Relating to Coronavirus/COVID-19

The novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. COVID-19 is extremely contagious and is believed to spread mainly from person-to-person contact and aerosol droplets. As a result, federal, state, and local governments and federal and state health agencies recommend social distancing and wearing masks in public.

We here at Sweet City Smiles have put in place preventative measures to reduce the spread of COVID-19; however, Sweet City Smiles or its team members cannot guarantee that you or your child(ren) will not become infected with COVID-19. Further, attending here or wearing a mask provided or purchased by Sweet City Smiles could increase your risk and your child(ren)'s risk of contracting COVID-19.

By signing this agreement, I acknowledge the contagious nature of COVID-19 and voluntarily assume the risk that my child(ren) and I may be exposed to or infected by COVID-19 by attending here and/or wearing a mask provided or purchased by Sweet City Smiles and that such exposure or infection may result in personal injury, illness, permanent disability, and death. I understand that the risk of becoming exposed to or infected by COVID-19 may result from the actions, omissions, or negligence of myself and others, including, but not limited to, Sweet City Smiles employees, volunteers, and family members. I voluntarily agree to assume all of the foregoing risks and accept sole responsibility for any injury to my child(ren) or myself (including, but not limited to, personal injury, disability, and death), illness, damage, loss, claim, liability, or expense, of any kind, that I or my child(ren) may experience or incur in connection with my child(ren)'s attendance at Sweet City Smiles or participation in dental procedures ("Claims").

On my behalf, and on behalf of my children, I hereby release, covenant not to sue, discharge, and hold harmless Sweet City Smiles, its employees, agents, and representatives, of and from the Claims, including all liabilities, claims, actions, damages, costs or expenses of any kind arising out of or relating thereto. I understand and agree that this release includes any Claims based on the actions, omissions, or negligence of Sweet City Smiles, its employees, agents, and representatives, whether a COVID-19 infection occurs before, during, or after participation in any Sweet City Smiles meeting or procedures.

_____ _____

Signature of patient, parent, or guardian | Date

_____ _____

Print name | Print name of parent or guardian