

JENNIFER SHERWOOD BRAGG, D.M.D., P.C.

KARA KEEL MOODY, D.M.D.

PATIENT INFORMATION

Name: _____ Name preferred: _____

Social Security # _____ - _____ - _____ Birth Date: ____/____/____

Address: _____

City/State/Zip : _____

Gender: () Male () Female Marital Status: () Single () Married () Divorced () Widowed

Name of Spouse: _____

Your Occupation: _____ Your Employer: _____

How did you hear about our office? Internet____ Magazine____ Phone book____ Radio____ Location____

Friend/Family/Patient _____ (If so, who?) Other: _____

DENTAL INSURANCE

Policy Holder: _____ Relationship to patient: _____

Policy Holder Birth Date: ____/____/____ Policy Holder Social Sec. # _____ - _____ - _____

Insurance Company/Address: _____

Ins. Co. Phone # _____ Plan Group # _____

Employer: _____ Occupation: _____

HOW CAN WE CONTACT YOU?

Home Phone: _____ Work Phone: _____ Ext: _____

Cell Phone: _____ Email Address: _____

Which is the best way to contact you regarding appointments? ()Home ()Work ()Cell ()Email

IN CASE OF EMERGENCY, YOUR NEAREST RELATIVE (OTHER THAN SPOUSE OR FRIEND)

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

Signature of Patient or Parent

Date

Doctor Signature

Date

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ Email: _____

Patient Number: _____ Social Security Number: _____

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 health care 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: Karen Dinsmore
Telephone: (770) 889-8420 Fax: (770) 781-5703
Email: braggdental@comcast.net
Address: 655 Atlanta Road, Suite 701, Cumming, GA 30040

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 take 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.

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. I understand that revocation of my Consent will not affect any action you took 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.

Signature: _____ Date: _____

JENNIFER SHERWOOD BRAGG, D.M.D., P.C.

KARA KEEL MOODY, D.M.D.

Insurance Waiver

In order to accommodate the needs and requests of our patients, we will file your insurance and only require that you pay your share at the time services are rendered. While we are pleased to be able to provide this service for you, it is extremely difficult for us to keep track of all the individual requirements of every insurance company. Each company has different stipulations regarding how often and which services may be performed. In addition, some of these plans require a doctor to "participate" in their plan by signing a contract.

It is your responsibility to inform us of any special requirements within your insurance contract regarding procedures. Make sure that Dr. Bragg is a participating provider with your plan. Any questions that you have regarding what is a covered procedure or the percent your plan pays needs to be addressed by your insurance company. In the event that a non-covered service is performed, insurance coverage is not in effect because we are not a participating office, or insurance coverage is not effective on the date of service, we will have no choice but **TO BILL YOU DIRECTLY FOR ALL CHARGES RELATED TO YOUR DENTAL VISIT.**

Initials _____

Cancellation Policy

Our practice is dedicated to quality care and exceptional service. We respect the importance of your time and work very hard to schedule appointments that accommodate the busy scheduling needs of all our patients. In return, we ask that patients make every effort not to change reserved dental appointments. Broken and missed appointments create scheduling problems for other patients as well as the practice. If you find that you must change your appointment, we **REQUIRE a minimum of 48 hours' notice** so that we may accommodate another patient. A charge of \$75.00 will be applied for any broken or cancelled appointments without advanced notification. Thank you for your cooperation in this matter. Initials _____

I the undersigned patient (or legally responsible party) authorize treatment to be rendered and assure financial responsibility. I understand that I am responsible for the remaining balance after insurance has been filed and payment has been received. I acknowledge that all non current balances on accounts over 60 days will be charged a service fee of 1.5% per month (18% annually) on the unpaid balance. At this time any professional courtesy and/or budget account balances will be added back to the account. Any additional costs incurred in collecting this account including court costs, agency fees and attorney fees will be added to your balance due.

Signature of person responsible for the account _____

Printed name _____ Date _____

HEALTH HISTORY

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs.

NAME _____ BIRTHDATE _____ AGE _____

Why are you seeking dental treatment? _____

Please answer each question. Circle yes or no. If in doubt, leave blank.

1. Are you in good health now? _____ Yes No
2. Are you now under the care of a physician? _____ Yes No
If so, what condition is being treated _____
3. Have you ever been hospitalized or had a serious illness? _____ Yes No
4. Do you have a history of chemical dependency, or drug or alcohol abuse? _____ Yes No
5. Have you ever had excessive bleeding following an extraction or do cuts take longer to heal now than previously? Yes No
6. (Women) Are you pregnant? If so, give due date _____ Yes No
7. Do you use tobacco in any form? If yes, how much? _____ Yes No
8. Do you use alcoholic beverages (more than 2 drinks per day)? _____ Yes No
9. Have you ever been told to pre-medicate prior to dental work? _____ Yes No
10. Do you have or have you ever had any of the following?

GENERAL

Tire easily, weakness	Yes	No
Marked weight change	Yes	No
Night sweats	Yes	No
Persistent fever	Yes	No

SKIN

Cosmetic Surgery	Yes	No
Eruptions	Yes	No
Change in skin color	Yes	No
Fever Blisters	Yes	No

EYES

Visual change	Yes	No
Glaucoma	Yes	No

EARS

Loss of hearing	Yes	No
Ringing in ears	Yes	No

NOSE

Frequent nosebleeds	Yes	No
Sinus problems	Yes	No

THROAT

Soreness/hoarseness	Yes	No
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NERVOUS SYSTEM

Stroke	Yes	No
Headache	Yes	No
Convulsions/Epilepsy/Seizures	Yes	No
Numbness/tingling	Yes	No
Dizziness/fainting	Yes	No
Psychiatric treatment	Yes	No

RESPIRATORY

Tuberculosis	Yes	No
Emphysema	Yes	No
Asthma/hay fever	Yes	No
Persistent cough	Yes	No
Difficulty breathing lying down	Yes	No

ENDOCRINE

Diabetes	Yes	No
Family history of diabetes	Yes	No
Thyroid condition/goiter	Yes	No
Other _____		

Autoimmune	Yes	No
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HEART/BLOOD VESSELS

Rheumatic Fever	Yes	No
Mitral Valve Prolapse	Yes	No
Heart Murmur	Yes	No
Chest pain/discomfort/Angina	Yes	No
Heart attack/trouble	Yes	No
Congenital Heart Disease	Yes	No
Shortness of breath	Yes	No
High blood pressure	Yes	No
Artificial heart valve	Yes	No
Pacemaker	Yes	No
Heart Surgery	Yes	No
Premed for dental procedures	Yes	No

BONES/MUSCLES

Osteoporosis	Yes	No
Arthritis/rheumatism	Yes	No
Artificial joints	Yes	No

DIGESTIVE SYSTEM

Hepatitis/Jaundice	Yes	No
Liver disease	Yes	No
Ulcers	Yes	No
Colitis	Yes	No

URINARY

Kidney disease	Yes	No
Increase in frequency of urination (night)	Yes	No
Burning on urination	Yes	No
Urethra discharge	Yes	No
Bloody urine	Yes	No
Venereal disease	Yes	No

BLOOD

Bruise easily	Yes	No
Hemophilia	Yes	No
Anemia	Yes	No
Blood transfusion	Yes	No

OTHER

Radiation therapy	Yes	No
Tumors or growths	Yes	No
Cancer	Yes	No
AIDS/HIV	Yes	No

11. Are you allergic or have you ever experienced any reaction to the following:

Local anesthetics (e.g. Novocaine)	Yes	No	Aspirin or codeine	Yes	No
Barbiturates/sedatives/sleeping pills	Yes	No	Sulfa drugs	Yes	No
Penicillin/other antibiotics	Yes	No	Other allergies _____		

12. Are you taking any of the following?

Antibiotics/sulfa drugs	Yes	No	Tranquilizers	Yes	No
Blood thinners	Yes	No	Insulin/other diabetes drugs	Yes	No
Blood pressure medication	Yes	No	Recreational drugs	Yes	No
Thyroid medication	Yes	No	Digitalis/other heart medications	Yes	No
Cortisone/steroids	Yes	No	Nitroglycerin	Yes	No
Antihistamines/allergy drugs/other cold remedies	Yes	No	Aspirin	Yes	No
Bisphosphonate	Yes	No	Other medication _____		

If yes to any of the above, list the name of the medications and dosage below:

1. _____
2. _____
3. _____
4. _____

13. Is there any disease, condition or problem not listed above that you think we should know about, or is there any activity that your doctor says you cannot do? If so, explain _____

14. Physician's name _____

15. Have you ever had any serious trouble associate with previous dental treatment? Yes No

If so, please explain _____

16. Does dental treatment make you nervous? No Slightly Moderately Extremely

17. Date of last dental visit _____

18. Have you ever been treated for periodontal disease, pyorrhea, or trench mouth? Yes No

19. Do you have or have you ever had any of the following?

MOUTH

Bleeding, sore gums	Yes	No
Unpleasant taste/bad breath	Yes	No
Burning tongue/lips	Yes	No
Frequent blister, lips/mouth	Yes	No
Swelling/lumps in mouth	Yes	No
Ortho treatments (braces)	Yes	No
Biting cheeks/lips	Yes	No
Clicking/popping jaw	Yes	No
Difficulty opening or closing jaw	Yes	No

TEETH

Loose teeth	Yes	No
Sensitive to hot	Yes	No
Sensitive to cold	Yes	No
Sensitive to sweets	Yes	No
Sensitive to biting	Yes	No
Food impaction	Yes	No
Clenching/grinding	Yes	No
Shifting of teeth	Yes	No
Change in bite	Yes	No

ORAL HYGIENE

Do you use the following?		
Brush	Yes	No
Dental floss	Yes	No
Fluoride rinse	Yes	No
Other _____		

How often do you brush? _____

Brush is: soft medium hard

I consent and authorize Dr. Jennifer Sherwood Bragg to use my photographs, video, slides, or any other image as may be necessary of me, with or without my given name, or with a fictitious name for advertising, education, or any other lawful purpose and I release and forever discharge her from any claim, demands or liability on account of such use or for the quality of the reproduction of the photograph or photocopy provided.

To the best of my knowledge, all of the preceding answers are true and correct.

If I ever have any change in my health or change in my medication, I will inform the dentist at my next appointment.

Signature of Patient, Parent or Guardian _____ Date _____

JENNIFER SHERWOOD BRAGG, D.M.D., P.C.

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SMILE ANALYSIS

WHEN I SEE A PICTURE OF MYSELF, THE FIRST THING I NOTICE ABOUT MY SMILE IS

SOMETHING I OFTEN NOTICE ABOUT OTHER SMILES I CONSIDER ATTRACTIVE IS

PLEASE MARK AN X BY ANY STATEMENT YOU AGREE WITH.

_____ I WISH MY TEETH WERE WHITER.

_____ I WISH I HAD A BIGGER SMILE.

_____ I THINK SOME OF MY TEETH ARE TOO SMALL.

_____ I THINK SOME OF MY TEETH ARE TOO LARGE.

_____ I WISH MY TEETH WERE STRAIGHTER.

_____ MY GUMS SHOW TOO MUCH WHEN I SMILE.

_____ I THINK THERE IS TOO MUCH SPACE BETWEEN SOME OF MY TEETH.

_____ BECAUSE I AM NOT TOTALLY PLEASED WITH MY SMILE, I SOMETIMES HESITATE TO SMILE.

_____ I HAVE OFTEN WISHED I COULD CHANGE SOME OF THE FEATURES OF MY SMILE.

_____ I AM CONCERNED ABOUT WHAT THE END RESULT MIGHT LOOK LIKE IF I CHANGE MY SMILE.

_____ I AM CONCERNED ABOUT THE COSTS RELATED TO ENHANCING MY SMILE.

_____ I THINK I NEED TO DO A BETTER JOB PROTECTING THE HEALTH OF MY SMILE.

_____ I FEEL AS THOUGH I DON'T REALLY KNOW ALL OF THE OPTIONS AVAILABLE TO ENHANCE MY SMILE.

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