WELCOME
TO OUR PRACTICE!

Please take a few minutes to answer the following questions so we can better assist you with your dental needs.

PATIENT INFORMATION

Date _____ Soc. Sec. # _____ Birthdate _____

Name _____ (Last Name / First Name / Initial) Home Phone _____

Address _____ Cell Phone _____

City _____ State _____ Zip _____ E-mail _____

Sex: ☐ M ☐ F ☐ Minor ☐ Single ☐ Married ☐ Long Term Partner ☐ Divorced ☐ Widowed ☐ Separated

Employer _____ Business Phone _____

Business Address _____ Occupation _____

Who should we thank for referring you? _____

In case of emergency, who should we contact? _____ Phone _____

PRIMARY DENTAL INSURANCE

Person Responsible for Account _____ (Last Name / First Name / Initial)

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Responsible Party Employed By _____ Business Phone _____

Business Address _____ Occupation _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

ADDITIONAL INSURANCE

Insured Name _____ (Last Name / First Name / Initial)

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Insured Employed By _____ Business Phone _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

Please complete reverse side

DENTAL HISTORY

Former Dentist _____ Date of Last X-Rays _____

City, State _____ How Often Do You Floss? _____

Date of Last Dental Visit _____ How Often Do You Brush? _____

Please check all that apply:

- Bad Breath ☐
- Bleeding Gums ☐
- Blisters on Lips or Mouth ☐
- Finger Nail Biting ☐
- Grinding Teeth ☐
- Lip or Cheek Biting ☐
- Loose Teeth or Broken Fillings ☐
- Orthodontic Treatment ☐
- Pain Around Ear ☐
- Periodontal Treatment ☐
- Sensitivity to Cold ☐
- Sensitivity to Heat ☐
- Sensitivity to Sweets ☐
- Sensitivity When Biting ☐
- Frequent Headaches ☐
- Jaw, Head or Neck Injuries ☐
- Jaw Difficulty: Clicking and/or Pain ☐
- Tooth Pain ☐

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

	Yes	No
1. Are you currently under medical treatment?	☐	☐
2. Have you ever had any serious illnesses or operations?	☐	☐
3. Are you currently taking any medication?	☐	☐
Please describe: _____		
4. Do you smoke?	☐	☐
5. Do you use alcohol, cocaine or other drugs?	☐	☐
6. Do you wear contact lenses?	☐	☐

7. Have you had any allergic reactions to the following:

	Yes	No
Local Anesthetics (eg. novocaine)	☐	☐
Penicillin or other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates (sleeping pills)	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Other	☐	☐

8. (Women Only) Are You:

Pregnant?	☐	☐
Nursing?	☐	☐
Taking birth control pills?	☐	☐

Please check all that apply:

- AIDS ☐
- Anemia ☐
- Arthritis, Rheumatism ☐
- Artificial Heart Valves ☐
- Artificial Joints ☐
- Asthma ☐
- Back Problems ☐
- Bleeding abnormally, with extractions or surgery ☐
- Blood Disease ☐
- Cancer ☐
- Chemical Dependency ☐
- Chemotherapy ☐
- Chronic Fatigue Syndrome ☐
- Circulatory Problems ☐
- Congenital Heart Lesions ☐
- Cortisone Treatments ☐
- Cough - persistent or bloody ☐
- Diabetes ☐
- Emphysema ☐
- Epilepsy ☐
- Fainting or Dizziness ☐
- Glaucoma ☐
- Headaches ☐
- Heart Murmur ☐
- Heart Problems ☐
- Hepatitis-Type _____ ☐
- Herpes ☐
- High Blood Pressure ☐
- HIV Positive ☐
- Jaundice ☐
- Jaw Pain ☐
- Latex Sensitivity ☐
- Kidney Disease ☐
- Liver Disease ☐
- Low Blood Pressure ☐
- Mitral Valve Prolapse ☐
- Nervous Problems ☐
- Pacemaker ☐
- Psychiatric Care ☐
- Radiation Treatment ☐
- Respiratory Disease ☐
- Rheumatic Fever ☐
- Scarlet Fever ☐
- Shortness of Breath ☐
- Sinus Trouble ☐
- Skin Rash ☐
- Stroke ☐
- Swelling of Feet/Ankles ☐
- Swollen Neck Glands ☐
- Thyroid Problems ☐
- Tonsillitis ☐
- Tuberculosis ☐
- Tumor or growth on head/neck ☐
- Ulcer ☐
- Venereal Disease ☐

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to _____ for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ Date _____

OFFICE FINANCIAL POLICY

- Payment is expected in full by cash or credit/debit card at each appointment as service is rendered. For your convenience, Visa, Discover, MasterCard are accepted.

- We will be happy to file your dental insurance claim on the first visit if we have received confirmation of insurance coverage. **YOU WILL NEED TO BE PREPARED TO PAY ANY AMOUNT THAT IS DETERMINED NOT PAYABLE BY YOUR INSURANCE PLAN, SUCH AS DEDUCTIBLE AND CO-PAY PERCENTAGES.**

- To insure prompt and efficient patient care, we require a 24 hour notice to reschedule or cancel appointments. A $25 reactivation fee may be assessed in order to reschedule if 24 hour notice is not given. Failure to give a 24 hour notice or being a "no show" for two appointments in a 12 month period may result in dismissal from our practice.

- **We must emphasize that as health care providers, our relationship is with you, not your insurance company. Your dental insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. As a PPO provider for your insurance we are NOT employees of the insurance company. You are ultimately responsible for checking with your insurance company regarding coverage. Pre-treatment estimates through your insurance company are encouraged but are no guarantee of coverage, per your insurance company.**

- The amount not covered by your insurance is payable at the time of services (deductibles and co-pays). If we do not receive payment from your insurance company within 40 days after the submission of a claim, you will be expected to pay for all dental services in full within 10 days of notification. In the event of duplicate payment you will be reimbursed.

- You are responsible for payment regardless of any insurance company's arbitrary determination of payment. Please be aware that some services provided may be non-covered services by your particular plan. It is your responsibility to know your plan.

- **ACCOUNTS OVER 90 DAYS ARE REFERRED TO AN OUTSIDE COLLECTION AGENCY FOR COLLECTIONS. PATIENT/PARENT IS RESPONSIBLE FOR ALL COLLECTION FEES, AGENCY FEES AND ATTORNEY COURT COSTS INVOLVED IN COLLECTION.**

I have read and understand the Office Financial Policy and agree to abide by its contents.

AUTHORIZATION FOR TREATMENT

I authorize Dr. Heather Colson Hardy to administer such medication and local anesthetic , and perform such diagnostic, photographic and therapeutic procedure as may be necessary for proper dental care. The information provided in the patient registration and the dental/medical histories is correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical records and any other information about my dental treatment to third party payors and or other health professionals.

Patient/Parent or Guardian Signature_____ Date _____

C. Heather Colson, DMD, PC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

** You May Refuse to Sign This Acknowledgement**

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

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

I give permission for Dr. Colson and staff to speak with the following persons regarding my dental care:

_____

_____

_____

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)

_____

_____

_____

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C. Heather Colson DMD, PC

(NAME OF PRACTICE)

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

NAME: _____

ADDRESS: _____

TELEPHONE: _____

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 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 out Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Sylvia Harris, OM

Address: 3000 North Patterson Street Valdosta, Georgia 31602

Telephone: 229-242-2449 Fax: 229-242-2699

Email: contactus@colsondental.com

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 the 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 personal representative on behalf of the patient signs this Consent, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

Patient Consent For Electronic Communication

You have requested that our practice communicate with you electronically. By utilizing our practice's electronic services, you agree that **Dr. C. Heather Colson, DMD, PC,** may send you any of the following that you identify as communication that can be sent through the Internet to an email address you designate.

Consent and Acknowledgement

I, _____, in the presence of my dentist or the dental practice's privacy official, agree that the practice may electronically communicate with me at the following email address.

Email Address: _____

Patient Date of Birth (for verification purposes): _____

I acknowledge that the practice may send the following to my email. Check each that apply, and then provide your initials at the end of each item selected.

- ❑ Information about my invoice or accounts payable. _____(Initials)
- ❑ Information about a specific dental visit. _____(Initials)
- ❑ Information about my dental visit. _____(Initials)
  Specify: _____

Acknowledgement

You must acknowledge each of the following before we can send communications electronically.

_____ All electronic communications from our practice will be encrypted.
_____ I am responsible for providing the dental practice any updates to my email address.
_____ I am able to receive information electronically and store it securely away from any public computer.
_____ I can withdraw my consent to electronic communications by calling (229) 242-2449

Patient's Signature: _____ Date: _____

If you do not want Electronic Communications
Please Complete The Following:

- ❑ I do not want electronic communications:

Patient's Signature: _____ Date: _____

Verification of Identity

Please provide us with the following information.

General Information

Name _____

Address _____

City _____ State _____ Zip _____

Date of Birth _____ SS# _____

Driver's License Number _____ State _____

Insurance Information

Name of Subscriber _____

Relationship to Subscriber _____

Group No. _____ Individual No. _____

Responsible Party. Who is responsible for charges today?

Name _____

Address _____

City _____ State _____ Zip _____

I certify that the above information is correct.

Signature of Patient _____ Date _____

Personal Representative

Name of Personal Representative _____

Relationship to Patient _____

Driver's License Number _____ State _____

For Internal Use

I verify that I obtained a copy of the patient's photo ID and insurance card and made of copy of each for our records.
Signature _____

Date _____ Patient Record No. _____

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