RX History on Ga. Aware? Yes or No
Date Checked: ___________
Patient Chart #___________

Health History Form

Title: (Mr., Mrs., Ms., Dr.) **Date:** ____________________

First Name:__________ **M.I.:**____ **Last Name:** __________ **Preferred Name:** __________

Date of Birth: __________ **Age:**______ **Sex: M F** **SSN:** __________

Marital Status: Married Divorced Legally Separated Widowed Single

Address:____________________

City:__________ **State:**__________ **Zip:**__________

Home phone: ( )__________ **Cell: ( )**__________ **Work: ( )** __________

Email Address: ____________________

Are you employed? Yes No - Full Part time - Where? __________

Student status: Yes No - Full Part time - School Name: __________

Primary Care Physician: __________**General Dentist:**__________

Pharmacy:____________________

How did you hear about our office? (Circle One) Website Phonebook Sign Other: __________

Family/Friend: Who?____________________

Legal Guardian's Information (for minor child only):

Name:__________ Date of Birth:__________ Relationship:__________

Address:__________ City/State:__________ Zip: __________

Home Phone: ( ) __________ Cell Phone: ( ) __________

Do you have insurance? YES or NO

Primary Dental Insurance Information (if applicable)	**Policy Holder's Information**
Insurance Co.:__________	Name:__________
Address:__________	Relationship to Patient:__________
__________	Date of Birth:__________Sex: M or F
Phone: ( ) __________	SSN:__________
Employer:__________	Address:__________
Group Name:__________	__________
Group Number:__________	Home Phone: ( ) __________
ID:__________	Cell Phone: ( ) __________
Claims Mailing Address:__________	Work: ( ) __________ EXT: __________
__________	

Primary Medical Insurance Information (if applicable)	**Policy Holder's Information**
Insurance Co.:__________	Name:__________
Address:__________	Relationship to Patient:__________
__________	Date of Birth:__________Sex: M or F
Phone: ( ) __________	SSN:__________
Employer:__________	Address:__________
Group Name:__________	__________
Group Number:__________	Home Phone: ( ) __________
ID:__________	Cell Phone: ( ) __________
Claims Mailing Address:__________	Work: ( ) __________ EXT: __________
__________	

Reason for today's visit: ____________________

Are you currently under the care of a specialist? YES NO

If yes, for what condition(s):____________________

Name of specialist(s): ____________________

Patient Name: ______________________________ **Birthday:** ______________________

GENERAL HEALTH QUESTIONAIRE

DO YOU HAVE OR HAVE YOU EVER EXPERIENCED THE FOLLOWING: (PLEASE ANSWER YES OR NO)

Anemia/Thin Blood	☐ YES	☐ NO	Heart Murmur	☐ YES	☐ NO
Angina/Chest pain	☐ YES	☐ NO	Hepatitis/Liver	☐ YES	☐ NO
Arthritis	☐ YES	☐ NO	High Blood Pressure	☐ YES	☐ NO
Artificial Joint Replacement	☐ YES	☐ NO	Immune Deficiency	☐ YES	☐ NO
Asthma	☐ YES	☐ NO	Kidney or Dialysis	☐ YES	☐ NO
Atrial Fibrillation	☐ YES	☐ NO	Lupus/Autoimmune	☐ YES	☐ NO
Bleeding Issues	☐ YES	☐ NO	Mitral Valve Prolapse	☐ YES	☐ NO
Bronchitis/Smoking History	☐ YES	☐ NO	Osteoporosis	☐ YES	☐ NO
Cancer	☐ YES	☐ NO	Psychiatric Therapy	☐ YES	☐ NO
Convulsions/Seizures	☐ YES	☐ NO	Rheumatic Fever	☐ YES	☐ NO
Cough/Cold Presently	☐ YES	☐ NO	Stomach Ulcer	☐ YES	☐ NO
Diabetes	☐ YES	☐ NO	Stroke/Weakness	☐ YES	☐ NO
Emphysema	☐ YES	☐ NO	Thyroid Issues	☐ YES	☐ NO
Glaucoma	☐ YES	☐ NO	TMJ Issues	☐ YES	☐ NO
Heart Attack/Heart Surgery	☐ YES	☐ NO	Tuberculosis/+PPD	☐ YES	☐ NO
Cardiac Stent	☐ YES	☐ NO	Gastric Reflux	☐ YES	☐ NO
Radiation Therapy (Head/Neck)	☐ YES	☐ NO	Sleep Apnea/CPAP	☐ YES	☐ NO
Recent Cortisone/Steroid Therapy	☐ YES	☐ NO	Sinus Issues/ Sinus Surgery/Polyps	☐ YES	☐ NO
Positive COVID-19 History	☐ YES	☐ NO			

Any other medical problems not listed above: ______________________________

____

Are you now using or have you ever used drugs such as: (THIS IS CONFIDENTIAL AND WILL NOT HINDER TREATMENT)
Cocaine, Heroin, Methamphetamine, Others? ☐ YES ☐ NO
Marijuana? ☐ YES ☐ NO
Are you a Smoker? ☐ YES ☐ NO **If Yes, How many a day?** ______________________
Are you a Drinker? ☐ YES ☐ NO **If Yes, How often?** ______________________

DO YOU HAVE ANY ALLERGIES OR SENSITIVITES TO THE FOLLOWING: (PLEASE ANSWER ALL QUESTIONS)

Aspirin	☐ YES	☐ NO	Sulfite Preservatives	☐ YES	☐ NO
Codeine	☐ YES	☐ NO	Latex	☐ YES	☐ NO
Iodine	☐ YES	☐ NO	Soy	☐ YES	☐ NO
Penicillin	☐ YES	☐ NO	Sulfa	☐ YES	☐ NO

Other: ______________________________

Have you or anyone that you are directly related to ever had any unusual reactions to anesthesia or surgery? YES or NO
If YES, describe: ______________________________

WOMEN:
Are you taking birth control pills? ☐ YES ☐ NO **(Antibiotics may interfere with these medications)**
Are you currently nursing? ☐ YES ☐ NO
Do you think you may be pregnant? ☐ YES ☐ NO **Date of your last menstrual cycle:**
Do you wish to consult your physician to rule out pregnancy before surgery? ☐ YES ☐ NO

Please list previous surgeries and/or hospitalizations: (IF NONE, PLEASE PUT NONE)

____

Please list all medications, pills, herbal medicines: (IF NONE, PLEASE PUT NONE) ______________________

____

Would you like to discuss any other issues with the Doctor? YES or NO ______________________

____

I certify that the above information is correct to the best of my knowledge:

______________________________ ______________________
Patient's Signature (Guardian's Signature if Patient is a Minor) **Date**

Beninato Oral Surgery
21 John Maddox Drive
Rome, GA. 30165
(706)-234-0718

Patient Disclosure Instructions

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (*check all that apply*):

- Home/Mobile Telephone: (______) ________________
  - ❑ O.K. to leave message with detailed information
  - ❑ Leave message with call-back number only
- Work Telephone: (______) ______________
  - ❑ O.K. to leave message with detailed information
  - ❑ Leave message with call-back number only
- Written Communication
  - ❑ O.K. to mail to my home address

I allow you to give my clinical information to or answer questions from (*check all that apply*):

❑ Spouse
❑ Parent
❑ Child
❑ Other (specify): ____
❑ None

EMERGENCY CONTACT:

NAME: ______________________________________ **RELATIONSHIP:** ____________________

PHONE NUMBER: (________) ______________________

____ __________________________
Patient's Signature (Guardian's Signature if Patient is a Minor) Date

____
Please Print PATIENT'S Name

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Financial Policy Guidelines

You are entitled to a clear understanding of your financial obligations before treatment is rendered. A wide variety of services are available in this office, therefore, we do not have a uniform policy that covers all procedures and treatments.

PAYMENT IN FULL IS EXPECTED AT THE TIME SERVICES ARE RENDERED

For your convenience, we do accept Visa, MasterCard, Discover, and American Express. We also offer Care Credit financing for qualified patients. **If time allows**, we will check your insurance benefits at time of 1st visit. On subsequent visits, for procedures that are a covered expense under your insurance contract, you will be required to pay the portion not covered by insurance. We do not determine the amount of coverage you receive from your insurance company. If your insurance company has not paid the balance of your account **within 45 days from the date of service**, you will have **15 days** to pay the balance. If your insurance company pays more than the balance due, we will send a refund check to you. You are responsible for any balance left after your insurance company has paid their portion. After completion of service, we will file your insurance for you and we will assist you in trying to receive maximum benefits.

If you want a **pre-determination of benefits**, please make this request at the time of your consultation as this takes time to receive.

Insurance is a contract between **you and your insurance company**. This office is NOT a part of this contract. We will file insurance claims as a courtesy to our patients. We will not become involved in disputes between you and your insurance company regarding what the insurance considers as their “usual and customary charges”, deductibles, co-payments, covered charges, or secondary insurance, other than to supply factual information as necessary to the insurance company. **You are ultimately responsible for the timely payment of your account.**

PLEASE BE READY TO PAY FOR TREATMENT WHEN RENDERED. You will be provided with an estimate of fees before the beginning of treatment. If you are unable to pay your portion of payment, we will schedule your treatment at another time.

Patients who schedule and then “break” their surgical appointment (without notifying the office at least 24 hours in advance of the scheduled appointment) will be charged a fee of $100.00. Therefore, please be kind enough to call us if you will not be able to keep your appointment.

By my signature, I have read, or have had this form read to me, and I understand the financial guidelines of the office.

____ __________________________
Patient’s Signature (Guardian’s Signature if Patient is a Minor) Date

____
Please Print PATIENT’S Name

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COVID-19 Pandemic Emergency Dental Treatment Consent Form

I, ____, knowingly and willingly consent to have dental treatment completed during the COVID-19 pandemic.

I understand the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms and still be highly contagious. It is impossible to determine who has it and who does not given the current limits in virus testing.

Dental procedures create water spray. It is unclear as to how long the ultra-fine nature of the spray may linger in the air, which can transmit the COVID-19 virus.

- I have been made aware of the CDC and ADA guidelines that under the current pandemic all non-urgent dental care is not recommended. Dental visits should be limited to the treatment of pain, infection, conditions that significantly inhibit normal operation of teeth and mouth, and issues that may cause anything listed above within the next 3-6 months. ___________ (Initial)

I confirm that I am not presenting any of the following symptoms of COVID-19 listed below:

- Fever
- Shortness of Breath
- Loss of Sense of Taste or Smell
- Dry Cough
- Runny Nose
- Sore Throat
- ___________ (Initial)

I understand that air travel significantly increases my risk of contracting and transmitting the COVID-19 virus. And the CDC recommends social distancing of at least 6 feet for a period of 14 days to anyone who has, and this is not possible with dentistry. ___________ (Initial)

- I verify that I have not traveled outside the United States in the past 14 days to countries that have been affected by COVID-19. ___________ (Initial)
- I verify that I have not traveled domestically within the United States by commercial airline, bus, or train within the past 14 days. __________ (Initial)

**** I promise to contact Dr. Beninato's Oral Surgery if I start experiencing any symptoms of COVID-19 within 14 days of treatment.** __________ (Initial)

Name____________________________________ Date_____________________