Athens Dental Associates
855 Sunset Dr Ste 10, Athens, GA 30606
(706) 549-1370
www.athensdentalassociates.com/

HEALTH HISTORY
| DOB:

Summary

Medical Conditions	**none listed**
Allergies	**none listed**
Medications	**none listed**

General Health Information

Are you currently under the care of a physician?	
Physician phone number	
Date of last physical exam	
Are you presently being treated for any injury or illness?	
Have you ever been hospitalized for an injury or illness?	
Are you pregnant or planning to become pregnant?	
Are you currently breastfeeding?	
Are you required to pre-med with antibiotics before dental treatment?	
Do you use alcohol?	
Do you use or have you ever used tobacco?	
Have you ever had an allergic reaction?	

Medical Conditions

Please check all conditions that you have history of or are currently being treated for	
Do you have a history or are currently being treated for any Digestive conditions?	
Do you have a history or are currently being treated for any Heart or Circulatory conditions?	
Do you have a history or are currently being treated for any Neurological conditions?	
Do you have a history or are currently being treated for any Lung or Breathing conditions?	
Do you have a history or are currently being treated for any Autoimmune conditions?	
Head or neck injuries?	
Artificial Joint?	
High cholesterol?	
History of cancer?	
Tumor or abnormal growth?	
Radiation therapy?	
Chemotherapy?	
HIV / AIDS?	

Osteoporosis / osteopenia?	
Type I or Type II diabetes?	
Anemia?	
Kidney disease?	
Liver disease?	
Thyroid disease?	
Measles/ chicken pox?	
Any other medical condition we should know of?	

Medications

Please check all medications you are currently taking	
Are you taking any pain medications?	
Are you taking any Antidepressants or Anxiety medications?	
Are you taking any Diabetes, Cholesterol, or Blood Pressure medications?	
Are you taking any Allergy or Asthma medications?	
Are you taking any Antibiotics?	
Are you currently taking any other medications or dietary supplements?	

Sleepiness Scale

How Sleepy are You? How likely are you to doze off or fall asleep in the following situations? You should rate your chances of dozing off, not just feeling tired. Rate from 0-3 with 0 being no chance of falling asleep and 3 being a high chance of falling asleep.	
Sitting and Reading	
Watching TV	
Sitting inactive in a public place(movie theater or meeting)	
As a passenger in a car	
Lying down in the afternoon	
Sitting and talking to someone	
Sitting quietly after lunch	
In a car, while stopped for a few minutes in traffic	

Financial Policy

FINANCIAL POLICY

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require that you read and sign prior to any treatment. It is our hope that this policy will facilitate open communication between us and help avoid potential misunderstandings, allowing you to always make the best choices related to your care.

INSURANCE:

Please remember your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We are not in network with any insurance company. As a courtesy to you, our office will file your dental claims. It is physically impossible for us to have the knowledge and keep track of every aspect of your insurance. It is up to you to contact your insurance company and inquire as to what benefits your employer has purchased for you. If you have any questions concerning your dental insurance and/or fees for service, it is your responsibility to have these answered prior to treatment to minimize any confusion on your behalf.

Please be aware some or perhaps all of the services provided may or may not be covered by your insurance policy. Any balance is your responsibility whether or not your insurance company pays any portion.

PAYMENT:

Understand that regardless of any insurance status, you are responsible for the balance due on your account. You are responsible for any and all professional services rendered. This includes but is not limited to: dental fees, surgical procedures, tests, office procedures, medications and also any other services not directly provided by the dentist.

We accept cash, checks, Visa, Mastercard, American Express, and Discover. Please keep in mind that there is a 3.5% service fee for ALL card transactions.

FULL PAYMENT is due at the time of service. If insurance benefits apply, ESTIMATED PATIENT CO-PAYMENTS and DEDUCTIBLES are due at the time of service, unless other arrangements are made.

UNPAID BALANCE over 60 days old will be subject to a monthly interest of 1.0% (APR 12%). If payment is delinquent, the patient will be responsible for payment of collection, attorneys fees, and court costs associated with the recovery of the monies due on the account.

MISSED APPOINTMENTS:

Unless we receive notice of cancellation 48 hours in advance, you will be charged $50. Please help us maintain the highest quality of care by keeping scheduled appointments.

I have read, understand and agree to the terms and conditions of this Financial Agreement.

Patient's signature: Date:

Doctor's signature: Date:

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XRAY POLICY

We require that you have Xrays taken in our office in responsible intervals with consideration of your individual dental health, age, signs of dental problems, and risk for oral disease throughout your lifetime as a patient at Athens Dental Associates.

Dental Xrays are a critical component of your dental care. They are a valuable diagnostic tool that helps assess the overall condition of your teeth and their roots, jaw placement, and overall composition of facial bones. Xrays can detect traces of oral health problems at their earliest stages, such as cavities, gum disease, infections, as well as some tumors well before symptoms develop. Your dentist cannot see these problems with a basic visual oral examination.

We cannot provide comprehensive dental care for you based on an incomplete diagnosis without being subject to negligence. It is our goal to provide the best treatment possible for ALL of our patients with full transparency. Thank you for understanding.

Patient's signature: Date:

Doctor's signature: Date: