CLARK GENERAL DENTISTRY CENTER
Rodney K. Clark, D.D.S.
1918 Forsyth Street
Macon, GA 31201
Phone: (478)746-0046/ Fax: (478)746-0970
clarkdentistrycenter.com

PATIENT REGISTRATION & TERMS

Welcome to Clark General Dentistry Center! It is very important that you complete all pages to the best of your ability and knowledge, and sign where indicated. Please bring this form with you on the day of your appointment. This information may need to be updated in the future.

How did you hear about our dental office? Please check one
Yellow Pages: _____Internet: _____
If patient referral, please list their name: _____

PATIENT INFORMATION:

NAME: _____
(LAST) (FIRST) (MIDDLE)

MAILING ADDRESS:

_____
(NUMBER) (STREET) (APARTMENT NUMBER) (CITY)

(STATE) (ZIP)

PHYSICAL ADDRESS (If P.O. Box is listed above)_____

_____

Home Phone Number ( )_____-_____/ Cell Phone Number ( )_____-_____

If you do not have a telephone, give a number where we can leave a message or contact your family:_____

Email Address:_____

BIRTHDATE:_____ AGE:_____SEX:_____HEIGHT:_____ WEIGHT:_____

SOCIAL SECURITY NUMBER: _____-_____-_____

MARITAL STATUS: (Please check one) _____SINGLE_____ MARRIED _____ WIDOWED _____DIVORCED

PATIENT OCCUPATION:_____PATIENT WORK PHONE: _____ Ext: _____

EMPLOYED BY:_____

EMPLOYER'S ADDRESS:_____
(NUMBER) (STREET) (CITY) (STATE) (ZIP)

NAME OF SPOUSE: _____

SPOUSE'S EMPLOYER: _____

In case of an emergency, name of friend or relative to contact:_____Relationship to patient:_____
Telephone number ( )_____Alternate number( )_____

DENTAL HISTORY:
What is your reason for an appointment today?_____

Are you in dental discomfort today?_____

Former Dentist:_____ Phone:_____

Date of last dental care: _____ Date of last dental X-rays:_____

FINANCIAL INFORMATION

Please be advised that all fees are due at the time services are rendered. Patients are required to pay all deductibles and co-insurance payments at each visit. We will file any outstanding charges to your dental insurance carrier. If you are without dental insurance coverage, please inquire about financing options through CareCredit.

If the patient is under the age of 18, please complete the following information for the parent or guardian completing this registration form and who will be financially responsible for the patient's account.

Guarantor Name: _____

Date of Birth _____-_____-19_____

Social Security Number_____-_____-_____

Relationship to patient:_____

Address:_____
Apt# _____
_____

Telephone Number: ( ) _____-_____/

Alternate Telephone Number: ( ) _____-_____

Does the patient have Medicaid? ____ Yes ____ No If yes, what is the Member ID number:_____

Your **DENTAL** Insurance Company: _____

Are you the subscriber to this Dental Insurance Plan? _____Yes ____No

If no, Subscriber's name:_____

Subscriber's Social Security Number: _____-_____-_____

Subscriber's Date of Birth: _____

Member ID #_____

Dental Insurance Company Name: _____

Secondary Dental insurance_____ Member ID#_____
Subscriber's Name _____Subscriber's Date of Birth:_____
Subscriber's Social Security Number _____-_____-_____

Was the patient injured on the job? _____ If so, date of accident:_____

Name of employer if other than above: _____

Address: _____
(Number) (Street) (City) (State) (Zip)

Were you injured in a traffic accident? _____ **If yes, additional documentation is needed**

Are you eligible for V.A. benefits? _____Yes _____ No V.A.# _____

Check (✓) if you have had problems with any of the following:

☐ Y ☐ N Bad Breath	☐ Y ☐ N Food collection between teeth	☐ Y ☐ N Periodontal treatment
☐ Y ☐ N Sensitivity to sweets	☐ Y ☐ N Bleeding gums	☐ Y ☐ N Grinding or clenching teeth
☐ Y ☐ N Sensitivity to cold	☐ Y ☐ N Sensitivity when biting	☐ Y ☐ N Clicking or popping jaw
☐ Y ☐ N Loose teeth or broken fillings	☐ Y ☐ N Sensitivity to hot	☐ Y ☐ N Sores or growths in mouth

How often do you brush? _____ Floss? _____
What would you like to change about the appearance of your teeth? _____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ☐ Y ☐ N
If yes, please describe: _____
Other information about your dental health or previous dental treatment: _____

Do you currently wear any of the following? Removable Denture? _____
Removable Partial Denture? _____ Fixed Bridge_____?
If yes to any of the above, how long has this prosthesis been worn? _____

MEDICAL INFORMATION:

Physician's Name: _____Phone:_____

Date of last visit: _____ Have you had any serious illnesses or operations? ☐ Y ☐ N

If yes, describe: _____

Are you currently under physician care? ☐ Y ☐ N If yes, describe:_____

Have you ever had a blood transfusion: ☐ Y ☐ N If yes, give approximate dates:_____

Pharmacy Name:_____Location:_____
Pharmacy Telephone Number: _____

Women: Are you pregnant? ☐ Y ☐ N **If yes, how many months? _____**
Nursing? ☐ Y ☐ N Taking birth control pills? ☐ Y ☐ N

Check (✓) yes or not whether you have had any of the following:

☐ Y ☐ N History of tobacco use?	**How often? _____**	**For how long?_____**
☐ Y ☐ N Recreational drug use ?	**How often? _____**	**For how long?_____**
☐ Y ☐ N Circulatory problems	**☐ Y ☐ N Herpes**	**☐ Y ☐ N AIDS/HIV**
☐ Y ☐ N Respiratory Disease	**☐ Y ☐ N Anaphylaxis**	**☐ Y ☐ N Cortisone treatments**
☐ Y ☐ N Hepatitis (Type_____)	**☐ Y ☐ N Rheumatic fever**	**☐ Y ☐ N Anemia**
☐ Y ☐ N Cough, persistent	**☐ Y ☐ N High blood pressure**	**☐ Y ☐ N Shingles**
☐ Y ☐ N Arthritis, Rheumatism	**☐ Y ☐ N Cough up blood**	**☐ Y ☐ N Jaw pain**
☐ Y ☐ N Shortness of breath	**☐ Y ☐ N Artificial Heart valves**	**☐ Y ☐ N Diabetes**
☐ Y ☐ N Kidney disease/malfunction	**☐ Y ☐ N Skin rash**	**☐ Y ☐ N Artificial joints**
☐ Y ☐ N Epilepsy	**☐ Y ☐ N Liver disease**	**☐ Y ☐ N Surgical implant**
☐ Y ☐ N Asthma	**☐ Y ☐ N Fainting**	**☐ Y ☐ N Material allergies (latex, wool, metal, chemicals)**
☐ Y ☐ N Swelling of feet/ankles	**☐ Y ☐ N Back problems**	
☐ Y ☐ N Thyroid disease/malfunction	**☐ Y ☐ N Blood disease**	**☐ Y ☐ N Glaucoma**
☐ Y ☐ N Mitral valve prolapse	**☐ Y ☐ N Tonsillitis**	**☐ Y ☐ N Blood Thinning Therapy**
☐ Y ☐ N Headaches	**☐ Y ☐ N Nervous problems**	**☐ Y ☐ N Ulcer/Colitis**
☐ Y ☐ N Cancer Describe:_____	**☐ Y ☐ N Heart murmur Describe:_____**	**☐ Y ☐N Pacemaker /Heart Surgery**
☐ Y ☐ N Chemotherapy	**☐ Y ☐ N Venereal Disease**	

Have you ever had any complications following dental treatment: ☐ Y ☐ N
If yes, please explain:_____

Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Y ☐ N
If yes, please explain:_____

Does the patient have any health problems that need further clarification? ☐ Y ☐ N
If yes, please explain:_____

Does patient have any known drug allergies (example sulfa or penicillin)? If yes, list all:

Is the patient currently taking any medications? If yes, list all (Attach additional pages if necessary)

1. MEDICAL INFORMATION RELEASE AUTHORIZATION

I hereby authorize Clark General Dentistry Center, P.C. and his employees to furnish to any representative of any insurance company with whom I have coverage, to my attorney, or to any court, any and all information that Clark General Dentistry Center, P.C., or his employees have or may hereafter have, either written or oral, pertaining to or in any manner connected with any disability, injury, illness, ailment, medical and/or personal history, treatment, examination, consultation, and operation, either past or present, and to furnish these insurance companies, my attorney, or any court upon request, copies of any records, charts, and reports pertaining thereto; and I further agree that no person, firm or corporation shall be hold liable in any manner for furnish or having furnished such information.

PATIENT'S SIGNATURE:_____ DATE:_____

RELATIONSHIP IF OTHER THAN PATIENT:_____

Authorization must be signed by the patient, or by the parent or guardian in case of a minor, or by the nearest relative when the patient is physically or mentally incompetent.

2. ASSIGNMENT OF INSURANCE BENEFITS TO PHYSICIAN

For value received, I hereby transfer, assign and set over to Clark General Dentistry Center, P.C. all insurance benefits of every kind and description for basic, surgical and/or dental coverage, which benefits would be payable directly to me but for this assignment for his services as described. I understand and agree that I am responsible for any balance due after the insurance company pays you.

PATIENT'S SIGNATURE:_____ DATE:_____

3. AGREEMENT FOR SECURITY

I hereby grant to Clark General Dentistry Center, P.C., a security interest in all of the above-described insurance benefits together with any proceeds thereof to secure the payment for services provided by Clark General Dentistry Center, P.C. I authorize Clark General Dentistry Center, P.C. to file a financing statement signed by him or his office describing the collateral, and to communicate with the parties paying such insurance benefits to me concerning the creation of this security interest. I hereby authorize joint payment of all drafts, checks or payments of such insurance benefits.

PATIENT'S SIGNATURE:_____ DATE:_____

4. PATIENT FINANCIAL RESPONSIBILITY

I will be responsible to Clark General Dentistry Center, P.C. for all amounts and balances incurred on my account in accordance with the Terms of Patient's Accounts as agreed below. I further authorize the sending of medical records and bills to my attorney or insurance company, and in the event of recovery by trial or settlement to allow my attorney or insurance company to pay directly to Clark General Dentistry Center, P.C. an amount sufficient to cover these bills and to deduct the same from any recovery which may be due me. I recognize that notwithstanding any anticipated recovery or insurance reimbursement that I continue to be fully and completely responsible for all amounts incurred in my patient account and will remit timely payment without delay.

PATIENT'S SIGNATURE:_____ DATE:_____

5. AUTHORIZATION FOR PRESENT AND FUTURE CREDIT INFORMATION RELEASE

This authorization is a continuing authorization. I hereby authorize Clark General Dentistry Center, P.C., and/or his agents to make an independent investigation and access and obtain information available in my credit history file wherever stored or maintained, both now, and at any future time **only when my patient account is delinquent**. I release Clark General Dentistry Center, P.C., and its agents and employees and any person or entity which provides information pursuant to this authorization and release, from any and all liabilities, claims, or lawsuits in regards to the information obtained from any and all of the above referenced sources used.

PATIENT'S
SIGNATURE:_____DATE:_____

6. Release of Liability

I understand that it is my responsibility to fully disclose all medical conditions that I currently have or may develop in the future. By not doing so, I understand I am placing myself at risk of adverse outcomes of treatment. I further understand that by failing to disclose this information, I cannot and will not hold Dr. Rodney K. Clark, Clark General Dentistry Center, P.C., or its associates liable for any adverse results.

Patient or Representative
Signature:_____Date:_____

TERMS OF PATIENT ACCOUNTS AND TREATMENT

A. INTRODUCTION.

Normally, insurance companies will pay on patient accounts between 30 and 120 days after a claim for benefits is filed. A patient's account is his or her responsibility, however, and regardless of your insurance coverage, payments are expected on accounts in a timely manner. If, after your insurance has paid, there is still a sizeable balance remaining, we will be glad to work with you on arranging a payment schedule to suit your financial condition. Insurance is filed as a courtesy to patients. In the event your insurance benefits pay less than estimated amounts, you are responsible for the remaining balance. **Accounts which are over 90 days old will have interest applied on unpaid balances at the rate of 18% per year (1 ½% per month).**

B. **STATEMENT OF TERMS**.

All patient accounts will be satisfied within thirty (30) days after initial billing. Any agreements concerning repayment or special repayment terms are not binding unless entered into in separate writing by the patient and this office. **Patient accounts older than sixty (60) days shall be treated as delinquent and will be referred for collections.** TIME IS OF THE ESSENCE. Patient will pay all expenses accrued in the enforcement of any rights concerning any account including the sum of fifteen (15%) percent of the principal and interest due on the account as attorneys' fees if collected by law or through an attorney at law or under advice there from. No delay or waiver in collection of a delinquent account or any course of dealing between the patient and this office shall operate as a waiver of any right to collect the account.

C. **ACKNOWLEDGMENT BY PATIENT**.

Patient has reviewed the foregoing and accepts the terms for the establishment of a patient account for payment of said account.
PATIENT'S
SIGNATURE:_____DATE:_____

6. ACKNOWLEDGMENT OF PATIENT CONFIDENTIALITY POLICIES OF CLARK GENERAL DENTISTRY CENTER, P.C.

This is an acknowledgement of privacy practices model for the purposes of Treatment, Payment, and Healthcare Operations as specified in the HIPAA Privacy Rules.

I consent to the use or disclosure of my protected health information by Clark General Dentistry Center, P.C. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Clark General Dentistry Center, P.C. I understand that diagnosis or treatment of me by Clark General Dentistry Center, P.C. may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Clark General Dentistry Center, P.C. is not required to agree to the restrictions that I may request. However, if Clark General Dentistry Center, P.C. agrees to a restriction that I request, the restriction is binding on Clark General Dentistry Center, P.C. I have the right to revoke this consent, in writing, at any time, except to the extent that Clark General Dentistry Center, P.C. has taken action in reliance on . My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me. I understand I have a right to review Clark General Dentistry Center, P.C.'s Notice of Privacy Practices prior to signing this document. Clark General Dentistry Center, P.C.'s Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Clark General Dentistry Center, P.C. The Notice of Privacy Practices for Clark General Dentistry Center, P.C. is also provided to me and is posted at the Clark General Dentistry Center, P.C.'s offices. This Notice of Privacy Practices also describes my rights and the Clark General Dentistry Center, P.C.'s duties with respect to my protected health information. Clark General Dentistry Center, P.C. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Patient's Signature: _____Date_____

Clark General Dentistry Center

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Financial Policy

Thank you for choosing Clark General Dentistry Center as your dental care provider. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Check, Visa, Mastercard, Discover Card, or American Express
- Convenient Monthly Payment Plans from CareCredit
    - Allow you to pay over time
    - No annual fees or pre-payment penalties

Please note:

Clark General Dentistry Center requires payment prior to the beginning of your treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received. Clark General Dentistry Center charges $35.00 for returned checks.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment. It is your responsibility to give us accurate and updated insurance information at each visit. Failure to do so may result in you being responsible for a balance that your insurance company may have otherwise paid. Many dental insurance pans have strict guidelines regarding timely filing which makes accurate information a necessity. If you are covered under more than one insurance plan, please remember to give us information on all plans at the time of service.

Never ignore a bill simply because you feel it is not your obligation or you think your insurance company should pay it. You cannot assume your insurance company will cover any balance once we have transferred the responsibility of that balance to you. We only transfer responsibility to you after we have had response from your insurance company.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

[1]Subject to credit approval

[2]However, if we do not receive payment from your insurance carrier within 60 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

We ask that you provide us with a credit card number to transfer any unpaid balances delinquent over 60 days. Please complete the following:

Credit Card Number:_____

Expiration Date: _____

Consent to Email or Text Usage for Appointment Reminders and Other Healthcare

Communications:
Patients at Clark General Dentistry Center may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information.

If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice.
_____ (Patient initials) I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing (see revocation section below).

The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Patient Name: _____
Patient/Patient Representative Signature: _____
Date: _____

Revocation
I hereby revoke my request for future communications via email and/or text.

__I hereby revoke my request to receive any future appointment reminders, feedback, and general health via text messages.

__ I hereby revoke my request to receive any future appointment reminders, feedback, and general health via email.

NOTE: This revocation only applies to communications from **Clark General Dentistry Center**.
Patient Name: _____
Patient/Patient Representative Signature: _____
Date: _____

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RODNEY K. CLARK, D. D. S.
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FAX: 478-746-0970

Missed Appointment Policy

At **Clark General Dentistry Center**, your scheduled appointment time is reserved just for you. We try not to overbook appointment times in order to provide excellent care and to be sure we have sufficient time to adequately examine you and to discuss your condition and treatment options in detail with you.

We will make every effort to accommodate your scheduling needs. In return, we ask that you help us by keeping your scheduled appointments, arriving on time and notifying us a minimum of **twenty-four (24) in advance** if you are unable to do so. When we receive advanced notice of cancellation, we are able to avoid lost revenue and misspent employee time, which keeps our overhead down and our fees reasonable. More importantly, we are able to accommodate other patients needing care. Failure to comply with this policy will necessitate the assessment of the following fee:

- **First missed appointment:** Your chart will be marked as a "no show" and a $25.00 fee will be applied.

- **Second missed appointment**: You will receive a letter stating this is your second missed appointment and that you have been charged a missed appointment fee ($25.00)

- **Third missed appointment:** A letter will be mailed informing you that you have now missed three appointments and you have been charged another missed appointment fee ($25.00)

- **Further missed appointments**: Further missed appointments will require immediate payment of our Standard Fee for Doctor's Visit ($115.00). **This fee must be paid prior to scheduling any future appointments.**

Please sign below that you have read and understand this policy
Sign: _____
Date: _____