Douglas Dental Care
Joel R. Tidwell, DDS
Dimitri Arfanakis, DMD
Medical and Dental History

Patient Name: ______________________ ______________________ ____ ____________________
Last First M Preferred Name

Please provide information regarding your medical history to the best of your knowledge.
If you require information, ask one of our staff members for assistance.

Are you in good health?	☐ Yes	☐ No
Has there been any change in your general health in the last year?	☐ Yes	☐ No
Are you now under the care of a physician for a particular problem?	☐ Yes	☐ No
Have you ever had any serious illnesses, operations, or hospitalizations?	☐ Yes	☐ No

Please provide your physician's name, address, and phone number below.

______________________ ______________________
Physician's Name Street

______________________ ______________________
Physician's Phone City, State, Zip

Do you have or have you taken any of the following?

☐*Artificial heart valves	☐ Cancer	☐ Kidney disease	☐ Stomach problems
☐*Congenital heart defect	☐ Chemotherapy	☐ Leukemia	☐ Tuberculosis
☐*Heart transplant	☐ Contact lenses	☐ Liver disease	☐ Tumors
☐*Endocarditis	☐ COPD	☐ Mental disorders	☐ Ulcers
☐*Joint replacement	☐ Diabetes	☐ Nervous disorders	☐ Allergy: Codeine
☐ Anemia	☐ Emphysema	☐ Pacemaker	☐ Allergy: Dairy
☐ Asthma	☐ Excessive bruising	☐ Persistent cough	☐ Allergy: Epinephrine
☐ ^Bisphosphonates	☐ Excessive thirst	☐ Pregnancy	☐ Allergy: Latex
☐ Bleeding disorders	☐ Heart attack/Stroke	☐ Radiation treatment	☐ Allergy: Penicillin
☐ Blood transfusion	☐ Heart palpitations	☐ Shunts or conduits	☐ Allergy: Seasonal
☐ Bronchitis	☐ High blood pressure	☐ Sinus problems	☐ Allergy: Sulfa drug

Please list any <u>conditions or allergies</u> you may have that are not listed above.

Please list any <u>prescription and/or over-the-counter medication</u> you are currently taking.

FOR FEMALE PATIENTS: Please note that if you are using oral contraceptives, it is important to understand that antibiotics (and other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you should use mechanical forms of birth control for one complete cycle of birth control pills after the course of antibiotics or other medication is completed. Please consult your physician for further guidance.

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Douglas Dental Care has my permission to ask the respective health care provider/agency for any pertinent information. I will notify Douglas Dental Care dentists and staff of any changes in health or medication. I hereby give consent for dental treatment which may include anesthesia. I will discuss any questions concerning treatment and fees with the dentist.

Signature: ____**Date:** ____________________

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Patient Name: ______________________ ______________________ ____ __________________
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Please provide information regarding your dental history to the best of your knowledge.
If you require information, ask one of our staff members for assistance.

Do you smoke cigarettes, cigars, or pipes? ☐ Yes ☐ No Amount: ____________/day
Do use use snuff or chew? ☐ Yes ☐ No Amount: ____________/day
Do you consume alcoholic beverages? ☐ Yes ☐ No Amount: ____________/day

Using tobacco products (cigarettes, cigars, snuff, etc...) and consuming alcoholic beverages increases oral cancer risk. Early detection through our advanced oral cancer screenings is key to increased survival. Are you interested in our advanced oral cancer screening procedure today? ☐ Yes ☐ No

Do you brush your teeth regularly? ☐ Yes ☐ No
Do you floss your teeth regularly? ☐ Yes ☐ No
Have you been told that you have periodontal (gum) disease? ☐ Yes ☐ No
Have you ever had a periodontal (gum) treatment? ☐ Yes ☐ No
Have you ever had a deep cleaning? ☐ Yes ☐ No
Do you experience bad breath? ☐ Yes ☐ No
Do you experience dry mouth? ☐ Yes ☐ No

Do you grind or clench your teeth? ☐ Yes ☐ No
Do your jaws make popping or clicking noises? ☐ Yes ☐ No
Do you have difficulty opening or experience pain in your jaw? ☐ Yes ☐ No
Are your teeth sensitive or uncomfortable? ☐ Yes ☐ No
Do you participate in contact sports? ☐ Yes ☐ No
Do you have a nightguard or mouthguard? ☐ Yes ☐ No

Do you snore? ☐ Yes ☐ No
Are you interested in anti-snoring aids to decrease snoring? ☐ Yes ☐ No

Would you like to improve your smile? ☐ Yes ☐ No
Would you like to whiten your teeth? ☐ Yes ☐ No
Would you like to straighten your teeth? ☐ Yes ☐ No

Please fill this section in only if you are a new patient.

When was your last dental appointment? __________________
Have you had your teeth cleaned within the last 12 months? ☐ Yes ☐ No
Have you had x-rays taken of your teeth in the last 12 months? ☐ Yes ☐ No

Please provide your previous dentist's name, address, and phone number below.

______________________________ ____
Dentist's Name Street

______________________________ ____
Dentist's Phone City, State, Zip

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Signature: ____**Date:** ____________________

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Dimitri Arfanakis, DMD
Patient Information and HIPPA

Patient Information

Patient name: ______________________________ ____________________________ ____ _________________________
Last First M Preferred Name

Gender: ☐ Male ☐ Female Status: ☐ Single ☐ Married ☐ Child ☐ Other

Parent/Guardian: ______________________________ ____________________________
Last First

DOB: ____/____/____ SS#: _________________________

Home Address: ____ ____
Street City, State, Zip

Telephone: (_______) _______-_________ (_______) _______-_________ (_______) _______-_________
Home Phone Work Phone Mobile Phone

Party Responsible For Account
(If not same as above)

Responsible Party: ______________________________ ____________________________ SS#: _________________________
Last First

Home Address: ____ ____
Street City, State, Zip

Telephone: (_______) _______-_________ (_______) _______-_________ (_______) _______-_________

Employer Insurance Information

1st Insured's Name: _______________________ _______________________ ____ DOB: ____/____/____
Last First M

1st Insured's Address: ____ ____
Street City, State, Zip

1st Insured's Employer: ____

1st Insurance: _______________________ _______________________ _______________________ _______________________
Name of Insurance Insurance ID# Group # Insurance Phone

2nd Insured's Name: _______________________ _______________________ ____ DOB: ____/____/____
Last First M

2nd Insured's Address: ____ ____
Street City, State, Zip

2nd Insured's Employer: ____

2nd Insurance: _______________________ _______________________ _______________________ _______________________
Name of Insurance Insurance ID# Group # Insurance Phone

Method of Payment: ☐ Cash ☐ Check ☐ Charge
Would you like to learn more about applying for credit in our office? ☐ Yes ☐ No
We appreciate the confidence our patients have in our quality of dentistry. Whom may we thank for referring you to us? _________________________

Be advised that the responsibility for payment rests on the patient or person responsible for the account, regardless of insurance coverage. For your convenience, we gladly file dental insurance forms on your behalf. If, for any reason, your insurance company does not pay within 60 days, you are required to make full payment and have your insurance company reimburse you. You will be kept informed as to what treatment is needed and what it will cost. All fees are due at the time of treatment unless other arrangements have been approved in advance. Overdue payments will bear a late charge of 1.5% per month (18% per year) from the date the fees are charged until they are paid. Returned checks incur a $25 fee. If, for any reason, your account is turned over to a collection agency, then the agency's fees and any attorney fees will be applied to your account. In the best interest of your dental work, we ask that you keep all reserved appointments. If this is not possible, please give us at least 24 hours' notice so another patient may be scheduled. If insufficient notice is given, we reserve the right to charge a cancellation fee.

I understand the above information. I have provided information to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency for any pertinent information. I will notify Douglas Dental Care dentists and staff of any changes in payment information. I agree to the terms above.
Signature: ____-____________________________**Date:** ___________________

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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 is available. Please ask one of our staff members for a copy. A copy is also available online at www.douglasdentalcare.com. We encourage you to read it carefully and completely before 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:

Douglas Dental Care
Joel R. TIdwell, DDS
Dimitri Arfanakis, DMD
3668 Highway 5, Douglasville, GA 30135
770-949-1821

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 Dr. Joel R. Tidwell, DDS, PC. Please understand that revocation of this 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 healthcare operations.

Signature: ____ Date: ______________

If this Consent is Signed by a personal Representative on behalf of the patient, complete the following:

Personal Representative's Name: ____ Date: ______________

Medical History Updates

Date	Has there been any change in your medical history?	Signature
1. ___/___/___	☐ Yes ☐ No List: ____	_____________________________
2. ___/___/___	☐ Yes ☐ No List: ____	_____________________________
3. ___/___/___	☐ Yes ☐ No List: ____	_____________________________
4. ___/___/___	☐ Yes ☐ No List: ____	_____________________________
5. ___/___/___	☐ Yes ☐ No List: ____	_____________________________
6. ___/___/___	☐ Yes ☐ No List: ____	_____________________________
7. ___/___/___	☐ Yes ☐ No List: ____	_____________________________
8. ___/___/___	☐ Yes ☐ No List: ____	_____________________________
9. ___/___/___	☐ Yes ☐ No List: ____	_____________________________
10.___/___/___	☐ Yes ☐ No List: ____	_____________________________

Relationship: ____