GOLDBERG
DENTAL GROUP

1016 Beverly Heights Drive
Augusta, GA 30907
p (706) 860-1484
f (706) 868-6856
augustageneraldentist.com

## PATIENT INFORMATION (CONFIDENTIAL)

Name _____ Date _____
First MI Last

Address _____ City _____ State _____ Zip _____

E-mail _____ Cell Phone _____ Home Phone _____

SS# _____ Birthdate _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If College Student, F.T. / P.T., Name of School _____ City _____ State _____

Patient's or Parent's/Guardian's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent's/Guardian's Name _____ Employer _____ Work Phone _____

Whom May We Thank For Referring You? _____

Person To Contact In Case of An Emergency _____ Phone _____

## RESPONSIBLE PARTY

Name of Person Responsible For This Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Driver's License _____ Birthdate _____ SS#/SIN _____

Employer _____ Work Phone _____

Is This Person Currently A Patient In Our Office ☐ Yes ☐ No

## INSURANCE INFORMATION

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Co. _____ Tel. # _____ GRP # _____ Policy / I.D. # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max annual benefit? _____

Do you have any additional insurance? ☐ Yes ☐ No If Yes, complete the following:

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS# _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Co. _____ Tel. # _____ GRP # _____ Policy / I.D. # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max annual benefit? _____

Patient Number

# PATIENT'S MEDICAL HISTORY

Patient's Name _____ Date of Birth _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication that you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

| | Yes | No |
|---|---|---|
| 1. Are you in good health | ☐ | ☐ |
| 2. Have there been any changes in your general health within the past | ☐ | ☐ |
| 3. Date of your physical exam: _____ | | |
| 4. Physician name _____ Address _____ Phone No. _____ | | |
| 5. Are you now under the care of a physician | ☐ | ☐ |
| 6. Have you ever been hospitalized for any surgical operation or serious illness please explain. | ☐ | ☐ |
| 7. Are you taken any medicine (s) including non-prescription medicine | ☐ | ☐ |
| If yes, what medicine (s) are you taken _____ | | |
| 8. Have you had any abnormal bleeding | ☐ | ☐ |
| 9. Do you bruise easily | ☐ | ☐ |
| 10. Have you ever required a blood transfusion | ☐ | ☐ |
| 11. Have you had a recent weight loss | ☐ | ☐ |
| 12. Have you ever taken fen-phen/redux | ☐ | ☐ |
| 13. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates | ☐ | ☐ |
| 14. Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours | ☐ | ☐ |
| 15. Do you use tobacco | ☐ | ☐ |
| 16. Do you or have you used controlled substances | ☐ | ☐ |
| 17. Are you wearing contact lenses | ☐ | ☐ |
| 18. Do you have persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks) | ☐ | ☐ |
| 19. Do you have any disease, condition or problem not listed above that you think I should know about | ☐ | ☐ |

Women Only:

| | | |
|---|---|---|
| Are you pregnant or think you may be pregnant | ☐ | ☐ |
| Are you nursing | ☐ | ☐ |
| Are you taking birth control pills | ☐ | ☐ |

| Are you allergic to or have you had reaction to: | Yes | No |
|---|---|---|
| Local Anesthetics like Novocaine | ☐ | ☐ |
| Penicillin or other Antibiotics | ☐ | ☐ |
| Sulfa Drugs | ☐ | ☐ |
| Barbiturates, Sedatives or Sleeping Pills | ☐ | ☐ |
| Aspirin | ☐ | ☐ |
| Iodine | ☐ | ☐ |
| Any Metals (E.G., Nickel, Mercury, Etc.) | ☐ | ☐ |
| Latex or Rubber | ☐ | ☐ |
| Other (please list) _____ | | |

| Do you have or have you ever had the following: | Yes | No |
|---|---|---|
| Rheumatic Heart Disease or Rheumatic Fever | ☐ | ☐ |
| Scarlet Fever | ☐ | ☐ |
| Heart Defect or Heart Murmur | ☐ | ☐ |
| Heart Trouble, Heart Attack or Angina | ☐ | ☐ |
| Chest Pain | ☐ | ☐ |
| Shortness of Breath | ☐ | ☐ |
| Pacemaker | ☐ | ☐ |
| Heart Surgery | ☐ | ☐ |
| High / Low Blood Pressure | ☐ | ☐ |
| Congenital Heart Problem | ☐ | ☐ |
| Swelling of Feet, Ankles, Hands | ☐ | ☐ |
| Hepatitis, Jaundice or Liver Disease | ☐ | ☐ |
| Stroke | ☐ | ☐ |
| Sinus Trouble | ☐ | ☐ |
| Lung or Breathing Problem | ☐ | ☐ |
| Asthma or Hay Fever | ☐ | ☐ |
| Hives or Skin Rash | ☐ | ☐ |
| Fainting or Dizzy Spells | ☐ | ☐ |
| Diabetes | ☐ | ☐ |
| Aids or HIV Infection | ☐ | ☐ |
| Allergies | ☐ | ☐ |
| Arthritis or Rheumatism | ☐ | ☐ |
| Joint Replacement or Implant | ☐ | ☐ |
| Stomach Ulcer | ☐ | ☐ |
| Kidney Trouble | ☐ | ☐ |
| Tuberculosis | ☐ | ☐ |
| Persistent Cough | ☐ | ☐ |
| Cough that Produces Blood | ☐ | ☐ |
| Chemotherapy (Cancer, Leukemia) | ☐ | ☐ |
| Sexually Transmitted Disease | ☐ | ☐ |
| Epilepsy or Seizures | ☐ | ☐ |
| Anemia | ☐ | ☐ |
| Glaucoma | ☐ | ☐ |
| Nervousness | ☐ | ☐ |
| Tonsillitis | ☐ | ☐ |
| Tumors | ☐ | ☐ |
| Mental Health Care | ☐ | ☐ |
| Back Problems | ☐ | ☐ |
| Chemical Dependency | ☐ | ☐ |
| Mitral Valve Prolapse | ☐ | ☐ |
| Cortisone Treatment | ☐ | ☐ |
| Cold Sores / Fever Blisters | ☐ | ☐ |
| Hypoglycemia | ☐ | ☐ |
| Eating Disorders | ☐ | ☐ |

# PATIENT'S DENTAL HISTORY

Patient's Name _____ Date _____

Reason for this visit _____

When was your last dental visit _____ What was done then _____

How often did you visit the dentist before then _____

Previous Dentist (Name and Location) _____

Have you had a complete series of dental films (x-rays) taken when/where _____

How often do you brush your teeth _____ often do you floss your teeth _____

Is your drinking water fluoridated _____

| | Yes | No |
|---|---|---|
| Do you gums bleed while brushing or flossing | ☐ | ☐ |
| Are your teeth sensitive to hot or cold liquids/foods | ☐ | ☐ |
| Are your teeth sensitive to sweet or sour liquids/foods | ☐ | ☐ |
| Do you feel pain to any of your teeth | ☐ | ☐ |
| Do you haves any sores or lumps in or near your mouth | ☐ | ☐ |
| Have you had any head, neck or jaw injuries | ☐ | ☐ |
| Have you ever experience any of the following problems in your jaw? | | |
| Clicking | ☐ | ☐ |
| Pain (Joint, Ear, Side of Face) | ☐ | ☐ |
| Difficulty in opening or closing | ☐ | ☐ |
| Difficulty in chewing | ☐ | ☐ |
| Do you have frequent headaches | ☐ | ☐ |
| Do you clench or grind your teeth | ☐ | ☐ |

| | Yes | No |
|---|---|---|
| Do you bite your lips or cheeks frequently | ☐ | ☐ |
| Have you noticed any loosening of your teeth | ☐ | ☐ |
| Does food tend to become caught between your teeth | ☐ | ☐ |
| Have you ever had periodontal treatment (Gums) | ☐ | ☐ |
| Ever worn a bite plate or other appliance | ☐ | ☐ |
| Have you ever had any difficult extractions in the past | ☐ | ☐ |
| Have you ever had any prolonged bleeding following extractions | ☐ | ☐ |
| Do you wear dentures or partials | ☐ | ☐ |
| If yes, date of placement _____ | | |
| Have ever received oral hygiene instructions regarding the care of your teeth and gums | ☐ | ☐ |

If you could change anything about your smile, what would you change? _____

_____

_____

AUTHORIZATION AND RELEASE

I certify that i have read understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____ Date _____

Signature of Patient or Parent/ Guardian if Minor

Doctor's Comments _____

_____

Signature _____ Date _____

_____

Patient Number

STEVEN R. GOLDBERG, D.D.S., P.C.

# ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgment

I, _____, have received/ read a copy of this office 's Notice of Privacy Practices. This acknowledgment applies to all minor members of my family.

_____

Signature

_____

Date

## For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (Please Specify)

_____

_____

_____

# STEVEN R. GOLDBERG, D.D.S., P.C.

1016 Beverly Heights Drive • Augusta, Georgia 30907
Telephone (706) 860-1484 • Toll Free 866-288-1484
Fax (706) 868-6856
www.augustageneraldentist.com • E-mail: info@augustageneraldentist.com


## OUR FINANCIAL POLICY

Dr. Steven R. Goldberg and staff are committed to providing you with the best possible care at an affordable price. Considerable care has been taken in setting our fees. We want to assure you that our charges accurately reflect the complexity of care rendered and the skill and expertise required for you care. Our fees are comparable to fees of other dentists in this geographical area. If you have dental insurance, we are here to help you receive your maximum allowable benefits. In order to achieve this goals, we need your assistance and your understanding of our payment policy.

Our Policy:

Payment is due at the time services are rendered deductible, co-payment, or non-covered services. We file an insurance claim for all charges including those applied to your deductible, so that once your deductible has been met, your insurance company will start paying your visits.

Your insurance is a contract between you, your employer and the insurance company. We must emphasize that as dental providers, our relationship is with you, not your insurance company. While the filling of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date services are rendered. We realize that temporary financial problems may affect timely payment on your account. If such problems do arise, we encourage you to contact us promptly for assistance in management of your account.

Returned checks will receive a $25.00 overdraft charges. Any balance older that 30 days may be subject to additional collection fees and interest charges.

Charges may also apply for missed appointments and appointments not canceled within 24 hours.

If you have any questions about the above information or any uncertainty regarding insurance coverage, do not hesitate to ask us. We are here to help you.

I have read and understand my financial responsibilities under this policy.

_____ _____

Patient/Guarantor Signature Date

**PLEASE NOTIFY US IMMEDIATELY IF YOUR INSURANCE CHARGES**

_____

Patient Number