# GOLDBERG
DENTAL GROUP

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

Welcome to our office. We will do our best to make your appointment as convenient and pleasant as possible. If an any time you have any questions regarding your treatment, your appointment, or fees, please feel free to ask.

Name ______________________ Date Of Birth ______________

Address ______________________ City __________ St. __________ Zip __________

Home Phone (______) __________ Mother's Work # (______) __________ Father's Work # (______) __________

Father's Name ______________________ Employed By ______________

Mother's Name ______________________ Employed By ______________

Father's SS# ______________________ Mother's SS# ______________

Person Responsible For Account ______________________

Referred By ______________________

Do You Have Dental Insurance? ☐ Yes ☐ No Insurance Company ______________

Insured's Name ______________________ Group # ______________

Insured's Birthdate ______________________ Insured's Social Security No. ______________

Date of Last Medical Examination ______________________

Does child have or has child ever have:

| | Yes | No |
|---|---|---|
| Anemia | ☐ | ☐ |
| Diabetes | ☐ | ☐ |
| Hepatitis | ☐ | ☐ |
| Allergies | ☐ | ☐ |
| to Penicillin | ☐ | ☐ |
| to Local Anesthetic | ☐ | ☐ |
| Abnormal Heart Condition | ☐ | ☐ |
| Abnormal Bleeding from the Cut | ☐ | ☐ |
| Rheumatic Fever | ☐ | ☐ |

| | Yes | No |
|---|---|---|
| Heart Murmur | ☐ | ☐ |
| Is any medication being taken now | ☐ | ☐ |

If so, what ______________________

______________________

Other physical condition ______________________

______________________

Blood Pressure (If Known) _____/______/______

| | Yes | No |
|---|---|---|
| Is your child under the care of a physician now | ☐ | ☐ |

Name of Physician ______________________

Telephone Number (__________) ______________

Parent or Guardian Signature ______________________ Date ______________

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)

____________________________________________

____________________________________________

____________________________________________

______________________
Patient Number

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