Chart #:_____
FOR OFFICE USE ONLY

Patient Information

Patient Name: _____ Date:_____
Last First MI
☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____
Social Security #: _____ Birth Date:_____
Phone (Home): _____ (Work): _____ Ext:_____ Best time to call: _____
Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time ☐M ☐T ☐W ☐T ☐F ☐S
Address: _____
Street Apartment #
_____
City State Zip Code

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment
Name: _____
☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____
Social Security #: _____ Birth Date: _____
Phone (Home): _____ (Work): _____ Ext:_____ Best time to call: _____
Address: _____
Street Apartment #
_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment
Employer Name: _____ Occupation: _____
Address: _____
Street City State Zip Code

Insurance Information

Primary
Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI
Insured's Birth Date: _____ ID #: _____ Group #:_____
Insured's Address: _____
Street City State Zip Code
Insured's Employer Name: _____
Address: _____
Street City State Zip Code
Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____
Insurance Plan Name and Address: _____
_____

Secondary
Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI
Insured's Birth Date: _____ ID #: _____ Group #:_____
Insured's Address: _____
Street City State Zip Code
Insured's Employer Name: _____
Address: _____
Street City State Zip Code
Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____
Insurance Plan Name and Address: _____

Payment Policy

In an effort to reduce cost, increase efficiency and maintain a high level of professional care, we expect payment of fees at the time services are rendered.

On reconstruction cases (crowns, bridges, partial, dentures, etc.) a 50% deposit is required before beginning treatment. The remaining balance may be made in 2-3 payments with final payment being due before the delivery of any case.

The best patient-doctor relationships are maintained when there is a complete understanding of the treatment rendered and the fee. If you have a question about a treatment plan, fees or payment please discuss any concerns with our business manager before any treatment is started.

Method of payment can be one or a combination of the following: cash at time of visit, check at time of visit, Visa, MasterCard, Discover Card, or Pulse Card. A fee will be charged for returned checks.

Consent for Services

I HEREBY AUTHORIZE Dr. Callahan or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by Dr. Callahan to make a thorough diagnosis of (name of patient)_____-'s dental needs.

Upon diagnosis, I authorize Dr. Callahan to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay for said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient:_____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient:_____
Signature of guarantor of payment/responsible party

Dr. Michael R. Callahan

MEDICAL HEALTH:

PATIENT NAME:_____ DATE OF BIRTH_____ DATE_____

Name, address and phone number of your Physician:_____

Name and phone number of your pharmacy:_____

Date of last physical examination:_____ Reason for examination:_____

What is your estimate of your general health? (Please Circle) Excellent Good Fair Poor

Are you under the care of a physician now? Yes ☐ No ☐ If so, why?_____

Have you been hospitalized within the last 5 years? Yes ☐ No ☐ If yes, when and for what reasons?_____

Have you ever had any major operations? If so, for what? When?_____

Have you had abnormal bleeding after cuts, surgery, or dental extractions? Yes ☐ No ☐

Do you use tobacco? Yes ☐ No ☐ Pipe____ Cigars____ Snuff____ Cigarettes____ Vape Daily_____

DO YOU OR HAVE YOU EVER BEEN INFORMED YOU HAVE ANY OF THE FOLLOWING:
(Please check or circle YES or NO.)

Yes No
- ☐ ☐ Mitral Valve Prolapse
- ☐ ☐ Rheumatic or Scarlet Fever
- ☐ ☐ Heart Murmur or Heart Birth Defects
- ☐ ☐ Rheumatic Heart Disease
- ☐ ☐ Infective Endocraditis
- ☐ ☐ Artificial Heart Valves
- ☐ ☐ Cardiac Pacemaker
- ☐ ☐ Heart Attack
- ☐ ☐ High Blood Pressure (If yes, is it controlled? Yes or No.)
- ☐ ☐ Angina (Chest Pain)
- ☐ ☐ Stroke
- ☐ ☐ Irregular Heart Beat or Heart Ailment
- ☐ ☐ Low Blood Pressure
- ☐ ☐ Kidney Disease
- ☐ ☐ Kidney Transplant
- ☐ ☐ Diabetes— Insulin Dependent_____ Controlled (diet, medications)_____
- ☐ ☐ Hypoglycemia or Hyperglycemia
- ☐ ☐ Hormonal Problems
- ☐ ☐ Excessive urination (more than 6 times per day)?_____
- ☐ ☐ Excessive thirst?
- ☐ ☐ Do you have a family history of diabetes? Who?_____
- ☐ ☐ Headaches (more than 3 a month)

Yes No
- ☐ ☐ Fainting Spells or Dizziness
- ☐ ☐ Sickle Cell Anemia
- ☐ ☐ Hemophilia
- ☐ ☐ Prolonged bleeding problems
- ☐ ☐ Leukemia
- ☐ ☐ Other Blood Disorders_____
- ☐ ☐ Respiratory or Lung Disease
- ☐ ☐ Tuberculosis
- ☐ ☐ Emphysema
- ☐ ☐ Swelling of feet and ankles
- ☐ ☐ Do you require extra pillows when you sleep or experience shortness of breath?
- ☐ ☐ Asthma (Do you use an inhaler? Yes or No.)
- ☐ ☐ Liver Disease
- ☐ ☐ Hepatitis Type_____
- ☐ ☐ Corticosteroid Therapy or other immunosuppressive therapy

OTHER
- ☐ ☐ Epilepsy or Seizures
- ☐ ☐ Artificial Joint Replacement (hip, knee, joints)
- ☐ ☐ Implant / Prosthetic Pins or Rods
- ☐ ☐ Lupus
- ☐ ☐ Arthritis
- ☐ ☐ Gout
- ☐ ☐ Hearing Aide
- ☐ ☐ Sinus Trouble
- ☐ ☐ Thyroid or Parathyroid Problems

Yes No
- ☐ ☐ Allergies
- ☐ ☐ Glaucoma or other eye problems
- ☐ ☐ Contact Lens
- ☐ ☐ Recurrent Sore Throat
- ☐ ☐ Enlarged Lymph Nodes
- ☐ ☐ Persistent Diarrhea
- ☐ ☐ Night Sweats
- ☐ ☐ Skin Rashes
- ☐ ☐ Stomach Ulcers (If yes, were they bleeding ulcers? Yes or No.)
- ☐ ☐ AIDS or HIV
- ☐ ☐ Sexually transmitted diseases (venereal disease, syphilis, genital herpes, etc.)
- ☐ ☐ Bruise easily
- ☐ ☐ Psychiatric treatment
- ☐ ☐ Neurological Disorders
- ☐ ☐ Emotional Problems or Depression
- ☐ ☐ Generally a nervous person
- ☐ ☐ Tumor or Abnormal Growth
- ☐ ☐ Muscular Disorders
- ☐ ☐ History of Fever Blisters, Canker Sores, or Cold Sores
- ☐ ☐ Alcohol / Drug Dependency
- ☐ ☐ Family History of Mouth Cancer
- ☐ ☐ History of Face or Skin Cancer
- ☐ ☐ Chemotherapy or Radiation Treatments

WOMEN: **(Please check)** Pregnant / Trying to get pregnant: Yes ☐ No ☐ Nursing: Yes ☐ No ☐ Taking birth control pills: Yes ☐ No ☐

MEN: Do you have any known prostate disorders? Yes ☐ No ☐

Please list any other serious illnesses, medical treatments, or any treatments that may affect your dental care_____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING SUBSTANCES:

- ☐ Local Anesthetic (such as Novacaine)
- ☐ Codeine
- ☐ Sedatives, Barbiturates, or Sleeping Pills
- ☐ Acrylic
- ☐ Latex Rubber
- ☐ Nitrous Oxide Gas (Laughing Gas)
- ☐ Erythromycin
- ☐ Penicillin
- ☐ Aspirin
- ☐ Sulfa Drugs
- ☐ Metals (gold, stainless steel, etc.)
- ☐ Fluoride
- ☐ Other _____

CURRENT MEDICATIONS (please list) _____

To the best of my knowledge, all of the preceding questions are correct. If I have any changes in my medical health or medications I will notify the dentist and staff without fail.

Patient Signature (or Responsible Adult if a minor) Date

— PLEASE COMPLETE BOTH SIDES —

G/A Printers, Lavonia, GA

DENTAL HISTORY:

What would you like for us to do for you?_____
When was your last visit to a dentist?_____
When were your full mouth x-rays taken? (small x-rays) _____ panoramic x-ray? (one large x-ray of jaw) _____
When was your last cleaning?_____
How often do you have cleanings? 3 months_____ 4 months_____ 6 months_____ 1 year or longer_____
Is there any condition or previous difficulty that your dentist should know about before undertaking treatment? Yes ☐ No ☐ If so, please explain:_____
Do you have any dental fears or unfavorable dental experiences that you would like to discuss? Yes ☐ No ☐ _____
Have you ever had a.) nitrous oxide (laughing gas) Yes ☐ No ☐
b.) sedatives (valium, diazepam, etc.) Yes ☐ No ☐
c.) if so, was it helpful and effective? Yes ☐ No ☐
Would you consider Nitrous Oxide Gas (laughing gas) or Sedatives (valium, diazepam, etc.) for dental treatment if possible, to help you relax? Yes ☐ No ☐
Are you nervous about today's visit? Yes ☐ No ☐
What bothers you the most about going to the Dentist?_____
Name of your previous Dentist:_____
How long were you a patient of your last Dentist?_____
What qualities do you look for or desire in your Dentist?_____

PLEASE CHECK ANY OF THE FOLLOWING THAT YOU MAY EXPERIENCE:

Yes	No	
☐	☐	Have you ever had an adverse reaction to local anesthetic such as lidocaine, novocaine, etc?
☐	☐	Have you ever been treated by a dental specialist; (orthodontist = braces, periodontist = gum treatment, endodontist = root canals, oral surgeon = jaw surgery or wisdom tooth extractions) please list Doctor's Name_____
☐	☐	Do you avoid brushing or chewing on any part of your mouth?_____
☐	☐	Have you ever had professional instructions in dental home care (tooth brushing, flossing, etc.)
☐	☐	How often do you brush?_____ How often do you floss?_____
☐	☐	Do you think you may have decay or gum disease?
☐	☐	Have you ever been told you have gum or or periodontal disease?

Yes	No	
☐	☐	Have you noticed any loose teeth?
☐	☐	Bleeding or sore gums?
☐	☐	Daily bad breath?
☐	☐	Daily bad taste?
☐	☐	Sensitivity to hot, cold, sweets, or air?
☐	☐	Does food catch between your teeth?
☐	☐	Do you want to keep your remaining teeth?
☐	☐	Do you grind or clench your teeth? In the day time or while sleeping?_____
☐	☐	Pain or problems while chewing
☐	☐	Have you ever worn a plastic bite plate, mouthguard, or splint?
☐	☐	Do you bite your lips or cheeks regularly?
☐	☐	Have you noticed any change in your bite?
☐	☐	Does your bite feel comfortable?
☐	☐	Do you have clicking, pain, discomfort, or popping in your jaw joints?_____
☐	☐	Have you ever been treated for TMJ?
☐	☐	Have you ever had your bite adjusted or teeth ground?

Yes	No	
☐	☐	Do you feel you are under a great deal of stress at this time of your life?
☐	☐	Do you feel pain to any of your teeth?
☐	☐	Do you breathe through your mouth while awake or asleep?
☐	☐	Do you snore at night?
☐	☐	Have you had any difficult extractions in the past?
☐	☐	Have you ever had a 'dry socket' after an extraction?
☐	☐	Have you ever had any previous serious injuries to the mouth, teeth, jaw, or head?
☐	☐	Do you often experience 'dry mouth'?
☐	☐	Do you have any sores or lumps in or near the mouth or head and neck area?
☐	☐	Do you drink two or more soft drinks a day?
☐	☐	Do you have dental implants?

_____
_____

REFERRAL: Whom may we thank for referring you to our office?_____

Doctor's Remarks:_____

_____

DOCTOR'S SIGNATURE_____ DATE_____

Cancellation and Broken Appointment Policy

We understand that illness, emergencies, flat tires, and bad weather do occur. We ask our patients to give us 48 hours' notice whenever possible, if they cannot keep an appointment. This allows us time to fill our schedule with other patients who may be waiting

.

Policy and Fees:
Cancellation or rescheduling of an appointment ***with 24 hours or more*** notification – ***no charge***
Cancellation or rescheduling of an appointment ***less than 24 hours*** may or may not be considered a broken appointment; it will be at our discretion.

Failure to give 24 hour advance notice:

- We allow for one (1) broken appointment within a 12 month period
- Any additional broken appointments within a 12 month period will be charged a fee

$30 for a hygiene appointment
$50 for a doctor's appointment scheduled for an hour or less.

Definition of "Broken Appointment": A broken appointment is when you

- **Cancel** or **reschedule** an appointment with **less than 24 hour notice**
- **Do not show up** for the scheduled appointment

Our number one concern is our patient's dental health. Providing services in a timely manner is critical to accomplish that goal. Our other goal is to keep the cost of dental services as economical as possible. The appointment you schedule for treatment is reserved for you and your treatment only. When you fail to keep your appointment without providing us adequate notice, this adds to the overall cost of care, as trained professionals and dental facilities are not being utilized.
We appreciate your understanding and consideration regarding our appointment policy and if you have any questions or concerns, never hesitate to ask us at Lavonia Laser Dentistry.

I have read and understand the above mentioned policy.

_____ _____
Patient signature (Parent or Guardian if minor) Date

Michael R. Callahan, D.M.D., P.C.
12991 Jones St.
Lavonia, Georgia 30553
706-356-1477

I understand that I am financially responsible for all charges. **Payment is expected as services are rendered.** We accept cash, check, debit card, Master Card, Visa, or payment options through Capital One or HelpCard upon credit approval.

I understand that the treatment plan and fees given to me at any time are only **guaranteed for 6 months.**

I understand that I must give a **24-hour notice or there will be a charge on any unexcused broken appointments.**

ABOUT YOUR INSURANCE:

We will be happy to help you with any insurance questions. We will also help you to receive the maximum benefits under your policy.

But please remember that **YOU ARE RESPONSIBLE FOR PAYMENT.** Remember, too, that no insurance company will cover ALL dental costs. It is your responsibility to pay any deductible, co-insurance, or other balance not paid for by your insurance company. If your insurance does not pay within 30 days the account will automatically begin to accrue interest. This will be noted on your monthly statements. Let us know if there is a problem that you are aware of with your claim status, so we can help you to resolve it as soon as possible. (Some insurance companies are just slow payers.) **In the event that your insurance company does not acknowledge your claim within 45 days, you will be responsible for the balance in full.** We **will provide you with all necessary documentation that will aid you in recovery of your benefits.**

Your insurance is an agreement between you and the insurance company only. We prepare and send your insurance claims as a service to our patients. We try to make insurance as simple and convenient for you as possible in this way.

I understand that in the event my account becomes thirty (30) days past due and is turned over to United Collection Firm of Georgia, Inc. that I will be responsible for all collection expenses incurred.

Thank you,

Dr. Michael Callahan

_____
Signature Date

I have been informed of HIPPA and the privacy of my records.

_____
Signature Date

Medical Information Release Form

(HIPAA Release Form)

Name: _____ **Date of Birth:** ____/____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:_____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (*day*)_____ between (*time*)_____

Signed: _____ Date: ____/____/_____

Witness:_____ Date: ___/____/_____