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

MICHAEL R. CALLAHAN, D.M.D.

PATIENT MEDICAL HISTORY

DATE_____

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

In order to safeguard your health, it is important that you answer the following questions. Please remember that the answers to these questions are held in strict confidence.

NOTE: If patient is a minor, write name and relationship of responsible adult - address and occupation will pertain to responsible adult.

Patient Name:_____ Sex: M F
LAST FIRST MIDDLE

Spouse's Name:_____

Address_____
STREET CITY ZIP

Home Phone_____ Business Phone_____ Employer_____ Occupation_____

Date of Birth_____ Marital Status_____

In Case of an Emergency, Contact:_____

Physician Name, Address & Phone_____

1. Date of last physical examination_____
2. Are you under any medical treatment now? If so, what? _____ ☐ yes ☐ no
3. Have you been hospitalized within the last 5 years? _____ ☐ yes ☐ no
4. Have you had any major operations? If so, what? _____ ☐ yes ☐ no
5. Have you had abnormal bleeding after cuts, surgery, or dental extractions? _____ ☐ yes ☐ no
6. Have you ever required a blood transfusion? _____ ☐ yes ☐ no
7. Have you had surgery or x-ray treatment for a tumor, growth, or other condition? _____ ☐ yes ☐ no
8. Do you use tobacco? _____ ☐ yes ☐ no
9. Do you have or have you ever had:

☐ yes	☐ no	mitral valve prolapse	☐ yes	☐ no	persistent cough	☐ yes	☐ no	blood disease or disorder
☐ yes	☐ no	heart ailment	☐ yes	☐ no	recurrent sore throat	☐ yes	☐ no	hemphilia
☐ yes	☐ no	rheumatic fever	☐ yes	☐ no	sinus trouble	☐ yes	☐ no	arthritis
☐ yes	☐ no	rheumatic heart disease	☐ yes	☐ no	hay fever	☐ yes	☐ no	venereal disease or syphilis
☐ yes	☐ no	heart murmur	☐ yes	☐ no	allergies	☐ yes	☐ no	herpes
☐ yes	☐ no	heart attack	☐ yes	☐ no	skin rashes	☐ yes	☐ no	stomach ulcer
☐ yes	☐ no	stroke	☐ yes	☐ no	epilepsy or seizures	☐ yes	☐ no	tumor or growth
☐ yes	☐ no	artificial heart valve	☐ yes	☐ no	fainting spells	☐ yes	☐ no	thyroid problem or hormone deficiency
☐ yes	☐ no	pacemaker	☐ yes	☐ no	liver disease	☐ yes	☐ no	glaucoma or other eye problems
☐ yes	☐ no	chest pain	☐ yes	☐ no	hepatitis or yellow jaundice	☐ yes	☐ no	contact lenses
☐ yes	☐ no	shortness of breath	☐ yes	☐ no	kidney disease	☐ yes	☐ no	implant/prothesis
☐ yes	☐ no	high blood pressure	☐ yes	☐ no	steroid therapy	☐ yes	☐ no	prosthetic joint replacement
☐ yes	☐ no	respiratory or lung disease	☐ yes	☐ no	AIDS, AIDS related condition			
☐ yes	☐ no	tuberculosis			or HIV positive			
☐ yes	☐ no	scarlet fever	☐ yes	☐ no	anemia			
☐ yes	☐ no	asthma	☐ yes	☐ no	diabetes			
☐ yes	☐ no	emphysema						

10. Are you allergic to, or have you ever reacted adversely to:
    - ☐ yes ☐ no a. Local anesthetic (such as novocaine)
    - ☐ yes ☐ no b. Penicillin or other antibiotics
    - ☐ yes ☐ no c. Sulfa drugs
    - ☐ yes ☐ no d. Barbiturates, sedatives, or sleeping pills
    - ☐ yes ☐ no e. Aspirin
    - ☐ yes ☐ no f. Codeine
    - ☐ yes ☐ no g. Other_____

11. Are you taking any of the following

If so, please list:

			Name	Dosage	Frequency	Date Started
☐ yes	☐ no	a. Antibiotics or sulfa drugs				
☐ yes	☐ no	b. Anticoagulants (blood thinners)				
☐ yes	☐ no	c. Medicine for high blood pressure				
☐ yes	☐ no	d. Diuretics				
☐ yes	☐ no	e. Cortisone (steroids)				
☐ yes	☐ no	f. Tranquilizers				
☐ yes	☐ no	g. Antihistamines				
☐ yes	☐ no	h. Aspirin				
☐ yes	☐ no	i. Insulin				
☐ yes	☐ no	j. Thyroid medication				
☐ yes	☐ no	k. Digitalis				
☐ yes	☐ no	l. Nitroglycerin				
☐ yes	☐ no	m. Other drugs for heart condition				
☐ yes	☐ no	n. Weight control medicine				
☐ yes	☐ no	o. Immunosuppressants				
☐ yes	☐ no	p. Other				

12. ☐ yes ☐ no Are you taking any over the counter or unprescribed medication? If so, please list:

_____

_____

WOMEN

13. ☐ yes ☐ no Are you pregnant?
- ☐ yes ☐ no Do you have any problems associated with your menstrual cycle?
- ☐ yes ☐ no Do you have any children? How many?_____
- ☐ yes ☐ no Are you taking birth control pills? (Some antibiotic medications will interfere and decrease the effectiveness of oral contraceptive, therefore, other birth control methods must be used while taking antibiotic medicines.)

PATIENT DENTAL HISTORY

1. What is the reason for this initial visit?_____
2. What are your dental complaints at this time?_____

_____
3. When was your last visit to a dentist?_____
4. When were your last full-mouth x-rays taken?_____
5. When was your last cleaning?_____
6. Is there any condition or previous difficulty with dental treatment that your dentist should know about before undertaking treatment? If so, please explain:_____

_____
7. Name of Prior Dentist:_____

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

PAYMENT POLICY: In compliance with the Truth in Lending law here is our credit policy: It is customary to take care of fee at time service is rendered. To assist you with this we accept VISA and MasterCard credit cards and Dencharge.
On reconstruction cases (crown and bridge, partial and dentures) 50% of the fee is due at first appointment and balance at time of insertion.
If you have dental insurance, we will accept assignment on that portion of your charges which are covered by insurance. However, it must be understood that you will be responsible for immediate payment of any deductible amount not covered by insurance; in addition, you will be responsible for any portion of the assigned amount not paid by your insurance company within 60 days.

My preferred method of payment is: ☐ Cash or Check at time of Visit ☐ Dencharge ☐ Medicaid

☐ MastercardNo._____ ☐ VISANo._____

☐ DentalInsuranceCompany_____ PolicyNo._____

If Dental Insurance assignment is accepted, I authorize payment directly to Dr. Michael Callahan any group insurance benefits otherwise payable to me and agree to the release of information relating to this claim. I certify that the medical and dental history information is correct to the best of my knowledge and that I have read and accept the above credit policy terms.

_____ Social Sec.#_____ Date_____

Signature (parent or guardian if patient a minor)

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: ___/____/_____

Michael R. Callahan, D.M.D., P.C.

DENTISTRY

12991 JONES STREET
P.O. BOX 736
LAVONIA, GA 30553
Telephone (706) 356-1477

CONSENT FOR TREATMENT

I am the (parent or guardian) of _____(name of child) who is a minor child, and I authorize examination and treatment as necessary by or under the supervision of Dr. Michael Callahan. This includes exposure of radiographs as necessary, use of local anesthetic, and use of appropriate medicaments and materials for such treatment.

I READ AND UNDERSTAND THE ABOVE INFORMATION AND THE INFORMATION GIVEN ME VERBALLY. BY MY SIGNATURE BELOW I CONSENT TO THE TREATMENT DESCRIBED IN THIS PAPER.

Signature _____ Date _____

Witness _____ Date _____