NU-SMILE FAMILY DENTISTRY
1657 River St.
VALDOSTA, GA 31601

DATE:_____

PATIENT NAME: _____ SS#_____

ADDRESS: _____CITY_____STATE___ZIP_____

HOME PHONE_____CELL_____WORK_____

BIRTHDATE_____FEMALE/MALE MARRIED/SINGLE/DIVORCED

EMPLOYER_____

DENTAL INSURANCE INFORMATION

INSURANCE COMPANY_____

NAME OF INSURED_____RELATIONSHIP TO PT _____

DATE OF BIRTH/INSURED_____SS#_____

EMPLOYER_____

NOTE: PLEASE GIVE CARD TO FRONT DESK TO MAKE PHOTOCOPY

DENTAL HISTORY

LAST DENTAL VISIT _____

REASON FOR TODAY'S VISIT_____

WHAT ARE YOUR DENTAL CONCERNS _____

MEDICAL HISTORY

PHYSICIAN NAME_____DATE OF LAST VISIT_____

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING_____

_____

ALLERGIES KNOWN_____

PREGNANT? YES/NO_NURSING? YES/NO __BIRTH CONTROL? YES/NO_

CIRCLE BELOW ANY THAT APPLY

AIDS
ARTIFICIAL HEART VALVE
ARTIFICIAL JOINTS
ARTHRITIS
ASTHMA
BLOOD DISEASE
CANCER
CHEMOTHERAPY
DIABETES
EPILEPSY
EYE DISEASE
GLAUCOMA
HEART DISEASE
HEART MURMUR
HEMOPHILIA
HEPATITIS
HIGH BLOOD PRESSURE
IMPLANTS/TRANSPLANTS
LATEX ALLERGY
MVP
MALARIA
MENINGITIS
MULTIPLE SCLEROSIS
MUSCULAR DYSTROPHY
PACEMAKER
PSYCHIATRIC CARE
RADIATION TREATMENT
RESPIRATORY DISEASE
RHEUMATIC FEVER
SCARLET FEVER
SICKLE CELL DISEASE
STEROIDS
STROKE
SURGICAL STENTS
THYROID DISEASE
TOBACCO HABIT
TUBERULOSIS
ULCERS

CONSENT FOR TREATMENT

TO THE BEST OF MY KNOWLEDGE, THE INFORMATION I HAVE PROVIDED IS COMPLETE AND CORRECT. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR IF I, OR MY MINOR CHILD, EVER HAVE A CHANGE IN HEALTH. I GIVE CONSENT FOR ME OR MY CHILD TO HAVE DENTAL TREATMENT PERFORMED BY DR. SHERRY COLVIN AND HER STAFF. I UNDERSTAND THERE ARE RISKS INVOLVED WITH THE ADMINISTRATION OF LOCAL ANESTHETICS, MEDICINES, AND WITH CERTAIN DENTAL PROCEDURES.

SIGNATURE PATIENT/PARENT/GUARDIAN DATE

_____

PLEASE PRINT _____

APPOINTMENTS

JUST AS IF A HOTEL RESERVES A ROOM FOR YOU, WE RESERVE A TREATMENT SUITE FOR YOU. WE RESERVE THE DOCTORS AND ASSISTANTS TIME JUST FOR YOUR TREATMENT. IF FOR ANY REASON YOU HAVE TO CHANGE YOUR APPOINTMENT, WE ASK THAT YOU GIVE OUR OFFICE A (48) HOUR NOTICE. OTHERWISE, THERE WILL BE A $25.00 CHARGE INCURRED FOR A "MISSED/BROKEN" APPOINTMENT. THIS WILL BE DUE PRIOR TO BEING SEATED AT YOUR NEXT VISIT.

INSURANCE

I CERTIFY THAT I AND/OR MY DEPENDENTS HAVE INSURANCE COVERAGE WITH _____ AND ASSIGN DIRECTLY TO DR. COLVIN ALL INSURANCE

BENEFITS, IF ANY, OTHERWISE, PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I AUTHORIZE THE USE OF MY SIGNATURE ON ALL INSURANCE SUBMISSIONS.

THE ABOVE NAMED DOCTOR MAY USE MY HEALTH CARE INFORMATION AND MAY DISCLOSE SUCH INFORMATION TO THE ABOVE NAMED INSURANCE COMPANY AND THEIR AGENTS FOR THE PURPOSE OF OBTAINING PAYMENT FOR SERVICES AND DETERMINING INSURANCE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.

REFUNDS

It is the policy of this office that, once a patient has entered into agreement of treatment and monies have been applied, there is no refund to be made. If for whatever reason, the patient decides to discontinue treatment, any monies that have been paid to Nu-Smile Family Dentistry will remain here on the account. You can however, use any credited monies remaining on your account for an immediate family member. (This is only if they are a listed dependent on your account here with us). These credit balances will remain on the account for a total of (6) months. If the credit has not been used within this allotted time, the credit will no longer be valid and the account will reflect a zero balance.

I _____(patient or guardian) have read and fully understand the policies of this establishment and agree to all of them without question.

_____ DATE _____
SIGNATURE OF PATIENT/PARENT/GUARDIAN

_____
PLEASE PRINT NAME OF PATIENT/PARENT/GUARDIAN