MOBLEY FAMILY DENTISTRY, P.A.
DENTAL & MEDICAL HISTORY

Dental History

Reasons for today's visit: _____

Date of last dental care: _____ Date of last dental xrays?_____

Former Dentist: _____ Address: _____ Phone: _____

Would you like for your records to be sent to our office? Yes / No (If yes, please complete our Records Release form.)

Have you had a negative experience with dental treatment at any point in your past? Yes / No If Yes, please explain:

_____

Do you feel that you grind your teeth or has anyone ever told you that you grind your teeth? Yes / No If Yes, please explain:

_____

Do you feel that you fall asleep too easily throughout the day, are overtired, or do not feel rested? Yes / No If Yes, please explain:

_____

Do you have any specific goals for your future dental treatment (for example: interest in braces, implants, veneers) Yes / No Please explain:

_____

Medical History

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 impact on your overall oral health. Thank you for answering the following questions:

Primary Physician: _____ Phone: _____ Approximate date of last visit: _____

Are you under the care of a medical specialist? Yes / No If Yes, please list:

Specialist Name: _____ Phone: _____

Specialist Name: _____ Phone: _____

Have you ever had an operation? Yes / No If yes, please list: _____

If Yes, please list any complications such as bleeding, infection, poor healing, etc.: _____

Have you ever been sedated for a medical procedure?
Yes / No
If Yes, please list any complications related to your sedation:
_____

Can you easily move your head and neck in all directions?
Yes / No
If No, please explain:
_____

Do you use tobacco? Yes / No
If Yes, what type? _____ How long? _____
Interested in quitting? Yes / No

Do you use controlled substances? Yes / No
What type? _____

Women- Are you: Pregnant/trying to get pregnant? Yes / No
If yes, when is your due date? _____
Taking oral contraceptives? Yes / No Nursing? Yes / No

Have you ever taken any medications such as Fosamax, Boniva, Actonel or any other medications containing bisphosphonates for a bone condition?

Yes / No If Yes, was the medication a ( ) Pill/tablet ( ) IV/injection ? How many years did you receive the medication? _____

Name of medication(s):_____

Are you allergic to any of the following? No Drug Allergies ☐

Aspirin NSAIDS Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa Drugs Other

If you circled any of the above, what were your symptoms when you had a reaction? _____

If other drug/material allergies, please list:_____

MOBLEY FAMILY DENTISTRY, P.A.
MEDICAL HISTORY

Do you have, or have you had, any of the following?

- ☐ AIDS/HIV Positive
- ☐ Alzheimer's Disease
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Breathing Problems
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Cold Sores/Fever Blisters
- ☐ Congenital Heart Disorder
- ☐ Convulsions
- ☐ Cortisone Medicine
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Easily Winded
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Excessive Thirst
- ☐ Fainting Spells/Dizziness
- ☐ Frequent Cough
- ☐ Frequent Diarrhea
- ☐ Frequent Headaches
- ☐ Genital Herpes
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack/Failure
- ☐ Heart Murmur
- ☐ Heart Pace Maker
- ☐ Heart Trouble/Disease
- ☐ Hemophillia
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Hives or Rash
- ☐ Hypoglycemia
- ☐ Irregular Heartbeat
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disesase
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Mitral Valve Prolapse
- ☐ Pain in Jaw Joints
- ☐ Parathyroid Disease
- ☐ Psychiatric Care
- ☐ Radiation Treatments
- ☐ Recent Weight Loss
- ☐ Renal Dialysis
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Spina Bifida
- ☐ Stomach/Intestinal Disease
- ☐ Stroke
- ☐ Swelling of Limbs
- ☐ Thyroid Disease
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors or Growths
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Yellow Jaundice

Have you ever had any serious illness not listed above? Yes / No If yes, please explain: _____

Comments: _____

_____

_____

_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT or GUARDIAN _____ DATE _____

Mobley Family Dentistry, P.A.
2281 Hog Mountain Road ▫ P.O. Box 979 ▫ Watkinsville, Georgia 30677
Phone 706.769.6671 ▫ Fax 706.769.2103 ▫ www.MobleyFamilyDentistry.com

MOBLEY FAMILY DENTISTRY, P.A.
MEDICATION LIST

If you are taking any prescribed medications, OTC medications, herbal supplements or vitamins, please complete this form.

My Name is: ______________________________

My Healthcare Provider's Name is: ______________________________

My Healthcare Provider's Phone Number is: ______________________________

I am currently taking the following:

MEDICATION:	WHEN I TAKE IT:	DOSE:	OTHER INSTRUCTIONS:

MOBLEY FAMILY DENTISTRY, P.A.
PATIENT REGISTRATION

Patient's First Name: _____ Middle: _____ Last: _____

Preferred Name: _____ Date of Birth: _____

Patient is covered by dental insurance: Yes / No

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Home Ph. _____ Work Ph. _____ Ext. _____ Cell: _____

Sex: M / F Marital Status: Married / Single / Divorced / Separated / Widowed / Partnered / Minor

Social Security Number: _____ Driver's License Number: _____

Email: _____ I would like to receive correspondence via email: Yes / No Text: Yes / No

Employment Status: Full Time / Part Time / Retired Student Status: Full Time / Part-Time

Employer: _____ School: _____

Emergency Contact Name: _____ Relationship to Patient: _____

Emergency Contact Phone Number: _____ 2nd Contact Number: _____

Who can we thank for referring you to our office? _____

If the Patient is not responsible for payment, please complete this section. Responsible Party:

First Name: _____ MI: _____ Last: _____

Preferred Name: _____ Date of Birth: _____

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Home Ph. _____ Work Ph. _____ Ext. _____ Cell: _____

Social Security Number: _____ Driver's License Number: _____

Email: _____ I would like to receive correspondence via email: Yes / No Text: Yes / No

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If the Patient has Dental Insurance, please complete this section:

Policy Holder's Name: _____ Patient's Relationship to the Policy Holder: _____

Policy Holder's SSN: _____ Policy Holder's Birth Date: _____

Employer: _____

Employer's Address: _____

Insurance Company: _____ Group Number:_____

Insurance Company Address: _____

If the Patient has Secondary Dental Insurance, please complete this section:

Policy Holder's Name: _____ Patient's Relationship to the Policy Holder: _____

Policy Holder's SSN: _____ Policy Holder's Birth Date: _____

Employer: _____

Employer's Address: _____

Insurance Company: _____ Group Number:_____

Insurance Company Address: _____

Mobley Family Dentistry, P.A.

FINANCIAL POLICY

Please Take Time to Read This Important Information

We appreciate your choosing us to serve your dental care needs. Our goal is to provide you with the best dental experience possible. To better serve you, it is necessary for you to be informed of the financial policies of our practice.

Dental Insurance

Dental insurance is a contract between you, your employer and the issuing company. As a courtesy to you, we will file your insurance claims if all information is made available to us. Our office is committed to helping you maximize your insurance benefits. However, because insurance plans vary and are constantly changing, we can only ***estimate*** your coverage and cannot guarantee any insurance payment. ***Your estimated portion must be paid at the time of service***. ***This does not mean you will not have a balance after the insurance company pays***. ***You are solely responsible for any outstanding balance***. If your insurance company issues checks to you, the total balance must be paid in full at the time of service. Be advised we are NOT a participating provider with any insurance company. However, we can file a claim with your insurance carrier and payment will be considered based on their out-of-network benefits. You will be responsible for whatever amount the insurance does not pay. ***We DO NOT write off outstanding balances***.
If you do not have dental insurance, payment in full is expected at the time of service.

Payment Options

We accept cash, **local checks**, **Visa**, **MasterCard**, **American Express** and **Discover**. We also offer interest-free financing through **Care Credit**.

Emergency Patients

If you are not an established patient and you have a dental emergency, you will be asked for payment in full BEFORE treatment is performed. We accept cash, debit and credit cards only. NO CHECKS. If you have insurance and we can verify benefits, then your estimated part is expected at the time of treatment. If we cannot verify benefits, then we ask for payment in full and we will either have the insurance check sent to you or we will issue you a check after we receive the insurance payment.

Responsible Party

If you are 18 or over, you are responsible for your balance regardless of insurance or student status.

A divorced parent bringing a minor child to the office will be the responsible party. This is regardless of whose name the insurance is in. ***Any amount due must be paid at the time of service***. We cannot bill the other parent, in whole or in part, for this amount.

THERE is a FINANCE CHARGE of 1.5% per month on ALL BALANCES OVER 60 DAYS.
**We reserve the right to charge for appointments missed or canceled without 24 hours notice. Charges range from $50 - $200 per hour.

I have read, understand and accept the provisions set forth in this policy.

Patient/ Guardian Signature: _____Date:_____

MOBLEY FAMILY DENTISTRY, P.A.

Acknowledgement of Receipt of Privacy Practice Notice

* You May Refuse to Sign This Acknowledgment*

I have received a copy of this office's Notice of Privacy Practices.

Print Name: _____

Signature: _____

Date: _____

For Office Use Only

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

__ Individual refused to sign

__ Communication barriers prohibited obtaining the acknowledgement

__ An emergency situation prevented us from obtaining acknowledgement

__ Other (Please Specify)

_____

_____

_____

Rhonda Mobley, DMD · Alan Mobley, DMD

AUTHORIZATION FOR CONFIDENTIAL COMMUNICATION OF PHI

_____ _____/_____/_____

Patient Name Date of Birth

Protected Health Information (PHI) is considered to be individually identifiable information relating to the past, present, or future health status of an individual.

☐ **I DO NOT authorize the release of my PHI to anyone.**

☐ **I authorize the release of my PHI to the individuals listed below. This could include treatment, diagnosis, billing, release of records, as well as communicating information about scheduling.**

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

☐ **I do not authorize the release of the following specific PHI:**

_____

_____

_____

You may change or revoke this consent at any time by completing a new form or sending us a letter.

_____ _____/_____/_____

Patient /Guardian Signature Date

_____

Relationship, if other than Patient