Reich Dental Center, P.C.

www.reichdentalcenter.com info@reichdentalcenter.com
4849 South Cobb Drive, SE | Suite 111 • Smyrna, GA 30080 (770)435-5450

Please fill out completly prior to your scheduled appointment to ensure we are prepared to provide you with a fun, informative and safe dental experience.

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____* (Last) _____* (First) ____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) **Gender:*** ◯ Male ◯ Female **Family Status:*** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date:* _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____* (Home) _____ (Mobile) _____ (Work) _____ (Ext) _____ (Fax) _____ (Other)

Address: _____* (Address 1) _____* (Address 2)

_____* (City) _____* (State) _____-_____* (Zip Code)

Provide the name, relationship and phone number of your emergency contact. *

How were you referred to Reich Dental Center? *

☐ Another Dental Office ☐ My Insurance Directory ☐ Google Reviews ☐ Internet Search ☐ Newsletter/Mailer
☐ Social Media ☐ Bill Board ☐ Our Location/Sign ☐ School/Work ☐ Other/Friend

Please list the name of the person,office or other source we should thank for referring you to our office. *

List the name of anyone that you would like to give our office permission to discuss your treatment and finances with. You may revoke this consent at any time.

This office abides by all Hippa privacy laws. Upon your request we can provide you a copy of the notice of privacy practices.

Primary Dental Insurance

Name of Insured: _____ _____ ____
Last First MI

Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Secondary Dental Insurance

Name of Insured: _____ _____ ____
Last First MI

Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well-being.

Would you consider yourself to be in fairly good health? ◯ Yes ◯ No

What is the date (or approximate date) of your last medical exam? _____

Your Primary Care Physician's name, address, & phone number: *

_____

_____

Please indicate if you have experienced any of the following:

- ☐ acetaminophen
- ☐ Allergies
- ☐ Alzheimer's
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Aspirin Allergies
- ☐ Aspirin Allergy
- ☐ Asthma
- ☐ Autism
- ☐ Back Problems
- ☐ Bactrim allergy
- ☐ Benadryl
- ☐ Biaxin
- ☐ Blood Disease
- ☐ Blood thinners
- ☐ Cancer
- ☐ cardiac disorder
- ☐ Cephazil
- ☐ Chron's Disease
- ☐ Codeine Allergy
- ☐ Codeine Allergy
- ☐ COPD
- ☐ Coronary Artery Dise
- ☐ Cystic Fibrosis
- ☐ Deaf/hearing loss
- ☐ Dementia
- ☐ Diabetes
- ☐ Difficult Anes
- ☐ Dizziness
- ☐ Emotional disorder
- ☐ Epilepsy
- ☐ Epinephrine Sensitiv
- ☐ Erythromycin allergy
- ☐ Erythromycin Allergy
- ☐ Fainting
- ☐ Fever blisters
- ☐ Fibromyalgia
- ☐ FL2 allergy
- ☐ General Anesthesia
- ☐ GERD
- ☐ Glaucoma
- ☐ Graves' disease
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Headaches
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Heart Valve Replacem
- ☐ Hemophelia
- ☐ Hepatitis
- ☐ Hepatitis C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Hystocytosis
- ☐ Ibuprofen Allergy
- ☐ Jaundice
- ☐ Keflex Allergy
- ☐ Kidney Disease
- ☐ Latex Allergy
- ☐ Levaquin allergy
- ☐ Lidocaine
- ☐ Liver Disease
- ☐ Low blood pressure
- ☐ Lung problems
- ☐ Lupus
- ☐ Mental Disorders
- ☐ MVP
- ☐ Naproxen allergy
- ☐ Nervous Disorders
- ☐ Nickel Allergy
- ☐ nut
- ☐ Osteoporosis
- ☐ Other
- ☐ OTHER
- ☐ Pacemaker or Shunt
- ☐ Pemphigus
- ☐ Peni/Amox Allergy
- ☐ Percocet Allergy
- ☐ Phosomax
- ☐ Prednisone allergy
- ☐ Pregnancy
- ☐ Premedication
- ☐ pulmonary hypertensi
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sciatica
- ☐ sickle cell anemia
- ☐ Sinus Problems
- ☐ Sjogren's syndrome
- ☐ Sleep Apnea
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Substance Abuse
- ☐ Sulfa Allergy
- ☐ Tetracyline Allergy
- ☐ Thyroid Disease
- ☐ Transplant
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ vancomycin
- ☐ Vertigo

Please mark any of the following to indicate Yes in response to the question: *

- ☐ Are you currently under the care of a physician due to a specific condition?
- ☐ Have you been hospitalized within the last 5 years due to a surgery or illness?
- ☐ Are you currently taking any prescription or non-prescription medications?
- ☐ Do you use tobacco (smoking or chewing)?
- ☐ Do you require the use of corrective lenses (contacts or glasses)?
- ☐ Has your medical doctor instructed you to premedicate before dental treatment?

If any of the previous questions are marked, please explain:

Do you have any other health issues or allergies? *

WOMEN ONLY: Are you pregnant? ◯ Yes ◯ No

If Yes, when is the due date? _____

What is the reason for your dental visit today? *

When was your last visit to the dentist (if to a different office)?

Prior Dentist's name, address, & phone number:

Please mark any of the following to indicate Yes in response to the question:

- ☐ Do your gums bleed when you brush or floss?
- ☐ Have you ever had a deep cleaning(scaling and rootplaning)?
- ☐ Do your teeth experience sensitivity to cold or hot temperatures?
- ☐ Are any of your teeth currently causing you pain?
- ☐ Have you ever had a root canal?
- ☐ Have you ever had a tooth extracted?
- ☐ Do you grind your teeth (either consciously or during sleep)?
- ☐ Are any of your teeth loose, or are you concerned about any teeth loosening?
- ☐ Do you currently have any dental implants, dentures, or partials?
- ☐ Have you ever had complications following dental treatment?

If any of the previous questions are marked, please explain:

If you could change anything about your mouth, teeth, or smile, what would it be? *

☐ ***To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next dental appointment without fail.**

Authorization

☐ * **I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.**

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

No Show or Late Cancelation Policy

We at Reich Dental Center understand that sometimes you may need to make changes to your dental appointment and that emergencies occur. If you are unable to keep your appointment please call us as soon as possible or with atleast 24 hours notice. We likely have patients waiting for an appointment and would like to shorten the waiting period for others when possible.

☐ * **I understand that in the event of my first no show or late cancelation appointment I will be issued a warning and Reich Dental Center will assist me in rescheduling my appointment.**

☐ * **I understand that in the event I have a second no show or late cancelation appointment that I will be charged a $50.00 fee before Reich Dental Center will assist me in rescheduling my appointment.**

☐ * **I understand that in the event I have a third no show or late cancelation appointment that I will be charged another $50.00 fee and will be at risk of being dismissed from the practice.**

Financial Policy

☐ * **I undertand that all estimated out of pocket cost and copays are due on or before the date services are rendered.**

☐ * **I understand that any quotes provided by Reich Dental Center is an ESTIMATE ONLY and ultimately any balance not covered by my dental insurance is my responsibility and I will be billed for any remaining balance.**

☐ * **I understand that Reich Dental Center will submit claims to my insurance on my behalf provided I have provided accurate and complete information. I understand that in the event my claim has not been paid by my dental insurance with in 60 days of treatment I am responsible for the balance. I also undertand that if any balance exceeds 90 days it will incrue 1.5% interest per month (18% annually) which I am responsible for.**

☐ * **I understand that in the event that I do not abide by the above financial policy that I will be at risk of being sent to collections and/or small claims court and I will be responsible for all reasonable court and attorney fees.**

Signature of patient, parent, or guardian:

Signature _____ **Date** _____

Relationship to Patient: * _____

Our goal is to dedicate your reserved appointment time to providing you a fun and safe dental experience. Please complete your onboarding process by sending a clear photo of your identification as well as the front and back side of your insurance card to our office's secure contact prior to your appointment. Email : info@reichdentalcenter.com
It is the patients responsibility to have any previous records including current dental xrays provided to our office prior to your appointment. You may have your previous dentist forward any records to info@reichdentalcenter.com
If any information listed is not provided prior to your appointment we require that you check in no later than 20 minutes prior to your scheduled appointment to ensure our staff has the appropriate time to accurately complete all onboarding steps.
In addition you will be sent a link with in 24 hours of your appointment for a covid related screening. This is required for all patients at every appointment.

Response Date: _____