BAIN DENTAL GROUP

429 Mitchell Avenue • Bowdon, GA • 30108
831 Dixie Street • Carrollton, GA • 30117
514 W. Bankhead Hwy • Villa Rica, GA • 30180

We would like to welcome you and your child to our practice!

We are committed to providing exceptional dental care to our patients in a compassionate, professional environment. The following information is provided to introduce you to our practice philosophy and policies.

Appointment Policies

At Bain Dental Group, the high-level of care we provide to all of our patients is very important to us. We make every effort to honor time commitments and we appreciate patients extending us the same courtesy. Patients are reminded of their appointments 2-3 days in advance by email, text, and/or phone. We ask that you give us 48 hours business notice if you are unable to keep your reserved appointment time.

When a patient short cancels or does not show up for their appointment, we have an inadequate amount of time available to try and fill this appointment with another patient who needs dental care. Short cancelled or missed appointments will be charged a $50 broken appointment charge. Repeat cancellations or missed appointments may result in the loss of future appointment privileges.

Our staff will attempt to contact you 48 hours in advance of your scheduled appointment as a helpful reminder. If an appointment is not confirmed by noon the day prior, it may be rescheduled to make room for a patient on our waiting list.

New Patient Appointments

We reserve 60 minutes for each new adult patient visit and 50 minutes for each new child visit. This allows time for us to listen to patient concerns and to properly diagnose and develop appropriate treatment plans.

Your check-in time is 30 minutes prior to your appointment time. This ensures that we have time to make sure your paperwork is in order and that we are able to ask and/or answer any questions that may arise. If you are not able to arrive for your scheduled check-in time, please be aware that this may affect the procedures that we are able to complete during your appointment.

Continuing Care

Our practice is focused on prevention and maintaining optimum oral health. We recommend comprehensive treatment and continuing care on an appropriate recall schedule.

Children and Adolescents

We are happy to see children of any age. We require that parents remain in the office with children under the age of 18 for the entire appointment, unless they have signed a parental release form. Failure to comply may result in the appointment being rescheduled.

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Payments and Insurance

-***<u>No estimate is a guarantee of payment.</u>*** Please understand, you are responsible for all charges not paid by your insurance. While we are in- network with most insurance companies, dental insurance generally does not cover all dental expenses. Dental insurance is designed to help reduce your out-of-pocket dental expenses and there will usually be some sort of out-of-pocket expense that you will be expected to pay at the time of service. Reimbursement levels are determined by your insurance provider and generally do not take into account up-to-date regional data in determining the reimbursement level. Additionally, there is no regulation regarding how insurance companies determine reimbursement and insurance companies are not required to disclose how they determine these levels. Insurance companies do not guarantee payment on claims and reserve the right to make payments based on their estimation of "Usual and Customary Rates."

-Being an in-network provider with your particular dental insurance company means that your treatment fees are based on a fee schedule that is generally lower than our standard rates. So, by going to an in-network dentist, you automatically receive a discount on your dental treatment.

-In addition to being an in-network provider with your dental insurance company, we will also file your insurance claims, track your claims, follow-up on delayed claims, and help deal with insurance family plans. We want to help you maximize your benefits and will provide digital dental X-rays and

a written diagnostic report should your insurance company have any questions about the services provided. We submit claims electronically, allowing for faster and more secure data transmission.

-Please provide our staff with your insurance information so that we can take over the hassle of dealing with the insurance companies. Also, make sure to bring your identification card and your insurance card to the office when you come in for your visit.

-Workers Compensation claims will be filed for you. Please understand the carrier will assign a dollar amount that will be paid towards the claim, which may or may not cover the entire fee. Any amount not covered by the carrier, will be your responsibility.

-Minors must be accompanied by a parent or legal guardian. If the parents are separated or divorced, the person accompanying the minor will be responsible for copayment at the time of service.

Payment for treatment is due and payable the day services are rendered. It is our goal, however, to assist all of our patients in obtaining the dental treatment they deserve. As a result, we offer several payment options, including cash, check, credit card, and third party financing. For patients with dental insurance, we will file the appropriate claim forms.

Reservation Fee

Due to the extensive amount of time our staff and doctors devote to preparing and reserving uninterrupted time for your appointment, we require a reservation deposit of $50 per hour. If you cancel with less than 48 hours notice or no show for the reserved appointment, this deposit amount will be charged as a missed appointment fee. When you arrive to your reserved appointment, however, this deposit amount will be used as a credit toward your treatment cost.

I have read, understand, and agree with the above written office policies.

Signature: _____ Date: _____

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Patient Information

Name: _____ Preferred Name: _____

Home Address: _____ City: _____ State _____ Zip: _____

Home #: _____ Work #: _____ Mobile #: _____

Email: _____

Sex: M / F Birth Date: ___ /___ /_____ SS#:_____

Family Status (circle): Single Married Divorced Child Spouse's Name: _____

How did you first hear about our office? (circle one):

Another patient*	Another Dental Office	Brochure	Online Search
Facebook	Work	School	Insurance Website
Sign –Drive by	Walk in	Other:_____	

*If you were referred by a patient, please write their name so we can enter them into our referral drawing!

_____

Person Responsible for Account

Name of responsible party: _____

Relationship to patient (Circle): Self Spouse Parent Other: _____

Home Address: _____ City: _____ State: _____Zip: _____

Home #: _____Work #: _____ Mobile #: _____

Email: _____

Birth Date: ___ /___ /_____ SS#:_____

Contact Information

What is the best way to communicate with you? Home Phone / Mobile Phone/ Text / Email

In the event of an emergency, whom should we contact? Name _____

Relationship_____ Home #: _____ Work #: _____ Mobile #: _____

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Insurance Information (Primary)

Name of Insured: _____ Relationship to patient: _____

Insured Birth Date: ___ /___ /_____

Insurance Plan Name: _____ Insurance Co Phone #: _____

Claims Address _____

City, State, Zip _____

Group #: _____ ID #: _____

Insurance Information (Secondary)

Name of Insured: _____ Relationship to patient: _____

Insured Birth Date: ___ /___ /_____

Insurance Plan Name: _____ Insurance Co Phone #:_____

Claims Address _____

City, State, Zip _____

Group #: _____ ID #: _____

Employment Information

Employer Name: _____ Phone: _____

Address: _____

City, State, Zip: _____

Cancellations and Missed Appointments

We require 48 hours advance notice of a cancellation. Patients who do not provide 48 hours notice of a cancellation or who do not present for a scheduled appointment may be charged a fee. Patients who fail to present for a second appointment may be charged a fee or dismissed from the practice. After the first missed appointment, a letter will be mailed reiterating our policy and reminding the patient of the risk of dismissal should another appointment be missed.

Patient Signature_____Date_____

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Child's Dental/Medical History

Patient Name _____ **Date of Birth** _____

Dental History

What is the reason for today's visit? _____
Is this the child's first visit to a dentist? ☐ Yes ☐ No If no, when was the last dental visit?_____
Former dentist, if any? _____ _____ Phone _____
Has the child ever had any dental X-rays? ☐ Yes ☐ No
Has your child ever had any injuries to the mouth, head or teeth? _____
Has your child ever had any problem with dental treatment in the past? _____
Has your child ever had any orthodontic treatment? _____
What type of water does your child drink? ☐ City water ☐ Well water ☐ Bottled water ☐ Filtered water
Has your child ever received fluoride supplements? ☐ Yes ☐ No If yes, what age? _____
How many times are the child's teeth brushed per day? _____ When? _____
Has the child sucked his or her thumb, fingers, or pacifier? ☐ Yes ☐No Does the habit still exist? _____
Does the child grind his or her teeth? ☐ Yes ☐ No

Medical History

1.) Is your child taking any prescription and/ or over the counter medications? ☐ No ☐ Yes
If yes, please list _____
2.) Is your child allergic to any medications? ☐ No ☐ Yes
If yes, please list _____
3.) Is your child allergic to any foods or materials? ☐ No ☐ Yes
If yes, please list _____
4.) Has your child been hospitalized? ☐ No ☐ Yes
When? _____ Reason? _____

Has your child had any history or ever been diagnosed with any of the following:

☐ Anemia
☐ Allergy/ Hay Fever
☐ Artificial heart valve
☐ Artificial joint/ limb
☐ Asthma
☐ Attention Deficit Disorder
☐ Autism
☐ Behavior/ learning disabilities
☐ Epilepsy/ seizure
☐ Birth defects
☐ Bleeding Disorder
☐ Bone/ joint/ orthopedic problem
☐ Brain injury
☐ Cancer, type _____
☐ Cerebral Palsy
☐ Chemotherapy
☐ Chicken Pox
☐ Chronic sinusitis
☐ Cleft lip/ palate
☐ Diabetes
☐ Digestive disturbances
☐ Eye problems
☐ Fainting
☐ Growth problem
☐ Hearing loss/ aids
☐ Heart murmur
☐ Heart problem
☐ Heart surgery
☐ Hepatitis
☐ HIV+ / AIDS
☐ Hormonal disturbances
☐ Kidney problems
☐ Liver problems
☐ Measles
☐ Mumps
☐ Nervous disorders
☐ Pneumonia
☐ Rheumatic Fever
☐ Scarlet Fever
☐ Shunt
☐ Sickle cell anemia
☐ Tetanus
☐ Tuberculosis
☐ Other:
_____
_____

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Pediatrician/ Physician Name _____ **Phone** _____

I understand that the above information will be used for my child's dental health. I have answered the questions to the best of my ability. If further information is needed you may contact my child's health care physician for any other information.

Parent Signature_____ **Date**_____

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Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____

State and federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with a Notice of Privacy Practices. Our Notice is available online. If you prefer a paper copy, please ask a team member for a copy of our Notice.

I acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

_____

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 the acknowledgement
- ☐ Other (Please Specify)

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Authorization for Release of Information to Family and/or Friends

Name of Patient_____ Date of Birth_____

Bain Dental Group is authorized to discuss my dental care and may release my confidential health information to the following:

NAME	RELATIONSHIP TO PATIENT

Rights of the Patient

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to **Bain Dental Group 831 Dixie Street Carrollton, GA 30117** I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing this authorization.

This authorization shall be in force and effective until revoked by the patient or representative signing the authorization.

Signature of Patient or Personal Representative _____ Date_____

_____Description of Personal Representative's Authority (attach necessary documentation)