

**PATIENT INFORMATION**

Name: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(Last) (First) (MI) (Preferred Name)  
Age: \_\_\_\_\_ Gender:  Male  Female Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_  
Home Phone #: \_\_\_\_\_ Cell: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Email: \_\_\_\_\_  
Marital Status:  Married  Single  Divorced  Widow  Widower  Domestic Partner  
Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(First & Last Name) (Relation) (Phone Number)  
Who may we thank for sending you to our office? \_\_\_\_\_  
What is the reason for your appointment? \_\_\_\_\_

**SPOUSE OR RESPONSIBLE PARTY INFORMATION**

The following is for:  Patient's spouse  Person responsible for payment  
First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
 Male  Female  Married  Single  Child  Other: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Phone (Home): \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_ Best time to call: \_\_\_\_\_  
Address: \_\_\_\_\_ / \_\_\_\_\_  
(Street) (Apt. #)  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

**INSURANCE INFORMATION**

Name of insured: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Is insured a patient?  Yes  No  
(Last) (First) (MI)  
Insured's Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security #: \_\_\_\_\_ ID #: \_\_\_\_\_  
Insurance Plan Name: \_\_\_\_\_ Group #: \_\_\_\_\_  
Insured's Employer Name: \_\_\_\_\_  
Patient's relationship to insured:  Self  Spouse  Child  Other: \_\_\_\_\_

**ASSIGNMENT OF INSURANCE BENEFITS AND RELEASE OF INFORMATION**

I, the undersigned, certify that I (or my dependants) have dental insurance coverage with \_\_\_\_\_  
(Name of Insurance Company)

And assign directly to Dr. Charles R. Fana, Jr, DMD PC / Compass Dental LLC all 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance whether manual or electronic.

**Responsible Party Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

## 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 important interrelationship with the dentistry you will receive.*

**Do you have, or have you had, any of the following? (Check all that apply)**

|   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> Aids/HIV Positive<br><input type="checkbox"/> Alzheimer's Disease<br><input type="checkbox"/> Anaphylaxis<br><input type="checkbox"/> Anemia<br><input type="checkbox"/> Angina<br><input type="checkbox"/> Arthritis/ Gout<br><input type="checkbox"/> Artificial Heart Valve<br><input type="checkbox"/> Artificial Joint<br><input type="checkbox"/> Asthma<br><input type="checkbox"/> Blood Disease<br><input type="checkbox"/> Blood Transfusion<br><input type="checkbox"/> Breathing Problem<br><input type="checkbox"/> Bruise Easily<br><input type="checkbox"/> Cancer<br><input type="checkbox"/> Chemotherapy<br><input type="checkbox"/> Chest Pains<br><input type="checkbox"/> Cold Sores/Fever Blisters<br><input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Cortisone Medicine<br><input type="checkbox"/> Convulsions<br><input type="checkbox"/> Diabetes<br><input type="checkbox"/> Drug Addiction<br><input type="checkbox"/> Easily Winded<br><input type="checkbox"/> Emphysema<br><input type="checkbox"/> Epilepsy or Seizures<br><input type="checkbox"/> Excessive Bleeding<br><input type="checkbox"/> Fainting spells/ Dizziness<br><input type="checkbox"/> Frequent Cough<br><input type="checkbox"/> Frequent Diarrhea<br><input type="checkbox"/> Frequent Headaches<br><input type="checkbox"/> Glaucoma<br><input type="checkbox"/> Heart Attack/ Failure<br><input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Heart Pace Maker<br><input type="checkbox"/> Heart Trouble<br><input type="checkbox"/> Hemophilia<br><input type="checkbox"/> Hepatitis A<br><input type="checkbox"/> Hepatitis B or C<br><input type="checkbox"/> Herpes<br><input type="checkbox"/> High Blood Pressure<br><input type="checkbox"/> Hives or Rash<br><input type="checkbox"/> Hypoglycemia<br><input type="checkbox"/> Irregular Heartbeat<br><input type="checkbox"/> Kidney Problems<br><input type="checkbox"/> Leukemia<br><input type="checkbox"/> Liver Disease<br><input type="checkbox"/> Lung Disease<br><input type="checkbox"/> Mitral Valve Prolapse<br><input type="checkbox"/> Psychiatric Care<br><input type="checkbox"/> Radiation Treatments | <input type="checkbox"/> Recent Weight Loss<br><input type="checkbox"/> Renal Dialysis<br><input type="checkbox"/> Rheumatic Fever<br><input type="checkbox"/> Rheumatism<br><input type="checkbox"/> Scarlet Fever<br><input type="checkbox"/> Seasonal Allergies<br><input type="checkbox"/> Shingles<br><input type="checkbox"/> Sickle Cell Disease<br><input type="checkbox"/> Sinus issues<br><input type="checkbox"/> Stomach/ Intestinal Disease<br><input type="checkbox"/> Stroke<br><input type="checkbox"/> Swelling of Limbs<br><input type="checkbox"/> Thyroid Disease<br><input type="checkbox"/> Tuberculosis<br><input type="checkbox"/> Tumors or Growths<br><input type="checkbox"/> Ulcers<br><input type="checkbox"/> Venereal Disease |
|---|--|---|--|

**Women: are you... (circle those that apply)**

Pregnant/ Trying to get pregnant? **Yes / No**

Taking birth control? **Yes / No**

Nursing? **Yes / No**

**Are you allergic to any of the following? (check those that apply)**

Aspirin     Penicillin     Codeine     Acrylic     Metal     Latex     Local Anesthetics  
 Other    If yes, please explain: \_\_\_\_\_

Are you under a physician's care now?..... **Yes**    **No**

\* If yes, please explain: \_\_\_\_\_

Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Have you been hospitalized or had a major operation?..... **Yes**    **No**

\*If yes, please explain: \_\_\_\_\_

Have you ever had a serious head or neck injury?..... **Yes**    **No**

\*If yes, please explain: \_\_\_\_\_

Do you take, or have you taken, Bisphosphonates (medication for bone health)? ..... **Yes**    **No**

Do you use controlled substances?..... **Yes**    **No**

Do you use tobacco?..... **Yes**    **No**

Are you taking any medications, pills, or drugs? ..... **Yes**    **No**

\*If yes, please list: \_\_\_\_\_

Have you ever had any serious illness not listed above?..... **Yes**    **No**

\*If yes, please explain: \_\_\_\_\_

Additional Comments: \_\_\_\_\_

**Dental Health Information**

Are you having any discomfort at this time? Explain: \_\_\_\_\_

Have you ever had any serious complications associated with previous dental procedures? **Yes or No**

If Yes, Explain: \_\_\_\_\_

Does dental treatment make you nervous? (Circle) **No Slightly Moderately Extremely**

Have you ever been treated for periodontal disease (gum disease, pyorrhea, or trench mouth)? **Yes or No**

\*If so, when? \_\_\_\_\_

How often do you brush? \_\_\_\_\_

What texture is your brush? (Circle) **Soft Medium Hard**

Do you have, or have you ever had any of the following? (Please check all that apply):

- |   |  |
|---|--|
| <input type="checkbox"/> Bleeding, sore gums              | <input type="checkbox"/> Sensitivity to biting             |
| <input type="checkbox"/> Unpleasant taste/bad breath      | <input type="checkbox"/> Shifting in bite                  |
| <input type="checkbox"/> Burning tongue/lips              | <input type="checkbox"/> Clenching/grinding; O Day O Night |
| <input type="checkbox"/> Frequent blisters, lips or mouth | <input type="checkbox"/> Swelling/lumps in mouth           |
| <input type="checkbox"/> Loose teeth                      | <input type="checkbox"/> Biting of cheeks/lips             |
| <input type="checkbox"/> Sensitivity to heat              | <input type="checkbox"/> Clicking/popping jaw              |
| <input type="checkbox"/> Sensitivity to cold              | <input type="checkbox"/> Difficulty opening or closing jaw |
| <input type="checkbox"/> Sensitivity to sweets            | <input type="checkbox"/> Food impaction                    |

Are you happy with your smile and the appearance of your teeth in general (Color, Shape, Spaces)? **Yes or No**

\*If "No", why not? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**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 my medical status.**

\_\_\_\_\_  
**SIGNATURE OF PATIENT, PARENT, or GUARDIAN**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**SIGNATURE OF DENTIST**

\_\_\_\_\_  
**Date**

**NOTES:**

## **Cancelled and Broken Appointment Policy**

Patients who fail to keep their scheduled appointments without adequate notice do cause problems for both the office, as well as other patients. We are better able to schedule you promptly and in your desired time frame if we know sufficiently in advance that you need to reschedule an appointment.

We strive to schedule patients one at a time to ensure the personal attention that you deserve. We make every effort possible to remind all patients of their scheduled appointments. Please understand that this is a courtesy. **DO NOT DEPEND ON THIS.** If we are unable to reach you, your appointment card will serve as your confirmation of the appointment and implies your obligation to be present.

In an effort to establish daily schedules that are efficient as well as considerate of your time and ours, we have adopted the following policy regarding broken and late cancelled appointments:

1. A late cancellation is defined as any scheduled appointment that a patient cancels without giving at least 48 hours advanced notice.
2. A broken appointment is any appointment which a patient fails to keep or arrives late.
3. Two late cancellations may result in a charge to the patient and/or legal guardian, not covered by an insurance plan.
4. One broken appointment will NOT incur a charge, however the second one and each one after will incur a fifty dollar charge for hygiene and/or one hundred per hour for Dr. Fana's time.
5. Multiple late cancellations and/or broken appointments may result in your ineligibility for future care in our office and may require a nonrefundable deposit when making an appointment.

**Insurance is not responsible and will not pay for broken appointments.**

We realize that circumstances sometimes arise on short notice which may result in the necessity to cancel an appointment. When such circumstances occur, we will exercise discretion in the decision to charge a fee. It is our sincere desire to be considerate of your time, and as we make every effort to do so, we hope that our patients will also be considerate of our desire to predictably serve our patients with the time available to us.

Thank you for your consideration and cooperation.

**Name of patient (print):** \_\_\_\_\_

**Signature of patient or guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## OUR OFFICE AND FINANCIAL POLICIES

Thank you for choosing Charles R. Fana, Jr., DMD PC/Compass Dental, LLC as your dental health provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. If you have any questions, please feel free to ask any staff member for more information.

### APPOINTMENTS

Your appointments are scheduled to respect your time. We reserve a significant amount of time and reserve a specific room for your care, and make every effort to see you at the appointed time. We appreciate your promptness and consideration in not changing your reserved time. However, if you must change an appointment, a **48-hour** notice is expected. A fee will be applied for appointments missed or arriving more than 15 minutes late without notice. Arrangements must be made in advance if a minor (under age 18) is to be seen without an adult present. (Initial) \_\_\_\_\_ ←

### INSURANCE

As a courtesy to you, we accept assignment of insurance benefits from most insurance companies. However, ***we do require you to pay your deductible and/or "estimated patient portion" at the time of service.*** The balance is your responsibility whether your insurance pays or not. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Patients who carry dental insurance should remember that all dental services performed are charged directly to the patient and not the insurance company. If you have dental insurance, you must provide us with your dental insurance card and a claim form if needed. We must be able to verify coverage before we can accept assignment of benefits. If requested, a dental preestimate can be submitted to your insurance company for review. This will allow you to know the estimated amount that the insurance company will pay. However, this office cannot render services on the assumption that our charges will be paid by an insurance company. Patient or responsible party needs to pay in full for claims not paid after 45 days.

*I understand that I am responsible for reading and understanding my dental insurance benefits. I am also responsible for notifying this office of any insurance plan or policy changes.* (Initial) \_\_\_\_\_ ←

### USUAL AND CUSTOMARY RATES

Please be aware that some of our services may be "non-covered", subject to an insurance company's arbitrary determination of usual and customary rates, or have time limitations imposed by the insurance company. Our fees reflect what is usual and customary for our area, as well as the quality of treatment that you receive. The adult accompanying a minor is responsible for full payment.

*I understand that I am responsible for any balance left unpaid by my insurance company.* (Initial) \_\_\_\_\_ ←

### PAYMENT OPTIONS AND ACCOUNT INFORMATION

In order to maintain our fees at a reasonable level, we do not send monthly statements. If a balance is over 30 days, a billing fee will be charged at the rate of 1.5% per month of the total balance, or \$7.00, whichever is greater. In the event we receive a returned check for insufficient funds or a closed account, there will be a \$35.00 fee charged to your account. If any delinquent account is turned over to a third party collection agency for non-payment, there will be a collection fee of 30% added to the bill. This is pursuant to Georgia Statutory Law "O.C.G.A. -13-1.11"

### PHOTOGRAPHY RELEASE

I am giving permission for Charles R. Fana, Jr., DMD PC/Compass Dental, LLC to use any intra-oral, pre-op or post-op photos taken of my oral cavity for patient education and advertising. I understand that the pictures will be of the mouth and teeth only and that no facial photos will be used. (Initial) \_\_\_\_\_ ←

- ❖ PAYMENT IN FULL IS DUE AT TIME OF SERVICE
  - ❖ WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, DISCOVER, & AMERICAN EXPRESS
  - ❖ WE ALSO OFFER AN EXTENDED PAYMENT PLAN THROUGH CARE CREDIT (upon approval)
- If you wish to utilize this option, please ask the front desk for an application.**

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**THANK you FOR UNDERSTANDING OUR GUIDELINES. PLEASE LET US KNOW IF YOU'VE ANY QUESTIONS OR CONCERNS**

*I have read, understand, and agree to the above office and financial policies.*

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Signature of patient or responsible party \_\_\_\_\_

Date \_\_\_\_\_

Staff \_\_\_\_\_

**CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION**

**Purpose of consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

**Notice of Privacy Practices:** You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our notice provides a description of your treatment, payment activities, healthcare operations, the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. We encourage you read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

**Revoke:** You will have the right to revoke this consent at any time by giving us a written notice of your revocation. Please understand that revocation of this Consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

**Emailing X-rays:** In providing the best treatment for our patient, it might be necessary for us to email x-rays to other specialists or dentists. This allows other offices to have a better diagnostic tool available to them and to have access for quicker service.

**Allowing for Discussion of Information:** If you would like us to discuss your personal health information with another individual, please select with who and what information we may discuss.

Spouse       Family Member       Friend       Other

Please provide us with their name(s): \_\_\_\_\_  
\_\_\_\_\_

Information to be disclosed: (please check all that apply)

- Appointment dates and times
- Treatment plans and referrals
- Financial and billing information
- Any other pertinent dental health information related to treatment at this office

I, \_\_\_\_\_ have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I do hereby grant permission for Charles R. Fana, Jr., DMD P.C./Compass Dental, LLC to disclose my personal health information to carry out treatment, payment activities, and health care operations. This permission will remain in effect unless written cancellation has been provided.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

Staff \_\_\_\_\_

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## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

"You May Refuse to Sign This Acknowledgement"

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

\_\_\_\_\_  
Please print name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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**For Office Use Only**

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

- The individual refused to sign.
- Communications barriers prohibited obtaining the acknowledgement.
- An emergency prevented us from obtaining acknowledgement.
- Other (Please Specify)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_