Winterville Dental, LLC

Phillip H. Durden, DMD, MAGD, FAACP Brandon W. Whitworth, DMD Chase M. Wootton, DMD

We would like to get to know you better!

Name: _____Preferred Name:_____

Male Female Date of Birth:_____ Age: _____Today's Date: _____

Address: _____SS #: _____

Home Phone:_____ Work Phone:_____ Cell Phone: _____

Occupation:_____ Employer: _____

Employer Address:_____

Spouse's Name: _____Date of Birth:_____

Spouse's Occupation: _____Spouse's Employer: _____

Employer Address:_____Employer Phone: _____

Who referred you to our office? _____

Person Responsible for Dental Investment: _____

Emergency Contact: _____ Phone:_____

Insurance Information:

Name of Insured: _____Insured SS#:_____Birthdate: _____

Name of Carrier: _____ Group#: _____

Carrier ID: _____

Other Coverage:

Name of Insured: _____Insured SS#:_____Birthdate: _____

Name of Carrier: _____ Group#: _____

Carrier ID: _____

104 Moores Grove Road • Winterville, Georgia 30683

Phone 706.742.7000 • Fax 706.742.2145 • www.wintervilledental.com

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Tell us about your Health

Are your teeth sensitive to:

- Heat? Y N
- Cold? Y N
- Sweets? Y N
- Biting Pressure? Y N

Does food catch between your teeth? Y N

Do your gums bleed when brushing? Y N

Have you noticed any gum swelling around any teeth? Y N

Do you have an unpleasant taste or odor in your mouth? Y N

Any difficulty opening or closing your mouth? Y N

Do you avoid any part of the mouth while brushing? Y N

Do you have difficulty chewing? Y N

Do you have any dental fears? Y N

_____

Last Dental Appointment:_____

Are you dissatisfied with your teeth and their appearance? Y N

Are you concerned about the finances required to return your teeth to health? Y N

Do you get frustrated because you always have something to be treated/repaired when you visit the dentist? Y N

Have you ever had any extractions? Y N

- If yes, how long have the teeth been missing? _____

Do you feel you will eventually wear dentures? Y N

Are you currently under a physician's care? Y N

Name: _____

Address: _____

_____

Phone:_____

Problems of the Jaw:

- Clicking of the jaw? Y N
- Pain (joint, ear, side of face)? Y N
- Headaches? Y N
- Clenching/Grinding? Y N

Do you snore? Y N

Are you sleeping well at night? Y N

Do you fall asleep easily and/or sometimes inappropriately? Y N

Do you feel tired or groggy on awakening? Y N

Have you ever been diagnosed with Obstructive Sleep Apnea? Y N

- If so, how are you being treated?

_____

Are you currently using a sleep appliance? Y N

General Health Problems: _____

_____

_____

Surgery: _____

_____

_____

Are you taking or have you ever taken an osteoporosis medication (such as Actonel, Boniva or Fosamax)? Y N

_____

Do you smoke or vape? Y N

Have you had any joints replaced? Y N

If yes, please specify:

_____

Have you ever had a reaction to a local anesthetic? Y N

Are you allergic to Penicillin? Y N

Are you allergic to Sulfa? Y N

Are you allergic to any other antibiotic? Y N

Are you allergic to Aspirin? Y N

Are you allergic to any other drugs? Y N

_____

Are you allergic to latex? Y N

Are you allergic to metals? Y N

Are you allergic to sedatives? Y N

Do you have any other allergies? Y N

_____

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Have you ever been afflicted with any of the following:

Heart Ailment?	Y	N
Diabetes?	Y	N
Rheumatic Fever?	Y	N
Epilepsy?	Y	N
High Blood Pressure?	Y	N
Respiratory Disease?	Y	N
Hepatitis?	Y	N
HIV Positive?	Y	N
Prolonged Bleeding?	Y	N
Healing Complications?	Y	N

Do you take blood thinners? Y N
(If yes, please list below)

_____

_____

_____

Women Only:
Are you pregnant or trying to become pregnant? Y N
Are you taking oral contraceptives? Y N

Why did you leave your last dentist?_____

_____

_____

What is your present dental problem?_____

_____

_____

If we may contact you by e-mail please provide us with your address _____

May we confirm your appointments with text messaging? Y or N

I certify that the above information and the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my dependent during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____Date: _____

Signature of patient (or parent/guardian if minor or dependent)

Express prior consent to contact consumer by cell phone:
You agree, in order for us to service your account or to collect monies you may owe,
Winterville Dental, LLC and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

I/We have read this disclosure and agree that Winterville Dental, LLC, its employees and /or agents may contact me/us as described above.

_____Date: _____

Signature of patient (or parent/guardian if minor or dependent)

_____Date: _____

Signature of dentist

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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/Supplement	When I take it	Dose	Other Instructions

☐ I have no medications to list at this time.

_____Date: _____

Signature of patient (or parent/guardian if minor or dependent)

WINTERVILLE DENTAL, LLC

PHILLIP H. DURDEN, DMD, MAGD, FAACP BRANDON W. WHITWORTH, DMD CHASE M. WOOTTON, DMD

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name:_____

Address:_____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number: _____

SECTION B: TO THE PATIENT-PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

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 our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to 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.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Sarah Strickland

Telephone: (706) 742-7000

Address: 104 Moores Grove Road, Winterville, Georgia 30683

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. 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.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

☐ By checking this box, you provide express written consent to contact you via SMS / text message. Standard messaging and data rates apply. Text STOP to opt-out at any time.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

I authorize the following for reminders of my appointments:

☐ Open Correspondence

☐ Messages at work Wk# _____

☐ Messages on Cell Cell# _____

☐ Text Messages Cell# _____

☐ Messages at home Hm# _____

☐ Email Email _____

☐ Postcard Address _____

☐ Other _____

I authorize the following person(s) to whom my medical and dental information may be released:

_____	_____	_____
Name	Relationship	Contact#
_____	_____	_____
Name	Relationship	Contact#
_____	_____	_____
Name	Relationship	Contact#

X_____ _____

Signature of Patient/Guardian Date

Photography Agreement

Dear Patient:

Dr. Durden, Dr. Whitworth and Dr. Wootton often take photographs for the purposes of case documentation, laboratory communication, continuing education lectures, PowerPoint slide presentations, in-office communication, and for various dental and/or other articles or publications.

I hereby grant permission for the use of any and all photography and x-rays of (patient name/or minor child) _____ to Winterville Dental, LLC for the purposes stated above. I also acknowledge that this is done voluntarily and without compensation.

X_____ _____

Signature of Patient/Guardian Date