French Smiles

Patient's Name

Health History

Medical Alerts:

Have you been under the care of a medical doctor in the past 2 years? Yes No

Physician's Name:

Medications, Supplements, Herbal Medicines, Aspirin - *please list here or give us a list to copy for your chart :*

Do you have any allergic or adverse reaction to any medication or substance? **YES** **NO**

Allergic to any of these?											
Aspirin	Y	N	Local Anesthetic	Y	N	Penicillin	Y	N	Latex	Y	N
Codeine	Y	N	Acrylic	Y	N	Sulfa Drugs	Y	N			

Any allergies not noted above:

Have you been in the hospital in the past 5 years? **Yes** **No**

Please indicate which of the following you have had or have at present:

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

Do you have or have you had any disease, condition, or problem not listed? **Yes** **No**

If yes, please list:

Do you wear a CPAP to sleep or been diagnosed with sleep apnea? **Yes** **No**

Women: Are you pregnant or think you might be pregnant? Y N Months _____ Nursing? Y N

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notifiy the dentist of any changes in my health or medication.

Patient/Guardian Signature _____ **Date** _____

Dentist Signature _____ **Date** _____

French Smiles

PATIENT REGISTRATION

IF THIS APPOINTMENT IS FOR YOU, START HERE

IF THIS APPOINTMENT IS FOR YOUR CHILD, START HERE

1

DATE

LAST NAME | FIRST | MI

PREFERS TO BE CALLED BY

ADDRESS

CITY | STATE | ZIP

HOME PHONE NO. | FAX

CELL | EMAIL

BIRTHDATE | AGE | MALE | FEMALE

MARRIED | SINGLE | DIVORCED | WIDOWED

SOCIAL SECURITY NUMBER

DATE

LAST NAME | FIRST | MI

ADDRESS

CITY | STATE | ZIP

HOME PHONE NO.

BIRTHDATE | AGE | MALE | FEMALE

SCHOOL | GRADE

SOCIAL SECURITY NUMBER

IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO.

2 DENTAL INSURANCE

PRIMARY CARRIER

INSURANCE COMPANY

GROUP NO.

EMPLOYER NAME

INSURED'S NAME

DATE OF BIRTH | RELATIONSHIP TO PATIENT

INSURED'S I.D. NO.

INSURED'S SOCIAL SECURITY NO.

SECONDARY CARRIER

INSURANCE COMPANY

GROUP NO.

EMPLOYER NAME

INSURED'S NAME

DATE OF BIRTH | RELATIONSHIP TO PATIENT

INSURED'S I.D. NO.

INSURED'S SOCIAL SECURITY NO.

3 GETTING TO KNOW YOU

IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?

NAME: | RELATIONSHIP:

YOU WERE REFERRED TO US BY

YOUR FORMER ADDRESS

CITY | STATE | ZIP

PERSON TO CONTACT FOR EMERGENCY

PHONE NUMBER

ADDRESS

CITY | STATE | ZIP

CLOSEST RELATIVE NOT LIVING WITH YOU

PHONE NUMBER

ADDRESS

CITY | STATE | ZIP

4 ACCOUNT INFORMATION

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

NAME

RELATIONSHIP TO PATIENT | SOCIAL SECURITY NO.

ADDRESS

CITY | STATE | ZIP

PHONE NO.

YOU

NAME

OCCUPATION

EMPLOYER'S NAME

ADDRESS | CITY

PHONE NO. | FAX NO.

YOUR SPOUSE

NAME

OCCUPATION

EMPLOYER'S NAME

ADDRESS | CITY

PHONE NO. | FAX NO.

French Smiles

CONSENT FOR TREATMENT

1. I authorize Dr. French & designated staff to take x-rays, study models, pictures and other diagnostic information deemed appropriate by doctor to make a thorough diagnosis of _____ dental needs.

2. I authorize Dr. French to perform all recommended treatment ***mutually agreed upon by me*** and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication as necessary for my care. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete discussion of any possible complications involved.

4. I give consent to Dr. French and/or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. Insurance is only an estimate, not a guarantee and ultimately I am the responsible party for payment. I understand that payment is due at the time of service unless other arrangements have been made.

Patient's Signature _____ Date _____

Parent/Responsible Party's Signature _____

Relationship to Patient _____ Office _____

French Smiles

HIPAA FORM – HHS.gov

Robert French, DDS, PC - Notice of Privacy Practices – We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect January 1, 2019, and will remain in effect until we replace it. -- We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request. -- You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice. HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records. -- Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you. -- Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information. - Required by Law. We may use or disclose your health information when we are required to do so by law. ---- Your Health Information Rights Access. ---- You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. -- Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law. -- Questions and Complaints: If you want more information about our privacy practices or have questions or concerns, please contact us. -- If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. -- We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services. Our Privacy Official: Sue D. Telephone: 770-985-2437 Fax: 770-817-2400, Address: 2381 Main Street East, Suite B, Snellville, GA 30078, E-mail: sue@frenchsmiles.com or patientcare@frenchsmiles.com.

I acknowledge that a copy of this office's Notice of Privacy Practices is available to me, as stated above.

Patient's Name (please print): _____ Signature: _____

Guardian/Parent's Name: _____ Signature: _____

Today's Date: _____

You may share my information relating to my dental care at French Smiles with the following:

Name _____ Relationship _____

Name _____ Relationship _____

Patient Initial/Signature _____

I give permission to send my dental care information to voicemail, text messages, and/or email _____ (initial/sign)

Best Phone # _____

Best email _____

If you would like your previous dental office to send your x-rays to us for your file, you may use this form to request them.

X-rayGuidelines:

Panorex or 'Pan' – 5 years or less

Full Mouth Series or "FMX" – 5 years or less

Bitewing Checkup X-rays – 1 year or less

Records Release Authorization

Patient's Name _____

Date of Birth _____

This is an authorization to provide copies of my and/or my dependents to provide copies of my and/or my dependent's dental records to French Smiles, Robert French DDS, PC .

Please email them to: patientcare@frenchsmiles.com

***** Please be sure to also include the dates that the x-rays were taken at your office, thank you!*

_____ (Signature of patient or guardian)

_____ Date

Robert French, DDS, PC
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