PATIENT REGISTRATION FORM

(This information is necessary for our files and your health and will be considered **CONFIDENTIAL**)

Last Name _____ First _____ Mi _____ M F

I prefer to be called: _____ Birthday: ___/___/___ Age: _____ Single Married Divorced

Social Security #: _____ Drivers License#: _____ Widowed Separated

Home Address: _____
Street City State Zip

Home Phone #: ( ) _____ Work Phone #: ( ) _____ Ext.: _____ Cell #: _____

Whom may we Thank for referring you? _____

Patient's Employer: _____ Occupation: _____

Employer's Address: _____
Street City State Zip

If patient is a student-Name of school: _____

Neighbor or Relative not living with you

His/Her Name: _____ Relation: _____ Home Phone #.: ( ) _____

Address: _____ _____ _____ _____ Work Phone #.: ( ) _____
Street City State Zip

Person Responsible for Account if other than Yourself

Name: _____ Relation: _____ Home Phone #.: ( ) _____

Employer: _____ Work Phone #: _____ Ext.: _____ Driver's License #: _____

Billing Address: _____ _____ _____ _____
Street City State Zip

Spouse/Parent Information

Name: _____ Birthday: ___/___/___ Social Security #.: _____

Employer: _____ Work Phone #: ( ) _____ Ext.: _____ Driver's License #: _____

Dental Insurance Information

Primary Insurance

Insurance Co. Name: _____ Phone #: ( ) _____ Group#: _____

Insurance Co. Address: _____ _____ _____ _____
Street City State Zip

Insureds' Name: _____ SS#: _____ Insureds' Birthday.: ___/___/___ Relation: _____

Insureds' Employer: _____ Employer Address: _____ _____ _____ _____
Street City State Zip

Secondary Insurance

Insurance Co. Name: _____ Phone #: ( ) _____ Group#: _____

Insurance Co. Address: _____ _____ _____ _____
Street City State Zip

Insured's Name: _____ SS#: _____ Insured's Birthday.: ___/___/___ Relation: _____

Insured's Employer: _____ Employer Address: _____ _____ _____ _____
Street City State Zip

PATIENT RESPONSIBLE FOR FEES: I understand that responsibility for payment for Dental Services provided in this office for myself or my dependent is mine. Unless prior special arrangements are made, accounts are to be paid within 30 days of the date on which examinations are provided. I hereby authorize that the payment from any insurance company due me be paid directly to the working practice In the event of default in payment patient or party responsible for fees agree to pay any and all costs of suit, collection and attorney's fees.

By signing below I consent to the dental treatment provided by this practice. The information provided is accurate to the best of my knowledge.

Signature - Patient or Responsible Party _____ Date _____

HEALTH QUESTIONNAIRE

MEDICAL HISTORY

Name of Physician_____ Phone: _____

Your current physical health is: GOOD FAIR POOR

Are you currently under the care of a physician? Y N Please explain: _____

Are you taking any prescription/over the counter drug(s)? Y N Please explain: _____

Please list each one: _____

Have you ever had any serious illness or operation? Y N Please explain:_____

DO YOU HAVE TO BE PREMEDICATED BEFORE DENTAL TREATMENT? Y N **HAVE YOU EVER TAKEN PHEN-FEN? Y N**

IF SO, HAVE YOU CONSULTED YOUR M.D. REGARDING HEART CONDITION. Please explain: _____

FOR WOMEN

Are you taking birth control pills? Y N Are you pregnant? Y N Are you nursing? Y N

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

Y	N	Heart Attack/Stroke	Y	N	High or Low Blood Pressure	Y	N	Ulcers
Y	N	Cancer/Chemotherapy	Y	N	Fever Blister	Y	N	Congenital Heart Defect
Y	N	Heart Murmur	Y	N	Severe/Frequent Headaches	Y	N	Radiation Treatment
Y	N	Rheumatic Fever	Y	N	Cardiac Pacemaker	Y	N	Asthma
Y	N	Heart Surgery/Pacemaker	Y	N	Psychiatric Problems	Y	N	Difficulty Breathing
Y	N	Shingles	Y	N	Epilepsy/Seizures/Fainting	Y	N	Hospitalized for any reason
Y	N	Mitral Valve Prolapse	Y	N	Diabetes	Y	N	Hepatitis
Y	N	Kidney Problems	Y	N	Drug/Alcohol Abuse	Y	N	Blood Transfusion
Y	N	Artificial Bones/Joints	Y	N	Venereal Disease	Y	N	Emphysema
Y	N	Artificial Valves	Y	N	Hemophilia/Abnormal Bleeding	Y	N	HIV+/AIDS
Y	N	Sinus Problems	Y	N	Glaucoma	Y	N	Anemia
Y	N	Tuberculosis (TB)	Y	N	Colitis	Y	N	Arthritis

Please list any medical condition(s) that you have ever had: _____

Are you allergic to any of the following drugs or materials?

Y	N	Penicillin	Y	N	Tetracycline	Y	N	Aspirin
Y	N	Erythromycin	Y	N	Codeine	Y	N	Antibiotics
Y	N	Sulfa Drugs	Y	N	Latex	Y	N	Other

Please list any other drugs that you are allergic to:_____

MEDICAL HISTORY

Previous Dentist_____ Phone: _____

Dental Complaint at this moment? _____

Have you ever had any unfavorable reaction from a local anesthetic? _____

Have you ever had any serious trouble associated with any previous dental treatment? _____

Explain: _____

How long since last dental X-Rays of your entire mouth? _____ How long since last dental treatment? _____

Do you have or do you use any of the following?

Y	N	Bleeding gums	Y	N	Complications from extractions	Y	N	Water jet device
Y	N	Food impaction	Y	N	Periodontal (gums) treatment	Y	N	Fluoride supplements
Y	N	Clenching or grinding	Y	N	Orthodontic treatment	Y	N	Fluoride treatments
Y	N	Bad breath	Y	N	Cigarettes, pipe or cigar smoking			
Y	N	Unpleasant taste	Y	N	Dental floss			

CONSENT FOR TREATMENT: I hereby authorized to the dentist(s) in charge of the care of the patient whose name appears on this form to administer any treatment, or to administer such anesthetic, analgesics, sedatives, nitrous oxide sedation and intravenous sedation; and to perform such dental operations or procedures as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures, anesthetics and/or drugs.

Signed _____ Date_____

Authorization must be signed by the patient, or by the nearest relative in the case of a minor or when the patient is physically or mentally incompetent.

Consent for services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare patients' insurance forms or assist in making collections from insurance companies and will credit any such collections to the patients account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1 ½ % per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

X_____ Date _____ Relationship to Patient:_____
Signature of patient, parent or guardian

X_____ Date _____ Relationship to Patient:_____
Signature of guarantor of payment/responsible party

Authorization

_____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office). I authorize the provider to release any information required to process insurance claims.

_____I authorize Erick V Pagan, D.M.D to provide copies of my dental records to any providers upon request. I understand that the specific type of information to be disclosed includes a detailed report of examinations, finding treatments, prognosis and copies of any and all other records, including x-rays. This is effective until cancelled in writing.

_____My dentist will determine a suitable treatment that may be beneficial in the diagnosis and treatment of my condition, therefore I authorize and direct Dr. Pagan or assistant of his choice to perform the procedures including the arranging of whatever incidental procedures and/or additional services, involving anesthesia, radiology, pathology and the like as he may deem advisable for my well being. Any tissue or member severed in surgery of procedure may be disposed of in the best discretion of the dentist. I understand that Dr. Pagan maintains personnel and facilities to assist in his performance of various dental procedures. Special diagnostic and therapeutic procedures all involve risks or complication, serious injury or even death, from both known and unknown cases. I am well aware that except in case of emergency or exceptional circumstances, these procedures are not performed unless the patient has had an opportunity to discuss them with the dentist. The nature and purpose of dental treatment and possible alternative methods of treatment will be explained to me, and I will be given a chance to ask any questions. I further understand that many factors contribute to the success of dental treatment and cannot be determined in advance; that each patient has the right to consent or refuse any proposed surgery or special procedure; that due to individual patient differences there exists a risk of failure, relapse selective retreatment or worsening of my present condition despite the best of efforts; that my failure to follow the dentists direction for follow up care will jeopardize the success of the treatment. My signature below constitutes my acknowledgment that i agree to the forgoing 1) each procedure has been explained to my satisfaction 2) that no guarantees or assurances have been given to me as to the results that may be obtained 3) that by allowing Dr. Pagan to complete treatment I consented to that proposed treatment.

X_____ Date _____
Signature of patient/parent/guardian

Pagan Affinity Dentistry
Washington, Georgia

COVID-19 Patient Screening Form 2020

Patient Name: **Birthdate:** **Date:**

Do you/they have a fever?	Yes	No
Are you/they having shortness of breath or other difficulties breathing?	Yes	No
Do you/they have a cough?	Yes	No
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	Yes	No
Have you/they experienced recent loss of taste or smell?	Yes	No
Are you/they in contact with any confirmed COVID-19 positive patients?	Yes	No
Do you/they have a sore throat?	Yes	No
Have you/they travelled to any foreign country within the last 14 days?	Yes	No

Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.

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You have come to our office for a routine dental evaluation and/or treatment that will be done during the COVID-19 pandemic. Please be advised of the following:

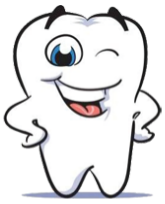
While our office complies with the State Health Department and Centers for Disease Control and Prevention infection control guidelines to prevent the spread of the COVID-19 virus, we cannot make any guarantees. Our staff are symptom-free, and to the best of their knowledge, have not been exposed to the virus. However, since we are a place of public accommodation, other persons (including other patients) could be infected, with or without their knowledge.

In order to reduce the risk of spreading COVID-19, we have asked you a number of "screening"questions above. For the safety of our staff and other patients, please be truthful and candid in your answers.

Please sign below

X_____

507 Spring Street, Washington GA 30673
support@paganaffinitydentistry.com
www.paganaffinitydentistry.com
Office (706) 678-2931
Fax (706 678-2939



Pagan Affinity Dentistry
Washington, Georgia

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES.

You may REFUSE to sign this acknowledgement

I _____, have received a copy
(Print Name)
of this office's Notice of Privacy Practices.

_____
Please print name

_____
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
- ❑ Communications barriers prohibited obtaining the acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Other (please specify)_____

_____

_____

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Release of Records

I _____, authorize _____

To release any copies of my X-rays or records containing treatment or diagnosis of needed treatment to:

Pagan Affinity Dentistry
Fax:706-678-2939
Drpaganoffice@gmail.com

AND/OR

Dependants:

I _____, authorize _____

To release any copies of my dependant _____'s X-rays or records containing treatment or diagnosis of needed treatment to:

Pagan Affinity Dentistry
Fax:706-678-2939
Drpaganoffice@gmail.com

Print Name _____

Patient Signature X_____ Date _____

(Parent /Guardian if pt is under age 18)

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Pagan Affinity Dentistry
Washington, Georgia

Oral Screening Consent Form

Complete each time the examination is performed and place it in the patient's chart.

Our practice continually looks for advances to ensure that we are providing the optimum level of oral health to our patients. We are concerned about oral cancer and look for it in every patient.

One american dies every hour from oral cancer. Late detection of oral cancer is the primary cause that both incidence and mortality rate of oral cancer continue to increase. As with most cancers, age is the primary risk factor for oral cancer. Tobacco and alcohol use are other major predisposing risk factors but **more than 25% or oral cancer victims have no such lifestyle risk factors.** Oral cancer risk patient profile is as follows:

Oral cancer risk by patient profile is listed below:

Increased Risk: Patients age 18-39 and sexually active patients (HPV 16/18)

High Risk: Patients age 40 and older; tobacco users younger than age 40

Highest Risk: Patients age 40 and older and lifestyle risk factors (tobacco use); patients with a history of oral cancer.

We have incorporated ViziLite Pro into our oral screening standard of care. We find that using Vizilite along with a standard oral cancer examination improves the ability to identify suspicious areas at their earliest stages. Vizilite Pro is a simple and painless examination that gives the best chance to find any oral abnormalities at the earliest possible stage. Early detection of pre-cancerous tissues can minimize or eliminate the potentially disfiguring effects of oral cancer and possibly save your life. The Vizilite exam will be offered to you annually.

This enhanced examination by the American Dental Association code revision committee as CDT-2007/08 procedure code D0431; however this exam may not be covered by your insurance. The fee for this enhanced exam is **$25 per scan** or a **$55 lifetime fee.**

☐ **YES. I authorize the clinician to perform the Vizilite Pro exam along with the standard oral cancer examination. I accept financial responsibility for this enhanced examination.**

☐ **NO. I would not prefer to have the Vizilite Pro exam at this time.**

Print Name:_____

Signature:_____ **Date:**_____