SUMRALL
FAMILY DENTAL
COSMETIC ▸ RESTORATIVE ▸ IMPLANTS

Confidential Patient Information

Patient Name: _____
Preferred Name: _____
Social Security #: _____
Date of Birth: _____ Male/Female
Single/Married/Minor/Other
Home: _____ Cell: _____ Work: _____
Email: _____
Address: _____
_____
Employer: _____

Responsible Party

Name: _____
Relationship: _____
Date of Birth: _____
Male/Female Single/Married/Other
Home: _____ Work:_____ Cell:_____
Address: _____
_____
Employer: _____

Emergency Contact

Name: _____ Relationship: _____
Home: _____ Work: _____ Cell: _____

To whom may we thank for referring you?

_____
_____

Primary Insurance

Name of Subscriber: _____
Date of Birth: _____
Social Security #: _____
Employer: _____
Insurance Plan Name: _____
Group #: _____ Member ID #: _____

Secondary Insurance

Name of Subscriber: _____
Date of Birth: _____
Social Security #: _____
Employer: _____
Insurance Plan Name: _____
Group #: _____Member ID #: _____

Consent

To the best of my knowledge, all of the proceeding answers and information provided is true and correct. If I have any changes, I will inform the front desk staff at the next appointment without fail.

_____ _____
Signature *Date*

Patient Health History

Are you ***ALLERGIC*** to any of the following?

Amoxicillin Aspirin Clindamycin Codeine Erythromycin Latex Penicillin Sulfa
Others? _____

Do you have a history of? ***Please Circle***

Anemia	Asthma	Artificial Joints
Cancer/Radiation	Diabetes	Dizziness/Fainting
Epilepsy	Excessive Bleeding	Glaucoma
Head Injuries	Heart Disease	Heart Murmur
Hepatitis	HIV/AIDS	High Blood Pressure
High Cholesterol	Jaundice	Kidney Disease
Liver Disease	Mental Disorders	MRSA
Mitral Valve Prolapse	Rheumatism	Sinus Problems/Hay Fever
Smoker	Stomach Problems	Stroke
Thyroidism	Tuberculosis	Tumors
Ulcers	Venereal Disease	

Current Medications: ***Please Circle***

Antibiotics	Heart Pill	Tranquilizers
Arthritis	Blood Thinners	Hormones
Thyroid	Water Pill	Aspirin
Cortisone Steroids	Birth Control	Diabetic Pills

Others Medications:

_____

_____

Name of Physician: _____ Physician Phone #: _____

Financial Responsibility

A 24 HOUR NOTICE OF CANCELLATION IS APPRECIATED. We reserve the right to charge a $50 broken appointment fee if not cancelled within the 24 hour time frame. I also understand that if a check is written to this office for fees incurred is returned for insufficient funds, there will be a $25 fee applied to my account.
The undersigned agrees, whatever as agent, guarantor, or patient, that in consideration of the services being rendered to the patient, the patient hereby, individually, obligates themselves to pay the amount of the account to this office in full; unless DELIQUENT accounts will incur ALL late fees, collection fees, and legal fees. This includes a 28% commission fee to all accounts that are sent to collections.

I HAVE READ CAREFULLY, UNDERSTAND AND AGREE TO THE FINANCIAL RESPONSIBILITIES AND ASSIGNMENTS OF INSURANCE BENEFITS AS STATED ABOVE.

_____ _____

Signature *Date*

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 will have the right to read our Notice of Privacy Practices before you decided whether to sign this consent. Our Notice provides a description of our treatment, payment actives, and healthcare operation and if the Use and Disclosure 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 at any time by contacting
Linda Meade
Phone # 478-929-1661
100 S. Houston Road
Warner Robins, Georgia 31088

Right to revoke: You 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 receive your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

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 health care options.

_____ _____

Signature *Date*

Receipt of Notice of Privacy Practices Written Acknowledgment

I have reviewed a copy of Dr. Joseph Sumrall's and Dr. Gran Sumrall's Notice of Privacy Practices.

_____ _____

Signature *Date*