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 #: _____

Medical 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

Name _____

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

☐ Amoxicillin ☐ Penicillin ☐ Latex ☐ Epinephrine ☐ Codeine ☐ Clindamycin ☐ Aspirin ☐ Sulfa

Others? _____

Do you have a history of? ***Please check the following if it applies***

- ☐ Alzheimer's disease
- ☐ ADD/ADHD
- ☐ Anemia
- ☐ Asthma
- ☐ Artificial heart valve
- ☐ Artificial joints
- ☐ Blood disease
- ☐ Cancer/radiation (type_____)
- ☐ Cold sores/fever blister
- ☐ Congenital Heart disorder
- ☐ Diabetes/ Hypoglycemia
- ☐ Dizziness/Fainting
- ☐ Epilepsy/seizures
- ☐ Glaucoma
- ☐ Heart attack/stroke
- ☐ Heart murmur
- ☐ Head injury
- ☐ Hemophilia/Excess Bleeding
- ☐ Hepatitis (type_____)
- ☐ High/low blood pressure
- ☐ HIV/AIDS
- ☐ Jaw Problems/TMJ/TMD
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Mental disorders/anxiety
- ☐ Mitral Valve Prolapse
- ☐ Neck or back problems
- ☐ Pacemaker
- ☐ Radiation Treatments
- ☐ Rheumatism/ Arthritis
- ☐ Scarlet fever
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Problems/Hay fever
- ☐ Skin rash/hives
- ☐ Smoker
- ☐ Stomach/intestinal problem
- ☐ Thyroid problems
- ☐ Tuberculosis (TB)
- ☐ Tumor/Growth
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Weight loss(unexplained)

Other _____

List current medications you are taking

_____

_____

Pharmacy Name _____

Phone _____

Name of Physician: _____ Physician Phone #: _____

Date of last visit: _____

Financial Responsibility

A 24 HOUR NOTICE OF CANCELLATION IS APPRECIATED. We reserve the right to charge a $50 broken appointment fee if not cancelled prior to 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
Jeremy Lindsey
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*