2700 Northside Crossing
Macon, Georgia 31210
(478) 477-2761 phone
info@walkerdentalgroup.com

NEW PATIENT INFORMATION

Patient Information

Date___________________

Last Name: ____

First Name:___________________________ Middle Initial:_______

Address: ____

City: ____

State: ________________ _ Zip: __________________

Email:____

Social Security No.:_____________________________________

Birthdate: _______________ ☐Male ☐Female

☐Married ☐Separated ☐Widowed ☐Minor

☐Single ☐Divorced ☐Other_____________

Patient's Employer: ______________________________________

Occupation: ____

Employer Phone: (_______) _____________________________

Spouse's Name: ____

Birthdate: ____________ Social Sec.No.:____________________

Whom may we thank for referring you?

____

Billing Information

Who is responsible for this account? _________________________

Relationship to patient: ____________________________________

Primary Dental Insurance: ☐Yes ☐No

Insurance Company: _____________________________________

Group No.: ____

Subscriber's Name: ______________________________________

Subscriber's Birthdate: ___________________________________

Subscriber's Social Security No.:____________________________

Subscriber's Relationship to patient: _________________________

Secondary Dental Insurance:

Effective December 1, 2014 Walker Dental Group will no longer accept payment from secondary dental insurance. We will file the primary insurance and collect your estimated out-of-pocket portion for the services rendered. You are responsible for filing and collecting payment from your secondary insurance company.

**This does not apply to patients who have BCBS FEDERAL as their primary insurance.

Patient Contact Information

Home Phone: (_____) __________________ Work Phone: (_____) __________________ Cell Phone: (_____) ___________________

May we contact you via text message or email? ☐Yes ☐No Please check on which numbers we may leave a message: ☐Home ☐Work ☐Cell

Emergency Contact:

Name: ____ Relationship to Patient: ____________________________________

Home Phone: (_____) __________________ Work Phone: (_____) __________________ Cell Phone: (_____) ___________________

Dental History

Reason for Today's Visit: ________________________________ Former Dentist: _____________________ City/State: ________________

How often do you brush:_________ How often do you floss: __________ Date of last dental visit: _________Date of last dental X-rays: ________

Please Mark "yes" or "no" to indicate whether you have experienced any of the following conditions:

Bad Breath	☐yes ☐no	Clicking/ pain in Jaw	☐yes ☐no	Mouth Breathing	☐yes ☐no	Sensitive Teeth	☐yes ☐no
Bleeding Gums	☐yes ☐no	Dry Mouth	☐yes ☐no	Pain when brushing	☐yes ☐no	Sores on lips/ mouth	☐yes ☐no
Tobacco Use	☐yes ☐no	Grinding Teeth	☐yes ☐no	Pain around ear	☐yes ☐no	Food collection in teeth	☐yes ☐no
Burning of Tongue	☐yes ☐no	Loose/ Broken Teeth	☐yes ☐no	Periodontal disease	☐yes ☐no	Sore gums	☐yes ☐no

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Health History

Physician's Name: ________________________________ Date of last visit: ______________________ City/State: ________________

Please Mark "yes" or "no" to indicate whether you have experienced any of the following conditions:

Have you ever taken any combinations of Ionimin/ Adipex/ Fastin (phentermine), Pondimin (fenfluramine), and Redux (dexfenfluramine) ☐yes ☐no

Have you ever taken a Bisphophonate drug, such as Aredia, Zometa, Reclast, Bonefos, Didronel, Fosamax, Actonel, Boniva, and/or Skelid ☐yes ☐no

If yes to any of the above drugs, Drug Name: __________________________ When taken__________________ How long __________________

Have you ever been told by a doctor to take antibiotics prior to a dental visit? ☐yes ☐no If yes, why: ________________ Did you take it today? ☐yes ☐no

AIDS/HIV	☐yes ☐no	Congenital Heart Lesions	☐yes ☐no	High Blood Pressure	☐yes ☐no	Sinus Trouble	☐yes ☐no
Anemia	☐yes ☐no	Cortisone Treatments	☐yes ☐no	Jaundice	☐yes ☐no	Skin Rash	☐yes ☐no
Arthritis, Rheumatism	☐yes ☐no	Cough	☐yes ☐no	Kidney Disease	☐yes ☐no	Special Diet	☐yes ☐no
Artificial Heart Valves	☐yes ☐no	Diabetes	☐yes ☐no	Liver Disease	☐yes ☐no	Stroke	☐yes ☐no
Artificial Joints	☐yes ☐no	Emphysema	☐yes ☐no	Low Blood Pressure	☐yes ☐no	Swollen Feet/Ankles	☐yes ☐no
Asthma	☐yes ☐no	Epilepsy	☐yes ☐no	Mitral Valve Prolapse	☐yes ☐no	Swollen Neck Glands	☐yes ☐no
Back Problems	☐yes ☐no	Fainting/Dizziness	☐yes ☐no	Pacemaker	☐yes ☐no	Thyroid Problems	☐yes ☐no
Bleeding Abnormally	☐yes ☐no	Glaucoma	☐yes ☐no	Psychiatric Care	☐yes ☐no	Tonsillitis	☐yes ☐no
Blood Disease	☐yes ☐no	Headaches	☐yes ☐no	Radiation Treatment	☐yes ☐no	Tuberculosis	☐yes ☐no
Cancer	☐yes ☐no	Heart Murmur	☐yes ☐no	Respiratory Disease	☐yes ☐no	Tumor/ Growth	☐yes ☐no
Chemical Dependency	☐yes ☐no	Heart Problems	☐yes ☐no	Rheumatic Fever	☐yes ☐no	Ulcer	☐yes ☐no
Chemotherapy	☐yes ☐no	Hepatitis Type_____	☐yes ☐no	Scarlet Fever	☐yes ☐no	Venereal Disease	☐yes ☐no
Circulatory Problems	☐yes ☐no	Herpes	☐yes ☐no	Shortness of Breath	☐yes ☐no	Weight loss	☐yes ☐no

WOMEN:

Are you pregnant? ☐yes ☐no Due Date:_____________________ Are you Nursing? ☐yes ☐no Taking birth control pills? ☐yes ☐no

Medications

List any medications you are currently taking and the correlating diagnosis:

____

____

____

Pharmacy Name____

Phone No. (________)______________________________________

Allergies

☐Aspirin ☐Local Anesthetic

☐Barbiturates ☐Penicillin

☐Codeine ☐Sulfa

☐Latex ☐Other____________

Authorization and Release

To the best of my knowledge, the information listed is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health. I certify that I, and/or my dependent(s), have coverage with ____ and assign directly to
Name of insurance Company(ies)
Dr. Ash P. Walker, DMD all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Dr. Ash P. Walker,DMD may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits for the related services. This consent will remain in effect as long as I remain a patient of Dr. Ash P. Walker, DMD.

____ ____________________
Please print name of Patient, Parent, Guardian, or Personal Representative Date

____ ____________________
Signature of Patient, Parent, Guardian, or Personal Representative Date

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name:____

Address: ____

Telephone:____

Email:____ Social Security:_____________________________

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:

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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 health care operations.

Patient/ Guardian Signature: ____ Date: __________________

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

Personal Representatives Name: ____

Relationship to Patient: ____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

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OFFICE POLICIES

FINANCIAL POLICY:

We are committed to providing you with the best possible care and your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions regarding our fees or our financial policies.

*We accept cash, major credit cards, checks and Care Credit.

*If you do not have all of the necessary insurance information required for us to verify your insurance benefits you are required to pay in full. (If we are able to verify the benefits after your appointment we will reimburse you when the insurance payment is received.)

*You are expected to pay your **estimated** out-of-pocket at the time of service**.**

*****We will file your insurance claims as a courtesy to you. If your insurance company has not paid within **60 days** you are responsible for the full balance.

*If your insurance company pays more than the balance due we will issue you a refund check at your request.

Insurance is a contract between you and your insurance company. We are not a party of this contract. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, etc. other than to supply factual information as necessary. You are responsible for the timely payment on your account. It is your responsibility to know if Walker Dental Group is a provider for your insurance company.

Regarding minors: The adult accompanying a minor will be responsible for payment of services. Minors must always be accompanied by an adult.

APPOINTMENT POLICY:

We understand that last minute changes in your schedule may be unavoidable and we will try to accommodate those changes to the best of our ability. When an appointment is scheduled, that time has been set aside just for you and when it is missed that time cannot be used to treat another patient.

We require that you give our office **24 business hours notice** in the event that you need to reschedule your appointment. This allows for other patients to be scheduled into that appointment time. If you miss an appointment without contacting our office within the required time, this is considered a missed appointment. A fee of $50.00 will be charged to you; this fee cannot be billed to your insurance company and will be your direct responsibility. No future appointments can be scheduled without the payment of this fee.

Additionally, if a patient is more than 15 minutes late for a scheduled appointment, we will consider this a missed appointment and the $50.00 cancellation fee will be charged.

OFFICE POLICY:

Walker Dental Group advises all patients to have preventative (prophy) appointments every six months (some patients may require 3-4 month appointments.) It is the responsibility of the patient (or parent/legal guardian) to make sure these appointments are scheduled.

Walker Dental Group requires that ALL patients have a comprehensive exam and X-Rays at our office. If your insurance company does not cover these services due to frequency limitations or any other reason you are responsible for the charges. If you choose not to have X-Rays for any reason you must sign an X-Ray refusal form.

I understand these are policies acquired by Walker Dental Group and I agree to abide by the terms indicated above.

Patient/ Guardian Signature: ____ Date:_______________________