

## Welcome to Dr. Stuart Coe Dentistry

We are genuinely pleased that you have chosen us for your dental care. Our practice realizes the importance of referrals and we value them greatly. We are always excited to see new smiles coming through our door!

At your first appointment, your doctor will complete a comprehensive oral examination. This includes a complete review of your medical and dental history, all necessary x-rays and intraoral photos, study models (if necessary), oral cancer screening, periodontal health evaluation, and examination of your teeth and soft tissues. Following this exam, your dentist will discuss their findings with you, develop a treatment plan that you are comfortable with, and then you will be scheduled according to your needs.

Please be prepared for your appointment by printing and completing the new patient registration forms. If you have dental insurance, be sure to provide all requested information to assist us in the benefit verification process. Also, read over our section on dental insurance for more information. Payment is expected at the time of the first visit. If you are covered by insurance, we will expect payment of your portion at the time of service unless prior arrangements are made. As a courtesy, we will file claims on your behalf with your dental insurance company. If you would like to finance your dental expenses we work with CareCredit and Lending Club and will be glad to provide you with information about both and how to apply. If you have any questions about finances please feel free to ask us at any time.

We ask that you make every effort to keep your appointments. Missing an appointment disrupts proper sequencing of care and delays completion of your treatment. If you need to reschedule your appointment, please call us at least 24 hours prior to your visit.

We very much appreciate your confidence in us and look forward to meeting with you!

Dr. Stuart Coe 11775 Pointe Place Suite 101 Roswell, Ga 30076

### **Practice Policies Relating to Dental Insurance Benefits**

During the past decade, dental benefit plans have become an integral part of healthcare planning for many families. Dental benefit plans are made available to employees or members through companies, unions, and associations and may vary considerably from one plan to the next.

You or your employer has purchased a specific benefit plan from literally hundreds of combinations available. Some plans base the amount of benefits on a chart or a schedule of fees arbitrarily developed by insurance carriers. For this reason, you may feel that a lower percentage of the reimbursement level indicated in your dental plan is received. For example, if your plan states that it will pay 80% of the cost of dental treatment, it means 80% of the fee arbitrarily determined by the insurance carrier, and not the actual fee charged by our office.

The type of treatment you need and receive from our doctors is based on their professional judgment; and not on your coverage by a dental benefit plan. We do not believe it is in your best interest for the doctors to compromise their recommended treatment in order to accommodate an insurance program's maximum benefits that may be considerably less than optimal. We are more than happy to discuss a treatment plan's advantages and disadvantages with you, thereby involving you, rather than your insurance company, in the decision making process.

As a courtesy to you, we will submit your claim form to your insurance carrier for payment. Please understand that this will not be a guarantee of payment from your carrier. Also at the time of treatment we will give you an estimate indicating what we, to the best of our knowledge, have estimated your insurance benefit to be. **Please remember that the financial obligation for dental treatment is between you and this office. The insurance company is responsible to you and not to this office. We cannot be responsible for limitations on payments from your insurance carrier.**

We will help you in every way in filing your claims, handling insurance questions, processing follow-ups or locating lost claims. No question is too small for you to ask, whether it is about your treatment, benefit plan, or statement. We are here to help you.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ By  
signing above I acknowledge that I have read and understand the practice policy relating to dental insurance benefits.

# Health History Form

**ADA** American Dental Association®

America's leading advocate for oral health

Email:  Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name:			Home Phone: <i>include area code</i>	Business/Cell Phone: <i>include area code</i>
<i>Last</i>	<i>First</i>	<i>Middle</i>	( )	( )
Address:			City:	State: Zip:
<i>Mailing address</i>				
Occupation:			Height:	Weight: Date of Birth: Sex: M F
SS# or Patient ID:	Emergency Contact:	Relationship:	Home Phone: <i>include area code</i>	Cell Phone: <i>include area code</i>
			( )	( )

If you are completing this form for another person, what is your relationship to that person?

Your Name

Relationship

**Do you have any of the following diseases or problems:** (Check DK if you Don't Know the answer to the the question) **Yes No DK**

Active Tuberculosis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Persistent cough greater than a 3 week duration.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cough that produces blood.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Been exposed to anyone with tuberculosis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.**

## Dental Information For the following questions, please mark (X) your responses to the following questions.

Yes No DK			Yes No DK				
Do your gums bleed when you brush or floss?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have earaches or neck pains?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to cold, hot, sweets or pressure?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any clicking, popping or discomfort in the jaw?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your mouth dry?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you brux or grind your teeth?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any periodontal (gum) treatments?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have sores or ulcers in your mouth?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had orthodontic (braces) treatment?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear dentures or partials?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any problems associated with previous dental treatment?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you participate in active recreational activities?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your home water supply fluoridated?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a serious injury to your head or mouth?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink bottled or filtered water?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date of your last dental exam:			
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY				What was done at that time?			
Are you currently experiencing dental pain or discomfort?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date of last dental x-rays:			
What is the reason for your dental visit today?							
How do you feel about your smile?							

## Medical Information Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

Yes No DK			Yes No DK				
Are you now under the care of a physician?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you had a serious illness, operation or been hospitalized in the past 5 years?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physician Name:	Phone: <i>include area code</i>	( )	If yes, what was the illness or problem?				
Address/City/State/Zip:			Are you taking or have you recently taken any prescription or over the counter medicine(s)?.....				
			<input type="checkbox"/>				
Are you in good health?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:			
Has there been any change in your general health within the past year?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____			
If yes, what condition is being treated?			_____				
			_____				
Date of last physical exam:			_____				

# Medical Information Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

(Check DK if you Don't Know the answer to the question) Yes No DK

Do you wear contact lenses?

**Joint Replacement.** Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?     
 Date: \_\_\_\_\_ If yes, have you had any complications? \_\_\_\_\_

Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease?

Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia®, Zometa®, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?     
 Date Treatment began: \_\_\_\_\_

**WOMEN ONLY** Are you:  
 Pregnant?     
 Number of weeks: \_\_\_\_\_  
 Taking birth control pills or hormonal replacement?     
 Nursing?

**Allergies.** Are you allergic to or have you had a reaction to:  
 To all **yes** responses, specify type of reaction. Yes No DK

Local anesthetics <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Metals <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Aspirin <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Latex (rubber) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Penicillin or other antibiotics <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Iodine <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Barbiturates, sedatives, or sleeping pills <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Hay fever/seasonal <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Sulfa drugs <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Animals <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Codeine or other narcotics <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Food <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
	Other <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

**Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.**

	Yes No DK	Yes No DK	Yes No DK
Artificial (prosthetic) heart valve <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		Autoimmune disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Glaucoma <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Previous infective endocarditis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		Rheumatoid arthritis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Hepatitis, jaundice or liver disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Damaged valves in transplanted heart <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		Systemic lupus erythematosus <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Epilepsy <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Congenital heart disease (CHD)		Asthma <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Fainting spells or seizures <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Unrepaired, cyanotic CHD <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		Bronchitis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Neurological disorders <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Repaired (completely) in last 6 months <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		Emphysema <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	If yes, specify: _____
Repaired CHD with residual defects <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		Sinus trouble <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Sleep disorder <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<i>Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.</i>		Tuberculosis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you snore? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
		Cancer/Chemotherapy/Radiation Treatment <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Mental health disorders <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
		Chest pain upon exertion <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Specify: _____
		Chronic pain <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Recurrent Infections <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
		Diabetes Type I or II <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Type of infection: _____
		Eating disorder <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Kidney problems <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
		Malnutrition <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Night sweats <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
		Gastrointestinal disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Osteoporosis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
		G.E. Reflux/persistent heartburn <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Persistent swollen glands in neck <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
		Ulcers <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Severe headaches/migraines <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
		Thyroid problems <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Severe or rapid weight loss <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
		Stroke <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Sexually transmitted disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
			Excessive urination <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?

Name of physician or dentist making recommendation: \_\_\_\_\_ Phone: Include area code ( ) \_\_\_\_\_

Do you have any disease, condition, or problem not listed above that you think I should know about?     
 Please explain: \_\_\_\_\_

**NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.**

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

Signature of Dentist: \_\_\_\_\_

Date: \_\_\_\_\_

**FOR COMPLETION BY DENTIST**

Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_