O'NEAL SMILES, LLC
Brandon K. O'Neal, DMD

PATIENT INFORMATION

Patient _____ Mr __ Ms__ Mrs __ Dr__ Hon__
Last name First name Middle initial

I prefer to be called _____ Gender: Male _____ Female _____

Birthdate _____/_____/_____ SSN _____ Drivers Lic# _____

Address _____

City _____ County _____State _____Zip _____

Email Address _____ Cell Phone _____

Home Phone _____ Work Phone _____

Employer/Address _____

Whom may we thank for referring you? _____

Physician Name _____ Phone_____

Pharmacy Name _____ Phone_____

Emergency Contact _____ Phone _____

Person Responsible for Account (if other than Patient):

Name _____ Relationship _____

Birthdate _____/_____/_____ SSN _____ Drivers Lic# _____

Address _____

City _____ County _____State _____Zip _____

Email Address _____ Cell Phone _____

Home Phone _____ Work Phone _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

** You may refuse to Sign this Acknowledgement**

I have received a copy or have been given access to the O'Neal Smiles, LLC *Notice of Privacy Practices*. I give my permission to O'Neal Smiles, LLC to

- Communicate with other health care professionals and dental insurance carriers (if applicable) as needed throughout the course of my care.
- Leave messages for me at my contact numbers provided and mail or email reminders to me regarding appointment dates and times.

_____ _____
PATIENT OR RESPONSIBLE PARTY SIGNATURE DATE

Health Information

Patient Name: _____ Date of Birth: _____

1. Are you now under the care of a physician? Yes ☐ No ☐

   If yes, please explain: _____

2. Are you allergic to or have you had any reactions to the following? Please check all that apply:

☐ Local Anesthetics (e.g. Novocain)	☐ Penicillin or any other Antibiotics	☐ Sulfa Drugs
☐ Barbiturates	☐ Sedatives	☐ Iodine
☐ Aspirin	☐ Any Metals (eg nickel, mercury, etc)	☐ Latex Rubber
☐ Other: _____		

3. Have you ever had any of the following? Please check those that apply:

☐ AIDS/HIV Positive	☐ Excessive Bleeding	☐ Jaundice	☐ Respiratory Problems
☐ Anemia	☐ Fainting/Seizures	☐ Joint Replacement/Implant	☐ Rheumatic Fever
☐ Angina	☐ Frequently Tired	☐ Kidney Disease	☐ Sexually Transmitted Disease
☐ Arthritis	☐ Glaucoma	☐ Leukemia	☐ Sinus Problems
☐ Artificial Joints	☐ Growths	☐ Liver Disease	☐ Stomach Problems
☐ Asthma	☐ Hay Fever	☐ Low Blood Pressure	☐ Stroke
☐ Blood Disease	☐ Head Injuries	☐ Mental Disorders	☐ Thyroid Problems
☐ Cancer	☐ Heart Attack	☐ Mitral Valve Prolapse	☐ Tuberculosis
☐ Diabetes	☐ Heart Disease	☐ Osteoporosis	☐ Tumors
☐ Dizziness	☐ Heart Murmur	☐ Pacemaker	☐ Ulcers
☐ Emphysema	☐ Hepatitis	☐ Pain in Jaw Joints	☐ Other: _____
☐ Epilepsy	☐ High Blood Pressure	☐ Radiation Treatment	_____

4. Have you been admitted to a hospital or needed emergency care during the past two years? Yes ☐ No ☐
   If yes, please explain: _____

5. Do you use tobacco? Yes ☐ No ☐

6. Women Only:

   Are you pregnant or think you may be pregnant? Yes ☐ No ☐

   Are you nursing? Yes ☐ No ☐

   Are you taking oral contraceptives? Yes ☐ No ☐

7. Are you currently taking any prescription or over-the-counter medications? If yes, please list:

   _____

8. Do you have any health problems that need further clarification? Yes ☐ No ☐

If yes, please explain: _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

Signature of Patient, Parent or Guardian _____ Date _____

O'NEAL SMILES, LLC
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Dental History

1. Date of Last Dental Visit: _____ Reason for this Visit: _____
2. Have you ever had any complications following dental treatment? Yes ☐ No ☐
   If yes, please explain: _____
3. Do you have any concerns about previous dental care or this dental visit? Yes ☐ No ☐
   If yes, please explain: _____
4. Do your gums bleed? Yes ☐ No ☐
5. Are your teeth loose? Yes ☐ No ☐
6. Have you ever been told that you have bad breath? Yes ☐ No ☐
7. Are your teeth sensitive to (circle all that apply) Sweets Cold Heat Pressure
8. Do you feel your teeth are starting to get longer? Yes ☐ No ☐
9. Do you get food stuck between your teeth easily? Yes ☐ No ☐
10. Do you ever experience tooth pain that is relieved by biting down on the affected area? Yes ☐ No ☐
11. What would you change about the condition of your mouth? _____

    _____

12. Please check any statement that you agree with about your smile:

    ☐ I wish my teeth were whiter.
    ☐ I wish I had a bigger smile.
    ☐ I think some of my teeth are too small.
    ☐ I think some of my teeth are too large.
    ☐ I wish my teeth were straighter.
    ☐ My gums show too much when I smile.
    ☐ I think there is too much space between some of my teeth.
    ☐ Because I am not totally pleased with my smile, I sometimes hesitate to smile.
    ☐ I have often wished I could change some of the features of my smile.
    ☐ I think I need to do a better job of protecting the health of my smile.

_____ _____
Signature of Patient, Parent or Guardian Date

O'NEAL SMILES, LLC • BRANDON K. O'NEAL, DMD

PATIENT AGREEMENT

FINANCIAL OPTIONS:

Payment for services rendered is due and payable at the time of treatment unless arrangements have been made in advance. We accept Cash, Personal Checks, American Express, Visa, Mastercard, Discover and CareCredit.

- There is a $35 NSF check charge for returned checks.
- Past due amounts are subject to 1½% monthly interest (18% annual percentage rate (APR)).

As a courtesy to our patients, we work with several third party financing companies that may afford you the opportunity to make monthly payments for your treatment. Some companies offer low interest plans to qualified applicants. Please inquire if you are interested in applying.

Responsible Party policy for minor children: The policy in our office is that the parent who requests treatment for and accompanies the child to the office is responsible for all fees incurred.

DENTAL INSURANCE: As a courtesy to our patients we are happy to submit claims to your PRIMARY dental insurance company. Your dental benefits are dependent on the plan that you or your employer have selected and it is important that YOU BECOME AN EXPERT ON YOUR PARTICULAR INSURANCE PLAN BENEFITS; especially to the extent that it will be a factor in your treatment decisions.

We ask that you...

- Take care of your portion of estimated fees and any applicable deductibles for your treatment on or before your appointment date.
- Update us immediately when your insurance coverage changes.
- Pay any amount due after insurance has paid their portion.

We will...

- Submit your insurance claims to your PRIMARY INSURANCE COMPANY ONLY.
- Provide necessary documentation to you, the patient, the facilitate your secondary claim, such as x-rays, narratives and primary carrier explanation of benefits.
- Be sensitive to your budget and help with creative financial options when necessary.
- Help you understand the process so everything goes smoothly for you.

The following information is required to allow us to process insurance for our patients:

Primary Carrier Name and Address: _____

Patient relationship to Employee: _____ Subscriber birthdate: _____

Subscriber name & address: _____

Subscriber ID# _____Subscriber gender: M F

Subscriber's Employer _____Group/Policy # _____

I have been informed of O'Neal Smiles, LLC financial and appointment policies. I agree to be responsible for all fees for services and materials incurred during the course of my treatment. To the extent permitted by law, I consent to the use of my protected health information by O'Neal Smiles, LLC to carry out payment activities in connection with my care.

_____ _____

Signature of Patient or Responsible Party **Date**

I hereby authorize payment of the insurance benefits otherwise payable to me directly to O'Neal Smiles, LLC.

_____ _____

Signature **Date**

Brandon K. O'Neal, D.M.D.

General & Cosmetic Dentistry

322 N. Main Street
Alpharetta, GA 30009

Phone: 770-475-9509
Fax: 770-740-8422

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

NAME: _____

Whom may we discuss your health records with?

Name_____Relationship_____Contact Phone_____

Name_____Relationship_____Contact Phone_____

Name_____Relationship_____Contact Phone_____

Name_____Relationship_____Contact Phone_____

SECTON 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. Upon request, a copy of our notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

RIGHT TO REVOKE: You will have to revoke this consent at any time by giving us written notice of revocation. Please understand that revocation of the consent will not affect any action we took in reliance in the consent before we received your revocation, and that we may decline to treat you or to continue treating you IF you revoke this consent.

I, _____, have received a copy of this office's Notice of Privacy Practices. I have had the full opportunity to read and consider the contents of this consent form and Notice of Privacy Practices. I understand that by signing this consent form, I am giving consent to your use and disclosure of my protected heath information to carry out treatment, payment activities, and healthcare operations.

PRINT NAME: _____

SIGNATURE: _____DATE: _____

O'NEAL SMILES, LLC
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APPOINTMENT POLICY

Dr. O'Neal's office is proud to be part of a team whose primary mission is to deliver the finest and most comprehensive dental care services today.

Our patients who have dental insurance are expected to pay the amount of their estimated co-pay and deductible at the time of service. Payment in advance may be required for certain treatment in order to reserve chair time and fund dental laboratory fees.

Deposit Policy:

Due to the extensive amount of time our staff and doctors devote to preparing and reserving uninterrupted time for appointments over 2 hours, we require a deposit of half of the treatment fee to make your reservation. Your Initials: _____

Effective September 13, 2023 there will be a $75.00 fee charged to your account for each patient scheduled and confirmed that cancels or breaks an appointment without 48 hour notice. Our office schedules each patient to see the doctor in a scheduled manner however we do understand that emergencies occur. When patients cancel or don't show up for an appointment without a reasonable notice we cannot possibly find a patient to fill in your time slot in such a short notice. We must prevent costs and loss of income by making sure that you understand our office's BROKEN APPOINTMENT POLICY.

There will be a 10-minute grace period after your appointment time. If there is any reason why you are running behind schedule for your appointment, we ask that you call the office to notify someone in our front office regarding your appointment time. If you are more than 10 minutes late we will have to ask you to reschedule your appointment to see the doctor or the hygienist. We ask for your cooperation so that all of our patients can be seen on time rather than waiting a long time. Please be sure that you understand the OFFICE POLICY when running late for an appointment.

I have read and understand the above office policy.

Patient Name: _____

Patient Signature: _____ **Date:** _____