Stephanie G. Lemus, DMD
Venkat Chalasani, DMD
11255 Parsons Road, Suite 100
Johns Creek, GA 30097

Today's Date: _____
Patient's Name: _____ Preferred name: _____
Date of Birth: _____ SS#: _____
If child, Parent's Name: _____

Street Address: _____
City, State, Zip Code: _____

Cell Number: _____ Email Address: _____
Home Number: _____ Best Method of Contact: Call / Text / Email

Emergency Contact Name: _____ Contact Number: _____

How did you hear about our office? _____

What brings you in to our office? If you have a specific problem, please describe the nature of the problem.
_____
_____
_____

If you have dental insurance, please provide the following information:

Insured's Name: _____ Insured's Employer: _____
Insured's SS#: _____ Insured's Date of Birth: _____

Insurance Company Name, Address, Phone:
_____ Group Number: _____
_____ ID Number: _____
_____
_____

Payment is expected at the time that service is rendered, unless prior financial arrangements have been made. Filing insurance claims is a service provided without charge, although you are still responsible for charges incurred.

Signature: _____ Date: _____

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Financial Policy

I understand that all responsibility for payment for all dental services provided in this office for myself or my dependents is mine, due and payable at time services are rendered.

Insurance

We will make every effort possible to assist you with your particular insurance coverage.
As a courtesy to our patients, we will prepare and submit your insurance claim form. We will provide an *estimate* that will show expected insurance reimbursement and the patient's share for every procedure. The patient's share will be due at the time of treatment. Should our estimate of patient share be too high, a refund will be made at the time we receive payment from the insurance company. If the estimate was low, the balance will be due at that time.
Should no insurance payment be made within 60 days of a submitted claim, the fee will become the sole responsibility of the patient. In the event that payments are not received by the agreed upon dates, I understand that an 18% annual finance charge will be added to my account. In the event your account goes to collections, you will be responsible for any attorney fees and court cost.

Authorization and Release

I authorize and request my insurance company to pay directly to the dentist any benefits otherwise payable to me. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company and other healthcare providers as necessary.

Photographic Release

In our office, photographs may be taken of our patients for aid in determining proper diagnosis and to help visualize the appropriate treatment options. I hereby authorize photographs to be taken of my face, jaws and teeth. I understand that the photographs are used in accord of my care and may be used in publication or as part of a demonstration. My name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs.

Cancellation / Late Arrival Policy

In our office, we do not overbook the schedule. We believe in spending time to do the best job we can for our patient. We only ask that you give us 48 hour notice prior to rescheduling your appointment. If not, a $50 charge will be posted to your account to help offset the cost of the missed appointment with less than 48 hour notice. In the event you are 10 minutes or more late, you may be charged for a missed appointment and may be asked to reschedule. We intend to keep a more personalized approach to providing the highest quality of dentistry in a small office environment.

I understand and agree to all of the above:

_____

Patient / Responsible Party Signature Date

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Acknowledgement of Privacy Practice

My signature confirms that I have been informed of my right to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that the information can and will be used to:

Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.
Obtain payment from third-party payers for my health care services.
Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my dental provider's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such Notice of Privacy Practices. I understand that my dental provider has the right to change the Notice of Privacy Practices. And that I may contact the office at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient's Name (Print): _____ Date: _____
Signature: _____ Relationship to patient: _____

Name of person we can share your information with (print): _____
Relationship to patient: _____