Please Complete This Form
And
Bring It with You To Your Visit

MICHAEL P. HEALEY D.D.S., P.C.
Preston Ridge II
3480 Preston Ridge Road
Suite 125
Alpharetta, GA 30005
(770) 993-9395

DATE: ____________________

This Medical/social history assists Dr. Healey in providing you with excellent dental care in a happy environment.
Thank you for completing the following confidential information.

Your Child

Child's Name ____________________
Nick Name ____________________ Sex ______
Birthday ____________________ Age ______
Address ____________________
City ____________ State/Prov ______ Zip/P.C. ______
Phone ____________________

Responsible Party

Name ____________________
Relationship ____________________
Address ____________________
City ____________ State/Prov ______ Zip/P.C. ______
SS# ____________________
E-Mail ____________________
Drivers License ____________________

Who is responsible for making appointments?

Name ____________________

Best daytime phone:
❑ ____________________ Home
❑ ____________________ Cell
❑ ____________________ Work

Who may we thank for referring you to our office?
____

Mother ❑ *Stepmother* ❑ *Guardian*

Name ____________________
Home Phone ____________________
Cell Phone ____________________
Work Phone ____________________ Ext. ______
E-Mail ____________________
Employer ____________________
Occupation ____________________
SS# ***(Required)*** ____________________
Date of Birth ____________________

Marital Status

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Father ❑ *Stepfather* ❑ *Guardian*

Name ____________________
Home Phone ____________________
Cell Phone ____________________
Work Phone ____________________ Ext. ______
E-Mail ____________________
Employer ____________________
Occupation ____________________
SS# ***(Required)*** ____________________
Date of Birth ____________________

Marital Status

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

SOCIAL HISTORY

Has your child ever visited a dentist before? ____________ If yes, when: ____________
How do you feel your child will react to Dr. Healey? ____________________
How does your child relate to children the same age? ____________________
How does your child relate to adults? ____________________
Name of brothers ____________________ Ages ______
Name of sisters ____________________ Ages ______
Are parents presently living together? ____________

PAYMENT ARRANGEMENTS:

For your convenience all fees are discussed privately prior to beginning treatment. Any questions regarding insurance are welcome by our staff. Unless arranged previously, payment is expected at time of services.

Please check the method of payment you prefer: ❑ ***Cash or Check,*** ❑ ***Master Card,*** ❑ ***Visa,*** ❑ ***Discover,*** ❑ ***AMEX***

MEDICAL HISTORY: Please indicate if you (referring to patient) have had any of the following:

	Yes	No		Yes	No		Yes	No		Yes	No
Heart Disease			Sinusitis, Hay Fever			Special Diets			Blood Disease		
Asthma			Tuberculosis			Rheumatic Fever			Cancer		
Chronic Cough			Epilepsy			Heart Murmur			Cleft Lip/Palate		
High Blood Pressure			Nervous Disorder			Scarlet Fever			Colic		
Kidney Trouble			Thyroid Disorder			Frequent Colds			Liver Disease		
Stomach Disorder			Hyperactivity			Immune Deficiency			Hepatitis		
Diabetes			Bleeding Disorder			Shortness of Breath			Anemia		
Sickle Cell Disease			Psychiatric Treatment			Fever Blisters			Heart Trouble		

To the best of your knowledge, have you ever been exposed to AIDS virus? .... Yes NO

Are you allergic to:

	Yes	No		Yes	No		Yes	No		Yes	No
Aspirin			Codeine			Local Anesthetic			Penicillin		
Other Antibiotics			Any other allergies to medications or substances?								

If yes, please list: ______________________________

List current medications: ______________________________

Pediatrician: ____________________ Phone No: ____________________

Yes	No	
		Has your child ever been hospitalized?
		Was your pregnancy full term?
		Did your child go home with you from the hospital?
		Were there complications during or after pregnancy?
		Has there been any concern by your Pediatrician about your child's developments?
		Are you happy with the way your child is growing?
		Do any family members or close relatives have significant medical problems? If yes: ____________________
		Does your child have any disease, condition, or problem not listed above? If yes: ____________________

DENTAL HISTORY

Do you feel your child will need braces? ______________________________

Have other family members had braces? ____________________ If yes, who? ____________

Have your childs tonsils been removed? ____________ Adenoids? ____________ When? ____________

Does your child:

Yes	No		Yes	No	
		Prefer breathing through mouth than nose?			Have finger habits (sucking thumb)?
		Have frequent headaches?			Chew gum?
		Have click or pop when opening jaw?			Chew on ice?
		Have pain in jaw when chewing?			Bite their nails?

CONSENT:

The undersigned hereby authorizes Michael P. Healey, D.D.S., P.C. to take radiographs, diagnostic models, photographs, or any other diagnostic aids deemed appropriate by Dr. Healey to perform a thorough diagnosis.

Patient: ______________________________ Date: ____________________

Patient or responsible party: ____________________ Relationship to patient: ____________

DOCTOR'S SUMMARY: ______________________________

MICHAEL P. HEALEY D.D.S., P.C.

Primary Insurance

Insurance Carrier ______________________

ID# ______________ Group# ______________

Customer Service Phone Number ______________

Ins. Co. Address ______________________

City ______________ St _____ Zip __________

Policy Holder Information

Insured's Name ______________________

Birth Date ___/___/___ SS# ______________

Employer ______________________

Relationship to Patient ______________

We understand how helpful it can be to know in advance how payment arrangements are handled when a visit to our office is necessary. Please read the following information carefully regarding your insurance.

As a courtesy to you, we will file for your PRIMARY dental insurance only if your policy allows you to choose your dentist. If your dental insurance is a restrictive policy (DMO plan), Dr. Healey's fees will not be covered, and payment in full will be expected at the time of visit. Secondary insurance filing will be your responsibility.

We will require a copy of your insurance card at the time of check–in, and it is your responsibility to fully understand your benefits and plan limitations. At the time of check–out we will not collect a co–payment for periodic or initial hygiene visits. We will send a billing statement, after your insurance company has paid their portion, for any remaining co–payment. If additional treatment is required, a minimum co–payment of 40% will be collected since dental insurance rarely covers the entire cost of care. As always, a Treatment Coordinator will discuss all fees with you prior to treatment.

If we do not have complete dental insurance information at the time of the visit, payment will be due in full.

Your insurance claim will be filed electronically and we will allow your insurance company 30 days to submit payment to us. In order to allow this to be a free service, we ask that you monitor the processing of the claim on a timely basis. If the account remains unpaid, you will receive a billing statement in 30 days and payment in full will be your responsibility at that time. Accounts 60 days past due will be subject to an 18% annual interest rate, and accounts 90 days past due will be turned over to collections.

For orthodontic benefits to be assigned to our office, 25% of the full case fee is due from you when treatment is initiated and your assigned insurance benefits will be reflected by a reduced monthly payment on your part. The case fee must be paid in full, three months prior to the completion of treatment. Again, we ask that you, the parent, do the follow up calls to insure that your orthodontic benefits are being paid in a timely manner. If your insurance company requires monthly receipts to be filed, as proof that treatment is continuing, we will provide you with the receipts and ask that you submit them. Balances not paid in full by the required date will be your responsibility and are subject to an annual interest rate of 18%.

If no orthodontic benefits are available, we do offer an extended payment plan that is affordable and convenient.

We do accept cash, personal checks, Visa®, MasterCard®, American Express®, Discover®.

★ ***Please see the back for signature*** ★