

SUH FAMILY DENTAL

3772 Satellite Blvd. Suite 200, Duluth, GA 30096

770.497.1045/ info@suhfamilydentalga.com

General Information

Patient Full Name {Last, First, MI} _____

Street Address _____

City _____ State _____ Zip code _____

Cell Phone _____ Work Phone _____ Email _____

Prefer Text, Call, or Email _____

If Minor: Guardian Name _____ Relationship _____

College Student? Y N Who Referred You? _____

Responsible Party for Payment

Name _____

Relationship to Patient _____ Address {if different than patient} _____

Employer _____ DOB _____

Insurance Information

Primary Co. _____ Subscriber Name _____ DOB _____

Member ID _____ Group # _____ Employer _____

Secondary Coverage? Y N-Please provide the same information for any secondary plan.

Ins Co _____ Subscriber _____ DOB _____

Member ID _____ Group # _____ Employer _____

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Dental History

Last dental exam/cleaning _____ X-Rays _____

Reason for today's visit _____

Do you have difficulty getting numb? Yes / No

Do you have any history of gum disease? Yes / No If yes-what gum treatments have you completed?

Medical History

Current physician{s} _____

Last medical physical _____

Current medical conditions _____

History of medical conditions/procedures _____

Current medications/supplements _____

Past medications _____

Allergies to medications? {Penicillin/Latex} _____

Please describe allergies _____

Current tobacco use including vaping/marijuana Yes/ No History of smoking? Yes/ No

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Medical History-continued

Have you ever been diagnosed with any of the following? {Check all that apply}

☐	Asthma/Emphysema	☐	Cancer/Chemotherapy
☐	HIV/Aids	☐	Glaucoma
☐	Heart Condition	☐	Infectious Hepatitis
☐	High/Low Blood Pressure	☐	Knee or Hip Replacement
☐	Kidney Problems/Disease	☐	Lung Trouble
☐	Osteoporosis	☐	Rheumatic Fever
☐	Seizures/Fainting	☐	TMJ {jaw joint} Issues
☐	Tuberculosis	☐	Anemia
☐	Anemia	☐	Bleeding Disorder/ Hemophilia
☐	Liver Disease	☐	Diabetes
☐	Reflux/Gerd	☐	Other

Financial Policy Before restorative treatment is performed, we will discuss fees, insurance details, and financial options. If you need financial arrangements, we will gladly discuss your options. Payment for services is typically due at the time of service unless other arrangements have been made.

Insurance Your insurance policy is a contract between you and your insurance company. Knowledge of you benefits is highly encouraged. Having insurance is never a guarantee of coverage and often does not cover every procedure we do. As a courtesy, we will file your claims {as long as we have all pertinent information}. We are not "contracted with most insurance companies, and your insurance will pay according to how the plan is written for "out of network". If your insurance only pays to you the subscriber/insured, we reserve the right to ask for full payment at the time of your service. We can file a Pre Estimate for restorative dentistry if you request us to.

Parents of Minors; For separated or divorced parents ; the parent/guardian who brings the child to the appointment is responsible for any co-payments or balances. If necessary, we are happy to hold credit card information securely on file.

Emergency New Patients For emergency visits, we require payment in full for your first visit. If you have valid insurance, we can provide you with the claim to file for any reimbursement.

Late Cancellations/Broken Appointments Appointment times are reserved specifically for you. We do require a minimum of 24 hours of notice for any change request. If your appointment is on a Monday, you will need to contact us by the prior Thursday. In the event of an unforeseen circumstance {ie illness}, we will gladly reschedule with no penalty. However, if you are continuously cancelling without adequate notice, a Broken Appointment Fee may be assessed {not to exceed \$175.00}.

Billing A statement of your balance will be provided after insurance has settled. The payment due date is reflected on the statement. If a financial arrangement is needed, it is your responsibility to contact us to discuss your options.

Patient/Guardian Agreement By signing below, I acknowledge that I have read and understand the of office policies of Suh Family Dental and agree to abide by them. I authorize Suh Family Dental to perform dental procedures deemed necessary by Dr. Ethan Suh.

Patient/ Guardian _____ Date _____