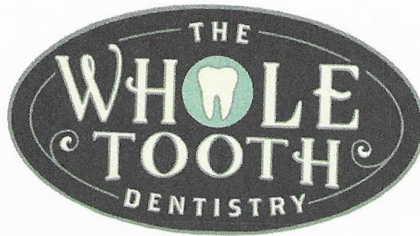


Welcome to your new dental home!

We are excited to have you here and honored you have chosen us to take care of your dental health needs!

Here's what you can expect from us...

We strive for quality dental care provided by supportive and caring hands. Our team is committed to provide you the very best diagnosis and treatment in a clean, friendly, and fun environment. In addition to exceptional dentistry and patient education, we will strive to be professional, courteous, and punctual. We know your time is important and we promise to make every effort to have you seated on time for your appointment.

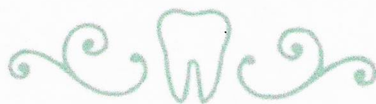
Hours:

Monday	Closed
Tuesday	8:00 AM- 5:00 PM (Lunch 1:00-2:00)
Wednesday	8:00 AM- 5:00 PM (Lunch 1:00-2:00)
Thursday	7:00 AM-2:00 PM
Friday	7:00 AM-2:00 PM

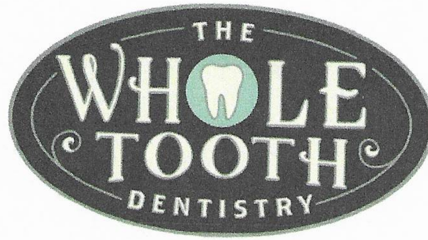
Contact Information:

Phone/Text (912)988-7723
Fax: (912)988-1891
Email: records@wholetoothdentistry.com

Please give us feedback on how we are doing and how we can improve! Let us know what you think about us and tell your friends!



Dr. Ruby E Barkley, D.M.D.
1000 Towne Center Blvd. Suite 505
Pooler, GA 31322
912-988-7723
WholeToothDentistry.com



Office Financial Agreement

Please understand that regardless of any insurance status, you are responsible for the balance due on your account. You are responsible for all professional services rendered.

MISSED APPOINTMENTS:

Please be considerate of our schedule and arrive on time. If you need to cancel your appointment, please give us a 48-hour notice. We are understanding of life's unexpected occurrences, but we will charge a $50.00 fee for repeated missed appointments.

INSURANCE:

Your insurance policy is a contract between you and your insurance company. As a courtesy to you, our office provides certain services, including filing claims and pre-treatment estimates which we will send to the insurance company at your request. It is your responsibility to contact your insurance company and inquire as to what benefits are provided to you. We provide you with an ESTIMATE of your out-of-pocket expenses with your treatment plan. Please be aware some or perhaps all the services provided may or may not be covered by your insurance policy. Any balance is your responsibility whether insurance company pays any portion or not. If you have any questions concerning the pre-treatment estimate and/or fees for services, it is your responsibility to have these answered prior to treatment to minimize any confusion on your behalf.

We are currently an in-network provider for Aetna, Cigna, Delta Dental, and Metlife.
For those uninsured, we do offer an in-house VIP program. Please speak to us for details and questions!

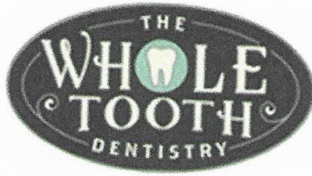
PAYMENT:

FULL Payment is due at the time of service. If insurance benefits apply, ESTIMATED PATIENT CO-PAYMENTS and DEDUCTIBLES are due at the time of service, unless other arrangements have been made prior to any services have been rendered. You will be billed for services not covered by your policy. Any balance over 60 days old are subject to an interest charge. After 90 days, an outside collection agency will be utilized incurring additional collection fees. As a result, payment will no longer be accepted by The Whole Tooth Dentistry.

By signing below, I have read, understand, and agree to the terms and conditions of this Financial Agreement.

_________________________________   ____________________

Patient/Guardian Signature   **Date**



New Patient Registration

Patient Information:

Name (Last, First): ______________________ Date: __________

Address: ______________________
Street City State Zip Code

Phone (Home): __________ (Work): __________ (Cell): __________

Social Security Number: ____-____-____ Birth Date: ____/____/____ Sex: (M / F)

Email: ______________________ Married Widowed Divorced Single Partnered

Employer (of insured party): ______________________ Employer Phone: __________

Address: ______________________
Street City State Zip Code

How did you hear about us? (We would like to thank them!) ______________________

Responsible Party:

Name: ______________________ Relation to Patient: __________

Address: ______________________
Street City State Zip Code

Phone (Work): __________ (Cell): __________ Email: __________

Insurance Information:

Primary Insurance: ______________________ Secondary Insurance: __________

Policy #: ______________________ Policy #: __________

Group #: ______________________ Group #: __________

Policy Holder Name: ______________________ DOB: __________ SSN: ____-____-____

Patient Relationship to Policy Holder: ______________________

Emergency Contact:

Name: ______________________

Phone (Home): ______________________ (Cell): __________

Relationship to Patient: ______________________

The Whole Tooth

Patient Name:________________________ **Birth Date:** __________ **Today's Date:**__________

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking can have important interrelationship with the dental care you will receive. Thank you for answering the following questions.

Name of Primary Care Physician ______________________________

Are you currently under the care of a Specialist? **Yes** **No** For what?____________________

Have you ever been hospitalized or had a major operation? **Yes** **No** If yes____________________

Have you ever had a joint replacement? **Yes** **No** If yes____________________

Have you ever had a serious head or neck injury? **Yes** **No** If yes____________________

Do you take, or have you taken, Phen-Fen or Redux? **Yes** **No** If yes____________________

Have you ever taken any medications with bisphosphonates? **Yes** **No** If yes, when & how long? __________
(examples: Fosamax, Boniva, Actonel, Prolia, Xgeva, Aredia, Reclast, Zometa)

Current use of tobacco? **Yes** **No** If previous, date stopped? ____________________

If yes, (circle): Cigarettes Chewing Tobacco E-cigarettes Other ____________________

Daily use/packs per day? ____________________ Number of years?____________________

Do you use controlled substances? **Yes** **No**

Women: Are you...

Pregnant/Trying to get pregnant? ☐ Yes ☐ No If pregnant, how many weeks? __________

Taking oral contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

ALL PATIENTS: Do you have, or have you ever had any of the following? **(Check all that Apply)**

☐ AIDS/HIV Positive	☐ Cortisone Medicine	☐ Heart Trouble/ Disease	☐ Psychiatric Care
☐ Alzheimer's Disease	☐ Diabetes	☐ Hemophilia	☐ Radiation Treatments
☐ Anaphylaxis	☐ Dialysis	☐ Hepatitis A	☐ Recent Weight Loss
☐ Anemia	☐ Drug Addiction	☐ Hepatitis B or C	☐ Rheumatic Fever
☐ Angina	☐ Easily Winded	☐ Herpes	☐ Rheumatism
☐ Arthritis/Gout	☐ Emphysema	☐ High Blood Pressure	☐ Scarlet Fever
☐ Artificial Heart Valve	☐ Epilepsy or Seizures	☐ High Cholesterol	☐ Shingles
☐ Artificial Joint	☐ Excessive Bleeding	☐ Hypoglycemia	☐ Sickle Cell Disease
☐ Asthma	☐ Excessive Thirst	☐ Irregular Heartbeat	☐ Sinus Trouble
☐ Blood Disease	☐ Fainting Spells/ Dizziness	☐ Kidney Problems	☐ Spina Bifida
☐ Blood Transfusion	☐ Fibromyalgia	☐ Leukemia	☐ Stomach/Intestinal Disease
☐ Breathing Problems	☐ Frequent Cough	☐ Liver Disease	☐ Stroke
☐ Bruise Easily	☐ Frequent Headaches	☐ Low Blood Pressure	☐ Swelling of Limbs
☐ Cancer	☐ Gastric Reflux	☐ Lung Disease	☐ Thyroid Disease
☐ Chemotherapy	☐ Glaucoma	☐ Mitral Valve Prolapse	☐ Tonsillitis
☐ Chest Pains	☐ Hay Fever	☐ Osteoporosis	☐ Tuberculosis
☐ Cold Sores/Fever Blisters	☐ Heart Attack/ Failure	☐ Pain in Jaw Joints	☐ Tumors or Growths
☐ Congenital Heart Disorder	☐ Heart Murmur	☐ Parathyroid Disease	☐ Ulcers
☐ Convulsions	☐ Heart Pacemaker		☐ Venereal Disease
			☐ Yellow Jaundice
			☐ **NONE**

Have you ever had any serious illness not listed above? Yes No If yes____________________

____

Initials

MEDICAL HISTORY (continued)

Are you allergic to any of the following:

☐ NKDA (No Known Drug Allergies)

- ☐ Aspirin
- ☐ Metal
- ☐ Other? If yes ______________
- ☐ Penicillin
- ☐ Latex
- ☐ Codeine
- ☐ Sulfa Drugs
- ☐ Acrylic
- ☐ Local Anesthetics

List ALL medications (over the counter and prescription) that you are taking and why:

DRUG NAME	DOSAGE	REASON PRESCRIBED

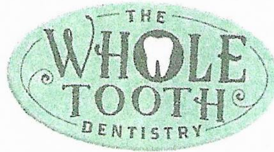
DENTAL HISTORY

Reason for today's visit ______________ Previous Dentist ______________

1. When was the last time you had your teeth cleaned? ______________
2. When were your last dental x-rays taken? ______________
3. Have you ever had deep cleaning? (been numbed for a cleaning) ☐ Yes ☐ No ______________
4. Have you ever had any problem or complication during a previous dental treatment? ☐ Yes ☐ No ______________
5. Do you clench or grind your teeth? ☐ Yes ☐ No
6. Does your jaw click or pop? ☐ Yes ☐ No
7. Have you experienced any pain or soreness in the muscle around your ear? ☐ Yes ☐ No
8. Do you have frequent headaches, neck aches or shoulder aches? ☐ Yes ☐ No
9. Are your teeth sensitive to (circle): HEAT COLD SWEETS PRESSURE? ☐ Yes ☐ No
10. Do your gums bleed or hurt? ☐ Yes ☐ No
11. Have you noticed your teeth changing? (for example: tipping, shifting, chipping or becoming loose?) ☐ Yes ☐ No ______________
12. If you could "wave a magic wand", what changes would you make in your smile? ______________
13. Do any of the following reasons keep you from making changes that you would like (circle): FEAR TIME MONEY OTHER? ______________

We want to know how to accommodate you, so please tell us:
Where are you as a dental patient?

[ ] Awesome/Love being here! [ ] It's Okay, Not Oppossed. [ ] Don't like being here, but I know I need to. [ ] Wimp [ ] Wife made me come here.



HIPAA PATIENT CONSENT FORM

Patient Name: ______________________________ DOB: ______________________

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you (the patient). The Notice contains a Patient Rights section describing your rights under the law (this may be requested at the front desk). You have the right to review our full Notice before signing Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict protected health information about you that is used or disclosed for treatment, payment or healthcare operations.

By signing this form, you consent to our use and disclosure of protected health information about your treatment, payment and healthcare operations. You have the right to revoke this Consent, in writing, signed by you. However, such revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or healthcare operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice. The Practice reserves the right to change the Notice of Privacy Policy.
- The patient has the right to restrict the use of their information.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon execution of this Consent. No insurance can be billed on the patient's behalf without this signed HIPAA consent form; therefore payment in full is required at the time services are rendered.

Information SHARING: Please list any individuals we can share your personal information with other than healthcare providers.

Name:______________________________ Relationship:______________________

Name:______________________________ Relationship:______________________

Name:______________________________ Relationship:______________________

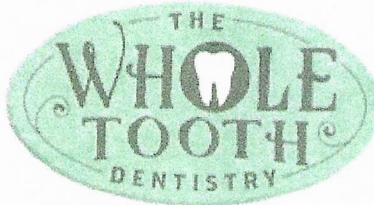
____
This HIPAA Consent/Sharing was signed by (Signature)

____
(Today's date)

Phone
(912) 988-7723

Fax
(912) 988-1891

records@wholetoothdentistry.com



1000 Towne Center Blvd., Suite 505
Pooler, GA 31322

Hours:

M	Closed
T	8am-5pm
W	8am-5pm
Th	8am-2pm
F	8am-2pm

Authorization For Release of Information

My signature below serves as authorization for The Whole Tooth to release or receive medical information for the purpose of referral. A copy of this signature is valid as the original.

To authorize the release of any medical information necessary to process claim.

Patient Name: ______________________ DOB: __________

Patient Address: ______________________

____

____

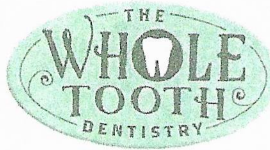
Additional Patients/DOB:

______________________ ______________________

______________________ ______________________

Please include: ☐ RADIOGRAPHS ☐ PERIO CHART ☐ PROGRESS NOTES

X______________________ ______________
(Patient/Guardian Signature) (Date)



Take our Smile Assessment ☺

Patient Name: **Birthday:** **Date:**

	Yes	No
Are you comfortable showing your teeth when you smile?	☐	☐
Are you happy with the appearance of your teeth?	☐	☐
Do you have unsightly crowns or fillings?	☐	☐
Are your gums or teeth sensitive?	☐	☐
Do you feel your teeth are too short?	☐	☐
Do you like the color of your teeth?	☐	☐
Are you missing teeth?	☐	☐
Are you happy with the alignment of your teeth?	☐	☐
Are your gums receding?	☐	☐
Are you anxious or fearful of treatment?	☐	☐
Are you familiar with the benefits of dental implants?	☐	☐
Are you interested in changing the appearance of your teeth?	☐	☐
Is fear holding you back from a perfect smile?	☐	☐
Is lack of time holding you back from a perfect smile?	☐	☐
Is cost holding you back from a perfect smile?	☐	☐
Is there something else, not listed, holding you back from a perfect smile?	☐	☐

Please feel free to explain any answers:

____

____

____

____