CHOICE DENTAL
FAMILY & COSMETIC DENTISTRY
Creating Healthy Beautiful Smiles

Thank you for choosing Choice Dental!

We would like to take this opportunity to introduce our team.

Jumoke Adedoyin DDS – Dr. Adedoyin graduated from Howard University College of Dentistry as the valedictorian in 2001. Her areas of interest include cosmetic dentistry, endodontics, peridontics, restorative dentistry and soft tissue management. She is committed to providing quality care for her patients while taking time to listen to your concerns and addressing any questions you may have. She enjoys spending time with her family, and relaxing with a good book.

Brittany Weber Dental Hygienist- Brittany graduated from West Central Technical College in Douglasville, Georgia. She is a Georgia native, and has been with our practice since 2006. Brittany is committed to educating our patients in oral hygiene, and periodontal disease, while offering a gentle touch during your routine visits. Brittany enjoys spending time with family and friends, as well as traveling.

Ke'Cia Ison Office Manager- Ke'Cia graduated from Georgia Medical Institute in February 2007 with certification in medical billing and as a medical administrative assistant. Ke'Cia was born in Anniston, Al and has been married to a US serviceman for 18 years. She recently joined our team and is happy to assist you with your billing concerns as well as any other concerns you may have. She enjoys reading novels, traveling and spending time with her family and friends.

Mandy Goessling Patient Care Coordinator- Mandy was Red Cross certified as a dental assistant in Vogelweh, Germany in 1992, and has been with our office since 2006. She has lived in the Atlanta area for 20 years. She looks forward to assisting you with your scheduling and insurance needs. Mandy enjoys golfing with her husband of 19 years, gardening, and trips to the beach with her family and friends.

Shalynn Carden Dental Assistant- Shalynn is the newest member of our dental team. She recently graduated from Medix School and is eager to assist Dr. Adedoyin to provide you with quality care. Shalynn enjoys spending time at home with her two children, as well family vacations.

Our team looks forward to meeting you and providing you with quality dental service in a caring and family environment.

4484 Jimmy Lee Smith Pkwy Ste. E114, Hiram, GA 30141 (770)222-7818, Fax- (770)222-7828

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Welcome to our office. We are pleased to provide you with the most up to date dental care available. We are committed to you health and safety, so you can be rest assured that all of out instruments are sterilized by steam or chemical methods in state of the art sterilization units.

Your initial visit includes a review of your medical and dental history. A thorough examination of your teeth and tissues will follow.

Payment is expected for services rendered at time of service. For your convenience, we accept cash, checks (processed electronically) and most major credit cards. If we have to bill you any charges, you will incur a 15% billing charge.

We also offer payment plans through Care Credit, which must be approved prior to the initiation of treatment.

We are participating providers for most major insurance companies and will be happy to file your claim. The patient is responsible for payment of all unpaid deductibles, non-covered services and co-payments at the time of service. We cannot guarantee that your insurance will pay for your treatment. You are ultimately responsible for the entire cost of your care and must pay all balances on your account.

Please consider your scheduled appointments carefully and arrive on time. Your appointment is reserved exclusively for you. We require a minimum of 24 hours notice to change or cancel your appointment. This allows us time to offer your appointment to another patient that needs it. Appointments broken or missed without notice will be subject to a cancellation fee of $27.00 and up to $200.00 for our endodontist. We make every effort to be respectful of your time and expect the same courtesy from our patients.

If you receive a statement from this office, the balance is due within 15 days.

I have read and agree to the terms of the above statements.

Patient or Guardian: ____________________________ Date ________20__

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PATIENT NAME ______________________ DATE__________

DENTAL HISTORY

Have you been having specific problems? ☐ Yes ☐ No Describe: ______________________

Last dental visit? __________ Purpose: __________ Last complete exam: __________

Has fear of discomfort kept you from regular visits? ☐ Yes ☐ No

How would you describe your present dental health? ☐ Good ☐ Fair ☐ Poor

Do you think you have active dental disease? Decay: ☐ Yes ☐ No Gum Disease: ☐ Yes ☐ No

Home care: Brush? ☐ Yes ☐ No Floss? ☐ Yes ☐ No Water Jet? ☐ Yes ☐ No Other: __________

Do your gums ever bleed? ☐ Yes ☐ No How often? __________ Are you troubled with bad breath? ☐ Yes ☐ No

How do you feel about ever losing your teeth? ______________________

Have you had any unusual effects from previous dental treatment? ☐ Yes ☐ No Describe: __________

____

MEDICAL HISTORY

Medical doctor's name: __________ Last physical exam: __________ (MONTH/DAY/YEAR) Doctor's Telephone: __________

(Women) Are you pregnant? ☐ Yes ☐ No How long?

Are you under a doctor's care now? ☐ Yes ☐ No If so, for what reason? __________

____

Are you taking any medications, pills or drugs? ☐ Yes ☐ No Please List: __________

____

Have you ever had any of the following?

			☐ Yes	☐ No	Cancer	☐ Yes	☐ No	Mononucleosis
☐ Yes	☐ No	Heart Trouble	☐ Yes	☐ No	Asthma	☐ Yes	☐ No	Prosthetic Joint
☐ Yes	☐ No	Arthritis	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No	Psychiatric Treatment
☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Stroke	☐ Yes	☐ No	Prolonged Bleeding
☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Herpes
☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No	A.I.D.S.
☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No	Diabetes	☐ None of the above		

Have you ever had any other serious illness? ☐ Yes ☐ No Explain: __________

Have you been hospitalized in the last two years? ☐ Yes ☐ No Why? __________

Drug allergies: ☐ None ☐ Yes Please list: __________

Do you wish to talk to the doctor about any problem not listed? ☐ Yes ☐ No

Comments: __________

DATE: __________ SIGNATURE: __________

Reviewed by: Doctor __________ Date __________ Blood Pressure: __________

I have read my MEDICAL HISTORY dated __________ and confirm that it adequately states past and present conditions.

DATE	EXCEPTIONS		PATIENT'S SIGNATURE	B.P.	REVIEWED BY
		None ☐			DR.
		None ☐			DR.
		None ☐			DR.
		None ☐			DR.
		None ☐			DR.
		None ☐			DR.
		None ☐			DR.
		None ☐			DR.
		None ☐			DR.
		None ☐			DR.

DENTAL AND MEDICAL HISTORIES

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SECTION A: PATIENT GIVING CONSENT

Patient Name: ____________________

Address: ____________________

Telephone: ____________________ E-mail: ____________________

Patient Number: ____________________ Social Security Number: ____________________

SECTION 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. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Dr. Olajumoke Adedoyin, DDS
Telephone: (770) 222-7818
Fax: (770) 222-7828
E-mail: jadedoyin@yourchoicedental.com
Address: 4484 Jimmy Lee Smith Pkwy, Suite E114, Hiram, GA, 30141

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SECTION C: SIGNATURE

I, ____________________ have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature: ____________________ Date: ____________________

If this Consent is signed by a personal representative (parent/guardian) on behalf of the patient, complete the following:

Personal Representative's Name: ____________________

Relationship to Patient: ____________________

SECTION D: FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify) ____________________

Signature: ____________________ Date: ____________________

You are entitled to a copy of this Consent after you sign it.

HIPAA CONSENT FORM

CHART-L6