DENTISTRY FOR MIDTOWN

855 Juniper Street NE, Atlanta, Georgia 30308

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL PATIENT INFORMATION

Please fill out form and mark fields that do not apply to you as NA.

Full Name____SS#_________________Date ______________________________

Mr.£ Ms.£ Dr.£ Mrs.£ Miss £

Nickname:____

Address____

City________________State_________Zip _____________

Home Phone #____________________________________

Business Phone # _________________________________

Cell Phone # _____________________________________

Birthday ____

£Married £Single £Divorced £Widowed £Partner

Spouse____

E-mail Address ___________________________________

For Dependent Patient Or / Child Dependent

Child Patient ____

Child's address, if different:

____

____

Home Phone #____

Birthday____________________Age_________Grade ______

School ____

ACCOUNT INFORMATION

PERSON RESPONSIBLE FOR ACCOUNT ____

Driver's license # __________________________________

Bank____ Your Spouse ____

Occupation_____________________________________ Occupation____

Employer_______________________________________ Employer____

Business Address ________________________________ Business Address ____

City _______________ State _______ Zip____________ City_________________State__________Zip_________________

Business Phone # ________________ Ext. ___________ Business Phone #___________________Ext._________________

DENTAL INSURANCE

PRIMARY CARRIER______________________________**EMPLOYER** ____

Social Security #__________________________________Group # ____

Insurance Co. ____________________________________ Date employed ____

Employee ____ 800 # ____

SECOND CARRIER - We do not file secondary insurance but will be glad to provide you with all paper work necessary.

GETTING TO KNOW YOU

Is another member of your family, or relative, a patient at our office?____

Who referred you to us? ____

Minor children and ages ____

Person to contact in an emergency_______________________________________Phone # ___________________________

Address____

Closest relative not living with you______________________________________Phone # ___________________________

Address ____

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MEDICAL HISTORY

1. Are you having pain or discomfort at this time?________ £ Yes £ No
2. Do you feel very nervous about having dental treatment?________ £ Yes £ No
3. Have your ever had a bad experience in the dental office?________ £ Yes £ No
4. Have you been a patient in the hospital during the past five years?________ £ Yes £ No

Physician's Name________ Phone # ________

Address ________

5. Have you taken any medicine or drugs during the past two years?________ £ Yes £ No

   Are you now taking any medication, drugs or pills?________ £ Yes £ No

   Please list ________

6. Are you allergic to any of the following:

£ Aspirin £ Erythromycin £ Local Anesthetic £ Other Antibiotics £ Sulfa

£ Codeine £ Tetracycline £ Penicillin £ Novacaine or Xylocaine

7. Are you aware of being allergic to any other medication, metals or substances?________ £ Yes £ No

   If yes, please list: ________

8. Mark any of the following which you have had or have at present:

£ Heart Attack
£ Angina Pectoris (Chest Pain)
£ High Blood Pressure
£ Heart Pacemaker
£ Artificial Heart Valve
£ Heart Surgery
£ Angioplasty
£ Congenital Heart Defects
£ Mitral Valve Prolapse
£ Rheumatic Fever
£ High Cholesterol
£ Blood Transfusion
£ Sickle Cell Disease
£ Hemophilia
£ Stroke
£ Bruise Easily
£ Anemia
£ Kidney Disease
£ Stomach Ulcers

£ Gastric Reflux
£ HIV Positive
£ AIDS
£ Venereal Disease (Syphilis, Gonorrhea, Herpes)
£ Emphysema
£ Thrush
£ Tuberculosis (TB)
£ Asthma
£ Hay Fever
£ Sinus Trouble
£ Allergic Reactions
£ Diabetes
£ Thyroid Disease
£ Glaucoma
£ Liver Disease
£ Yellow Jaundice
£ Hepatitis A (Infectious)
£ Hepatitis B or C (Serum)

£ Arthritis
£ Rheumatism
£ Osteoporosis
£ Artifical Joints (Hip, Knee)
£ Cortisone Medicine
£ Bisphosphonates (Fosomax, Actonel, Boniva)
£ Chemotherapy
£ Radiation Treatment
£ Bleeding Gums
£ Pain in Jaw Joints
£ Epilepsy or Seizures
£ Fainting or Dizzy Spells
£ Psychiatric Treatment
£ Anxiety/Nervousness
£ Depression
£ Drug or Alcohol Addiction
£ Cold Sores/Fever Blisters
£ Others________

UPDATE FOR OFFICE USE

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9. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired?________ £ Yes £ No
10. Do you smoke or use tobacco products?________ £ Yes £ No
11. Do you use more than 2 pillows to sleep?________ £ Yes £ No
12. Have you lost or gained more than 10 pounds in the past year?________ £ Yes £ No
13. Do you ever wake up from sleep short of breath?________ £ Yes £ No
14. Are you on a special diet?________ £ Yes £ No
15. Has your medical doctor ever said you have a cancer or tumor?________ £ Yes £ No
16. Do you have any disease, condition or problem not listed?________ £ Yes £ No

FOR WOMEN ONLY:

Are you pregnant? £ Yes £ No If yes, due date?________ Are you taking birth control pills? £ Yes £ No

CONSENT: The undersigned hereby authorizes Doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (name of patient)________ and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered. I further understand that a 1½% finance charge (18% annually) will be added to any balance over 60 days. In the event of default I (we) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Patient________ Date________ Witness________

Parent or responsible party________ Relationship to patient ________

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Notice of Privacy Practices

The Department of Health and Human Services has established a “Privacy Rule” to help insure that personal healthcare information is protected for privacy. The Health Insurance and Portability and Accountability Act of 1996 (“HIPAA”) is a federal program that requires all medical records and other individually identifiable health information used by us in any form are kept confidential.

As our patient we want you to know that we respect the privacy of your personal medical/financial records and will do all we can to secure and protect that privacy. Our staff is trained to release only the minimum information to only those in need of your healthcare information regarding *treatment, payment, or healthcare operations,* in order to provide health-care that is in your best interest.

The following rights may be exercised by presenting a written request to our Privacy Officer with respect to your protected health information:

- The right to inspect and copy your protected health information
- The right to amend your protected health information
- The right to obtain a copy of this notice, in its entirety, upon request
- The right to request restrictions on information for certain uses including disclosures to family members or any other person identified by you

You may refuse to consent to the use or disclosure of your personal health information - this must be done in writing. However, under this law we may also refuse to treat you as our patient, if you should refuse to disclose your personal health information.

We would like to assure you, as our highly valued patient, that we are in compliance with government rules and regulations concerning your privacy. Our practice will continually strive to comply with “HIPAA” guidelines concerning the proper disclosure of your Personal Health Information.

Dentistry for Midtown, LLC

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Notice of Privacy Practices Consent

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this practice has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this practice at any time 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. I also understand that the practice is not required to agree to my requested restrictions; however, if the practice does agree then it is bound to abide by such restrictions.

Patient Name (please print): ____

Signature OF PATIENT: ____

Date: ____

Signature of parent or guardian: ____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Consent, but was unable to do so as documented below:

Date:	Initial:	Reason

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Appointment/Financial Guidelines

Appointment Cancellation or Rescheduling ***Initials***_____________

When you schedule a dental or hygiene appointment, that time is reserved just for you. We understand that emergencies do arise and will take this into consideration; however, we require the following notification in consideration of other patients waiting to schedule appointments.

- **Dental *Appointments*** - 48-hour notice or a cancellation fee of $50.00
- **Hygiene *Appointments*** - 48-hour notice or a cancellation fee of $50.00

Insurance ***Initials***_____________

This practice is not an in-network provider with all insurance companies. However, you may receive out-of-network benefits and we will be glad to assist you by filing your insurance with your primary carrier. Please remember, our agreement is with you and not your insurance carrier. We have no control over the coverage you or your employer haven chosen. If your insurance information changes, it is your responsibility to notify our office of the change.
We are happy to calculate an estimate for you based on your individual insurance coverage. Please understand it is only an estimate and not a guaranteed amount of your insurance payment. The patients' estimated responsibility after insurance is due at the time of service unless other financial arrangements have been made prior to treatment. As the patient, you are ultimately responsible for total payment for services rendered regardless of insurance payment.
Your insurance claim is filed electronically within 24 hours of service. If your insurance carrier does not respond or payment is not received within 30 days, we will re-send the claim. The practice will also send any additional documentation of need as requested by insurance company. Additional follow-up with the insurance company or resubmission of claims after 90 days is the responsibility of the policy holder. It is your responsibility to contact your insurance company or pay the balance in full.
You will receive a statement of account from our office each month that will show any payment(s) made by you and/or your insurance carrier. If payment is not received for the balance within 90 days after treatment and your insurance claim has been filed, finance charges will accrue at 1½% of the unpaid balance monthly.

Payment for Treatment ***Initials***_____________

Fees for treatment are due at the time of service unless financial arrangements have been made prior to treatment. You will receive a statement of account from our office each month. This is our only means of communicating with our patients regarding the status of their account. If payment is not received within 90 days, finance charges will accrue at 1½% of the unpaid balance monthly.

If you have insurance, you are welcome to leave your credit card number on file with us for your convenience. Therefore, if there is a remaining balance after insurance, we can apply it to your card and send the receipt to you. We are pleased to accept Mastercard, Visa, American Express, and Discover. Payment to our office is neither contingent nor dependent upon your insurance company .

- Returned Check Fees - $35.00
- Collection Fees - There is a collection fee for accounts over 120 days old.

  *I (we) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note. By my signature below. I authorize said assignee to release all information necessary to secure payment from outside sources.

I acknowledge that I have read and understand all the above policies

Signature____ Date _____________________________

Print Name____

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Periodontal Screening Questions

Warning Signs of Gum/Periodontal Disease

1. Do my gums bleed easily when I brush or floss?__________________________________£ Yes £ No
2. Are my gums red, swollen or tender?____£ Yes £ No
3. Do I have bad breath or a bad taste in my mouth that does not seem to go away?_________£ Yes £ No
4. Do I have diabetes or osteoporosis?____£ Yes £ No
5. Am I a smoker?____£ Yes £ No
6. Does anyone in my family have periodontal disease?______________________________£ Yes £ No
7. Do I brush and floss my teeth **in**frequently?__________________________________£ Yes £ No
8. Was my last dental visit more than six months ago?_______________________________£ Yes £ No
9. Do I have teeth that feel loose, or are there gaps appearing between my teeth?___________£ Yes £ No
10. When I bite, are there changes in the way my teeth fit together?_______________________£ Yes £ No