

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

SS#: \_\_\_\_\_ Reason for visit today? \_\_\_\_\_

List ALL medications you are currently taking: NONE Medical Doctor: \_\_\_\_\_  
(Please bring list of medications with you) Emergency contact: \_\_\_\_\_

List ALL previous surgeries and give dates: NEVER HAD SURGERY

**\*Are you allergic or have you ever reacted adversely to any of the following? PLEASE CIRCLE!**

Penicillin Demerol Tetracycline Darvon Eggs Erythromycin  
Aspirin Latex Percodan Codeine Valium Other antibiotics

\*Do you have any known allergies to medications or substances including local anesthetic? YES NO

\*Have you ever been told by a doctor to pre-medicate with an antibiotic before a dental visit because of a heart murmur, stent, shunt, or artificial joint? YES NO

**Please circle YES or NO for the following questions:**

HEART DISEASE		KIDNEY DISEASE		ANESTHESIA HISTORY	
YES	NO	YES	NO	YES	NO
YES	NO	YES	NO	YES	NO
YES	NO	YES	NO	YES	NO
YES	NO	NEUROLOGIC		YES	NO
YES	NO	YES	NO	YES	NO
YES	NO	YES	NO	OTHER	
YES	NO	YES	NO	YES	NO
YES	NO	YES	NO	YES	NO
YES	NO	YES	NO	YES	NO
YES	NO	ENDOCRINE DISEASE		YES	NO
YES	NO	YES	NO	YES	NO
YES	NO	YES	NO	YES	NO
YES	NO	YES	NO	YES	NO
YES	NO	YES	NO	YES	NO
YES	NO	MUSCULOSKELETAL DISEASE		YES	NO
	Type: _____	YES	NO	YES	NO

LIVER DISEASE		IF FEMALE	
YES	NO	YES	NO
YES	NO	YES	NO

GI (Digestive Concerns)		IF FEMALE	
YES	NO	YES	NO
YES	NO	YES	NO
YES	NO	YES	NO

LUNG DISEASE		BLOOD/CLOTTING DISORDER	
YES	NO	YES	NO
	Date of last attack: _____	YES	NO
YES	NO	YES	NO
YES	NO	YES	NO
YES	NO	YES	NO
	# of years: _____ Pack/day: _____	YES	NO
YES	NO	YES	NO
YES	NO	INFECTIOUS DISEASE	
YES	NO	YES	NO
		YES	NO

**\*Is there any health condition not listed above: YES NO**  
**If YES, Please list:** \_\_\_\_\_

*\*I have read, understand, and answered the above questions. I will not hold my doctor, surgeon, or any members of his staff, responsible for any errors or omission that I have made in completion of this form. Patient signature: (Parent or guardian if under 18):*

Signature: \_\_\_\_\_

How will you be paying today? Cash                      Check                      Charge  
Insurance? Yes    Medicaid? Yes                      Peachcare? Yes

**“Please allow us to get a copy of your insurance card.”**

Person Responsible for the bill:

Name: \_\_\_\_\_ Social Security # \_\_\_\_\_

Address: (if different from patient) \_\_\_\_\_

Home Phone: (if different from patient) \_\_\_\_\_ Work Phone: \_\_\_\_\_

THE UNSURED IS RESPONSIBLE TO MAKE SURE COVERAGE IS IN FORCE. WE ACCEPT INSURANCE AS A COURTESY. WE CANNOT GUARANTEE INFORMATION GIVEN TO US FROM YOUR INSURANCE COMPANY IS CORRECT.

The following is our policy, which is in compliance with the truth in lending law:

- Payment is expected when services are rendered
- Returned check fee is \$30.00
- We do not have payment plans
- To assist you, we accept most credit cards, personal checks, or cash.
- In large cases such as crowns, bridges, and dentures, ½ of the total cost can be paid at the time of the impression. The remaining ½ is due upon delivery.
- In signing below I agree with the payment policy.

\_\_\_\_\_  
DATE

\_\_\_\_\_  
Signature (Patient-Parent-Guardian)

**IF YOU HAVE INSURANCE: Please read, check all boxes in square, date & sign at bottom.**

Please Note: Our office does not verify insurance benefits, therefore if your insurance company requires pre-certification or pre-determination you will need to contact them.

We accept assignment of your insurance as a courtesy. You are expected to pay a percentage of deductible at the time of service. This percentage is only an ESTIMATE. When your insurance pays, a small balance may be due. This will be billed to you through our automated billing service. Payment is expected within 30 days. Failure to do so will prevent us from taking assignment of your insurance in the future. We allow your insurance company 60 days to pay a claim. If no payment is received within this time period the balance is due in full. It is your responsibility to make sure all claims are received by your insurance company. Check with them approximately 15 days after date of service. We will resubmit, at your request, any claims not received. Any checks sent to you by mistake must be signed over to us immediately. By signing below you agree to this reimbursement plan and also allow us to file your insurance electronically.

Please check ALL boxes below and sign:

<input type="checkbox"/>	I authorize use of this form in all my insurance submissions.
<input type="checkbox"/>	I authorize release of information to all my insurance companies.
<input type="checkbox"/>	I understand that I am responsible for my bill.
<input type="checkbox"/>	I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies
<input type="checkbox"/>	I authorize payment direct to my doctor (do not check this if you want payment to come directly to you)
<input type="checkbox"/>	I permit a copy of this authorization to be used in the place of the original.

DATE: \_\_\_\_\_

Signature on file: \_\_\_\_\_



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Athens Family Dental Center

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# NOTICE OF PRIVACY PRACTICES

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THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.  
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

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## OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect **April 14, 2003**, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

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## USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment for you.

**Payment:** We may use and disclose your health information to obtain payment for services we provide you.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**To Your Family and Friends:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

**Persons Involved In Care:** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative, or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the persons' involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

**Marketing Health-Related Services:** We will not use your health information for marketing communications without your written authorization.

**Required by Law:** We may use or disclose your health information when we are required to do so by law.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail, postcards, or letters).

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## **PATIENT RIGHTS**

**Access:** You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$10.00 for each page, \$\_\_\_\_\_ per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

**Restriction:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

**Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request.

**Amendment:** You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why information should be amended.) We may deny your request under certain circumstances.

**Electronic Notice:** If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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## **QUESTIONS AND COMPLAINTS**

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

**Contact Office: Paula Davis**

**Telephone: 706-548-3279**

**Fax: 706-546-6475**

**Address: 3380 Old Jefferson Rd.**

**Athens, GA 30607**

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Athens Family Dental Care

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# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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\*You May Refuse to Sign This Acknowledgement\*

I, \_\_\_\_\_, have received a copy  
of this office's Notice of Privacy Practices.

\_\_\_\_\_  
Please Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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### For Office Use Only

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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
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

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