



Medical And Dental History

PATIENT NAME _____ DATE _____

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, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? _____ Yes _____ No _____ N/A
 Have you ever been hospitalized or had a major operation? _____ Yes _____ No _____ N/A
 Have you ever had a serious head or neck injury? _____ Yes _____ No _____ N/A
 Are you taking any medications, pills, or drugs? _____ Yes _____ No _____ N/A
 Do you use tobacco? _____ Yes _____ No _____ N/A
 Do you use controlled substances? _____ Yes _____ No _____ N/A
 Women, are you _____ Pregnant/Trying to get pregnant? _____ Nursing? _____ Taking oral contraceptives?

Are you allergic to any of the following?
 __Aspirin __Penicillin __Codeine __Acrylic __Metal __Latex __Local Anesthetic __Other _____

Do you have, or have you had any of the following? *Conditions may require medication

| | | | | |
|--|--|--|---|---|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Congenital Heart Disease | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Low BP | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Swelling of the Legs |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Heart Murmur* | <input type="checkbox"/> Mitral Valve Prolapse* | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Pace Maker* | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Parathyroid Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Artificial Heart Valve* | <input type="checkbox"/> Easily Winded | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Artificial Joint* | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Herpes | <input type="checkbox"/> Renal Dialysis | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> High BP | <input type="checkbox"/> Rheumatic Fever* | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> Hives or Rash | <input type="checkbox"/> Rheumatism | _____ |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Scarlet Fever | _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Shingles | _____ |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Sickle Cell Disease | _____ |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Sinus Troubles | _____ |

Former Dentist's Name _____ Phone # _____ Date of last visit _____

Reason for present dental visit _____

Is there any information you would like us to know that may better help us to serve your dental needs?

How did you hear about us? _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in my (or patient's) medical status.

Signature of Patient, _____ Date _____
 Parent, or Guardian

Signature of Doctor _____ Date _____



Patient Information

To new patients: It's nice to get acquainted.

Welcome to our office. Your kindness in furnishing the following information will be appreciated and will be used in strict confidence to prepare your clinical chart.

Patient's Full Name _____ Nickname _____ Age _____
Birth date _____ Social Security No. _____
Address _____ City _____ Zip _____
Home Phone _____ Cell Phone _____ Bus. Phone _____
Email _____
Employer _____
Physician _____ Phone # _____
Dental Problem _____
Spouse's Full Name _____
Spouse's Social Security Number _____
Employer _____ Bus. Phone _____ Cell Phone _____
Are there currently any other family members who are patients here? ___ Yes ___ No
If yes, indicate names _____
Who should we thank for this referral _____

Person Responsible For Account _____ Relationship _____
Home Address _____ City _____ Zip _____
Home Phone _____ Cell Phone _____ Bus. Phone _____
Method of Payment: ___ Cash ___ Debit Card ___ Check ___ Care Credit ___ Visa ___ Master Card ___ American Express ___ Discover

In compliance with the TRUTH IN LENDING LAW, here is our credit policy; it is customary to take care of the fee at the time the service is rendered unless other arrangements have been made. For your convenience we do accept all the above forms of payment.

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1.5% finance charge (18% APR) may be added to my account.

Signature _____ Date _____

Employee with Insurance _____ Relationship _____
Employed by _____ Occupation _____
Business Address _____ Bus. Phone _____
Social Security No. _____ Birth date _____ Sex ___ F ___ M
Dental Insurance Co. _____ Group Plan # _____
Mail Claims To _____
City _____ State _____ Zip _____ Phone _____



Dental Insurance

If you have dental Insurance, as a service to you, we will gladly file your insurance claims for you. We ask that you facilitate this matter by providing us with the following:

1. Your insurance card at your first visit for us to obtain a copy of.
2. Patient deductibles will have to be met at the time services are begun unless previously satisfied.
3. That part of treatment not covered by insurance (patient Co-payment) is to be paid at the time of service unless other arrangements are made in advance. Our staff will advise you of these approximate charges prior to treatment.

Please be aware that while we are pleased to offer this service, acceptance of insurance assignment by our office does not relieve the patient of ultimate responsibility for the fees incurred. Claims pending more than 60 days should be paid by the patient and reimbursed by the carrier. (GA law requires that claims be responded to by the carrier within 30 days of receipt.)

I authorize the release of any information to process insurance claims.

Signed _____ Date _____

I authorize payment of benefits directly to Gwinnett Dental Care, P.C.

Signed _____ Date _____

Consent

I hereby authorize the doctor or designated staff to take X-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (Name of Patient) _____'s dental needs.

Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I consent to the use of appropriate medication and therapy as deemed necessary. I fully understand that using anesthetic agents embodies a certain risk.

Patient _____ Date _____ Witness _____

Parent or Responsible Party _____ Relationship to Patient _____

I certify that the above information is true and accurate to the best of my knowledge.

Signed _____ Date _____

As a courtesy, our office asks that you please give us a **24 hours notice** if you cannot keep an appointment, this makes it possible to give your appointment time to another patient.



Patient Consent to Receive Mail and/or Telephone Messages

NAME _____

Do we have your permission to:

Send recall reminders to your home? ___ Yes ___ No

Leave appointment, billing, or dental
information on your answering machine,
voicemail, or e-mail: ___ Yes ___ No

I give permission to share appointment, billing, or dental information with the person named below:

NAME _____

Signature of Patient, Parent, or Guardian _____ Date _____

Acknowledgment of Receipt of Notice of Privacy Practices

I have received a copy of the Notice of Privacy Practices with an effective date of April 14, 2003.

Signature of Patient, Parent, or Guardian _____ Date _____



Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new right to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include crowns, fillings, teeth cleaning services, etc.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your dental plan for your dental services.
- **Health Care Operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health-related services including release of information to friends and family members that are directly involved in your care or who assist in taking care of you. We will use and disclose your protected when we are required to do so by federal, state or local law. We may disclose your PROTECTED HEALTH INFORMATION to public health authorities that are authorized by law to collect information, to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding, response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We will release your PROTECTED HEALTH INFORMATION if requested by a law enforcement official for any circumstance required by law. We may release your PROTECTED HEALTH INFORMATION to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs. We may release PROTECTED HEALTH INFORMATION to organizations that handle organ, eye or tissue donation and transplantation if you are an organ donor. We may use and disclose your PROTECTED HEALTH INFORMATION when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat. We may disclose your PROTECTED HEALTH INFORMATION if you are a member of US or foreign military forces and if required by the appropriate authorities. We may disclose your PROTECTED HEALTH INFORMATION to federal officials for intelligence and national security activities authorized by law. We may disclose PROTECTED HEALTH INFORMATION to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations. We may disclose your PROTECTED HEALTH INFORMATION to correctional institutions or law enforcement.