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

__AIDS/HIV Positive
__Alzheimer's Disease
__Anaphylaxis
__Anemia
__Angina
__Arthritis/Gout
__Artificial Heart Valve*
__Artificial Joint*
__Asthma
__Blood Disease
__Blood Transfusion
__Breathing Problems
__Bruise Easily
__Cancer
__Chemotherapy
__Chest Pains
__Cold Sores/Fever Blisters
__Congenital Heart Disease
__Convulsions
__Cortisone Medicine
__Diabetes
__Drug Addiction
__Easily Winded
__Emphysema
__Epilepsy/Seizures
__Excessive Bleeding
__Excessive Thirst
__Fainting Spells/Dizziness
__Frequent Cough
__Frequent Diarrhea
__Frequent Headaches
__Genital Herpes
__Glaucoma
__Hay Fever
__Heart Attack
__Heart Murmur*
__Heart Pace Maker*
__Heart Disease
__Hemophilia
__Hepatitis A
__Hepatitis B or C
__Herpes
__High BP
__Hives or Rash
__Hypoglycemia
__Irregular Heartbeat
__Kidney Problems
__Leukemia
__Liver Disease
__Low BP
__Lung Disease
__Mitral Valve Prolapse*
__Pain in Jaw Joints
__Parathyroid Disease
__Psychiatric Care
__Radiation Treatment
__Recent Weight Loss
__Renal Dialysis
__Rheumatic Fever*
__Rheumatism
__Scarlet Fever
__Shingles
__Sickle Cell Disease
__Sinus Troubles
__Spina Bifida
__Stroke
__Swelling of the Legs
__Thyroid Disease
__Tonsillitis
__Tuberculosis
__Tumors or Growths
__Ulcers
__Venereal Disease
__Jaundice
__Other_____
_____
_____

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, Parent, or Guardian _____Date_____

Signature of Doctor_____Date_____

Patient Information (Under 18)

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_____
Physician_____ Phone #_____
Dental Problem_____
Father's Full Name_____
Employed by_____ Bus. Phone_____ Cell Phone_____
Social Security Number_____
Mother's Full Name_____
Employed by_____ Bus. Phone_____ Cell Phone_____
Social Security Number_____
E-mail_____
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 make. 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 REVIE 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 by 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 and 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 PROTCTED 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.