North Atlanta
AESTHETIC DENTISTRY

PATIENT INFORMATION

Patient's Last Name:	First:	Middle Initial:	Preferred Name:

Is this your legal name? ☐ Yes ☐ No	Marital Status (circle one): Single/ Married /Divorced /Separated	Birth date:	Age:	Sex: ☐ M ☐ F

Street Address:	Email Address:	Cell Phone:

City:	State:	ZIP Code:

Occupation:	Employer:	Work Phone:

How did you hear about our office?

INSURANCE INFORMATION

Policyholder:	Birth date: / /	Phone:	Address (if different):

Policyholder SSN:	Insurance Company:	Insurance Phone:

Policy ID Number:	Group#:	Employer:

IN CASE OF EMERGENCY

Name of Emergency Contact:	Relationship to patient:	Phone:

PATIENT CONSENT

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to North Atlanta Aesthetic Dentistry, PC. I understand that I am financially responsible for all charges whether or not I have insurance. I also authorize North Atlanta Aesthetic Dentistry or my insurance company to release any information required to process my claim. I authorize the use of this signature on all my insurance submissions.

Signature _____ Date_____

MINOR/CHILD Consent: I, being the parent or guardian of the patient listed above, do hereby request and authorize the dental staff to perform recommended services for my child, including but not limited to x-rays, the administration of fluoride, local anesthetics, or nitrous oxide as deemed advisable by the doctor(s), whether or not I am present at the actual appointment when the treatment is rendered.

Signature_____ Date_____

Time 11:41 AM | North Atlanta Aesthetic Dentistry | Date 1/25/2016

Updated Medical History

Patient Name: | Birth Date: | Date Created:

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

Are you under a physician's care now?	○ Yes ○ No	If yes
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes
Are you taking any medications, pills, or drugs?	○ Yes ○ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes
Are you on a special diet?	○ Yes ○ No	
Do you use tobacco?	○ Yes ○ No	

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 ☐ Sulfa Drugs ☐ Local Anesthetics

Do you use controlled substances?	○ Yes ○ No	If yes
Other?	☐	If yes

Botox and Facial Fillers

Are you currently using Botox or facial fillers? ○ Yes ○ No

Do you have, or have you had, any of the following?

AIDS/HIV Positive ○ Yes ○ No	Cortisone Medicine ○ Yes ○ No	Hemophilia ○ Yes ○ No	Radiation Treatments ○ Yes ○ No
Alzheimer's Disease ○ Yes ○ No	Diabetes ○ Yes ○ No	Hepatitis A ○ Yes ○ No	Recent Weight Loss ○ Yes ○ No
Anaphylaxis ○ Yes ○ No	Drug Addiction ○ Yes ○ No	Hepatitis B or C ○ Yes ○ No	Renal Dialysis ○ Yes ○ No
Anemia ○ Yes ○ No	Easily Winded ○ Yes ○ No	Herpes ○ Yes ○ No	Rheumatic Fever ○ Yes ○ No
Angina ○ Yes ○ No	Emphysema ○ Yes ○ No	High Blood Pressure ○ Yes ○ No	Rheumatism ○ Yes ○ No
Arthritis/Gout ○ Yes ○ No	Epilepsy or Seizures ○ Yes ○ No	High Cholesterol ○ Yes ○ No	Scarlet Fever ○ Yes ○ No
Artificial Heart Valve ○ Yes ○ No	Excessive Bleeding ○ Yes ○ No	Hives or Rash ○ Yes ○ No	Shingles ○ Yes ○ No
Artificial Joint ○ Yes ○ No	Excessive Thirst ○ Yes ○ No	Hypoglycemia ○ Yes ○ No	Sickle Cell Disease ○ Yes ○ No
Asthma ○ Yes ○ No	Fainting Spells/Dizziness ○ Yes ○ No	Irregular Heartbeat ○ Yes ○ No	Sinus Trouble ○ Yes ○ No
Blood Disease ○ Yes ○ No	Frequent Cough ○ Yes ○ No	Kidney Problems ○ Yes ○ No	Spina Bifida ○ Yes ○ No
Blood Transfusion ○ Yes ○ No	Frequent Diarrhea ○ Yes ○ No	Leukemia ○ Yes ○ No	Stomach/Intestinal Disease ○ Yes ○ No
Breathing Problems ○ Yes ○ No	Frequent Headaches ○ Yes ○ No	Liver Disease ○ Yes ○ No	Stroke ○ Yes ○ No
Bruise Easily ○ Yes ○ No	Genital Herpes ○ Yes ○ No	Low Blood Pressure ○ Yes ○ No	Swelling of Limbs ○ Yes ○ No
Cancer ○ Yes ○ No	Glaucoma ○ Yes ○ No	Lung Disease ○ Yes ○ No	Thyroid Disease ○ Yes ○ No
Chemotherapy ○ Yes ○ No	Hay Fever ○ Yes ○ No	Mitral Valve Prolapse ○ Yes ○ No	Tonsillitis ○ Yes ○ No
Chest Pains ○ Yes ○ No	Heart Attack/Failure ○ Yes ○ No	Osteoporosis ○ Yes ○ No	Tuberculosis ○ Yes ○ No
Cold Sores/Fever Blisters ○ Yes ○ No	Heart Murmur ○ Yes ○ No	Pain in Jaw Joints ○ Yes ○ No	Tumors or Growths ○ Yes ○ No
Congenital Heart Disorder ○ Yes ○ No	Heart Pacemaker ○ Yes ○ No	Parathyroid Disease ○ Yes ○ No	Ulcers ○ Yes ○ No
Convulsions ○ Yes ○ No	Heart Trouble/Disease ○ Yes ○ No	Psychiatric Care ○ Yes ○ No	Venereal Disease ○ Yes ○ No
Yellow Jaundice ○ Yes ○ No			

Have you ever had any serious illness not listed	○ Yes ○ No	If yes

Comments:

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 medical status.

Signature of Patient, Parent or Guardian:

X Date:_____

OFFICE POLICY AND FINANCIAL AGREEMENT

CANCELLATIONS

_____ As a courtesy to our patients, our office will attempt to contact every patient to confirm appointments. We offer a variety of ways for our patients to confirm their appointments such as email reminders, confirmation calls and messages. We ask that our patients give a **24 hour** notice when rescheduling or cancelling an appointment so we may offer the appointment to another patient. A **$50.00** cancellation fee will be charged for any appointment cancelled or rescheduled without a **24 hour** notice. After a series of three failed or broken appointments outside of the **24 hour** notice, a deposit will be needed to reschedule your next appointment.

DENTAL/MEDICAL INSURANCE

_____ Our office is **NOT in-network** with any insurance company except Cigna Total Care DPPO. We are considered **OUT OF NETWORK** providers. Insurance gives our office general information regarding your plan and coverage. We will file your insurance claims as a service to you and we work with your insurance company to provide the most accurate **estimate** of your benefits and your out of pocket expense. It is the patient's responsibility to provide correct insurance information at the time of your appointment. We do not receive updates from your employer or insurance company if changes occur. With insurance companies paying only a portion of your care and without a guarantee of payment prior to the service; we encourage our patients to be prepared to pay all costs of care in the event the insurance denies your claim. After 60 days of non-payment from the insurance company, the total cost of treatment will be the responsibility of the patient. Co-insurance portions not paid by the insurance are due by you in full at the time the service is done.

PAYMENT OPTIONS

_____ We offer a variety of ways to pay for your services. We gladly accept: VISA, MASTERCARD, DISCOVER and AMERICAN EXPRESS. We also accept cash and personal checks. If you are interested in financing please ask for details. After 90 days of non-payment your account may be sent to a collections agency. The patient is responsible to pay any collection cost and/ or attorney fees associated with the recovery of your payment due.

PHOTO RELEASE

_____ I give permission for North Atlanta Aesthetic Dentistry, P.C., to use any photographs or radiographs (without identifying information) to be used for educational or promotional purposes within our practice.

ALL FINANCIAL ARRANGMENTS MUST BE MADE AND AGREED TO PRIOR TO THE SERVICE BEING DONE.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician's certifications.

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 organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization 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 you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

_____ _____

Patient Name Date

_____ _____

Signature Relationship to Patient
(If patient is a minor)

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can gain access to this information. Please review it carefully.

Protected health information, about you, is maintained as a record of your contacts or visits for healthcare services with our practice. Specifically, "protected health information" is information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related health care services.

Our practice is required to follow specific rules on maintaining the confidentiality of your protected health information, using you information, and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your protected health information. It also describes how we follow applicable rules and use and disclose your protected health information to provide your treatment, obtain payment for services you receive, manage our health care operations and for other purposes that are permitted or required by law.

We are required to abide by the terms of the Notice of Privacy Practices. We reserve the right to change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. A revised Notice of Privacy Practices may be obtained by calling the office and requesting that a copy be mailed to you, or asking for one at the time of our next appointment.

Your Rights Under The Privacy Rule

Following is a statement of your rights, under the Privacy Rule, in reference to your protected health information. Please feel free to discuss any questions with our staff.

- You have the right to receive, and we are required to provide you with, a copy of the Notice of Privacy Practices- We are required to follow the terms of this notice. We reserve the right to change the terms of our notice, at any time. If needed, new versions of this notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment.
- You have the right to authorize other use and disclosure- This means you have the right to authorize or deny any other use or disclosure of protected health information that is not specified within this notice. You may revoke an authorization, at any time, in writing, except to the extent that your Healthcare Provider or our office has taken an action in reliance on the use or disclosure indicated in the authorization.

- You have the right to designate a personal representative-This means you may designate a person with the delegated authority to consent to, or authorize the use or disclosure of protected health

information.

- You have the right to inspect and copy your protected health information- This means you may inspect and obtain a copy of protected health information about you that is contained in your patient record. We have the right to charge a reasonable fee for copies as established by professional, state, or federal guidelines.
- You have the right to request a restriction of your protected health information- This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members of friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. In certain cases, we may deny your request for a restriction.
- You may have the right to request an amendment to your protected health information- This means you may request an amendment of your protected health information for as long as we maintain this information. In certain cases, we may deny your request for an amendment.
- You have the right to request a disclosure accountability- This means you may request a listing of disclosures that we have made, of your protected health information, to entities or persons outside of our office.

How We May Use or Disclose Protected Health Information

Following are examples of uses and disclosures of your protected health care information that we are permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

- Treatment- We may use and disclose your protected health information to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your protected health information, as necessary, to a pharmacy that would fill your prescription. We will also disclose protected health information to other Health care Providers who may be involved in your care and treatment.
- We may also call you by name in the waiting room when your Healthcare Provider is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests and to provide information that describes or recommends treatment alternatives regarding your care. Also, we may contact you to provide information about health related benefits and services offered by our office.
- Payment- Your protected health information will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that

your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

- Healthcare Operations- We may use or disclose, as-needed, your protected health information in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, and auditing functions. It also includes education, provider credentialing, certification, underwriting, rating, or other insurance-related activities. Additionally, it includes business administrative activities such as customer service, compliance with privacy requirements, internal grievance procedures, due diligence in connection with the sale or transfer of assets, and creating de-identified information.
- Regional Information Organization – The practice may elect to use a regional information organization or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

Other Permitted and Required Uses and Disclosures

We may also use and disclose your protected health information in the following instances as outlined below. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information.

- To Others Involved in Your Healthcare- Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person, that you identify your protected health information that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, general condition or death. If you're not present or able to agree or object to the use or disclosure of the protected health information, then your Healthcare Provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your healthcare will be disclosed.
- As Required by Law- We may use or disclose your protected health information to the extent that is required by law.
- For Public Health- We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information.
- For Communicable Diseases- We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable

disease or may otherwise be at risk of contracting to spread the disease or condition.

- For Health Oversight- We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections.

- In Cases of Abuse or Neglect- We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made in a manner that is consistent with the requirements of applicable federal and state laws.
- To The Food and Drug Administration- We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, to monitor product defects or problems, to report biologic product deviations, to track products, to enable product recalls, to make repairs or replacements, or to conduct post-marketing surveillance, as required.
- For Legal Proceedings- We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.
- To Law Enforcement- We may also disclose protected health information, as long as applicable legal requirements are met, for law enforcement purposes.
- To Coroners, Funeral Directors, and Organ Donation- We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected heath information to a funeral director, as authorized by law, in order to permit the funeral director to carry out his/her duties. Protected health information may be used and disclosed for cadaver organ, eye or tissue donation purposes.
- For Research- We may disclose your protected health information to researchers when an institutional review board has reviewed and approved the research proposal and established protocols to ensure the privacy of your protected health information.
- In Cases of Criminal Activity- Consistent with applicable federal and state laws, we may disclose your protected health information if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information, if it is necessary for law enforcement authorities, to identify or apprehend an individual.
- For Military Activity and National Security- When the appropriate conditions apply, we may

use or disclose protected health information of individuals who are Armed Forces personnel: (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits; or (3) to foreign military authority if you are am member of that foreign military service.

- For Workers' Compensation- Your protected health information may be disclosed as authorized to comply with workers' compensation laws and other similar legally-established programs.
- When an Inmate- We may use or disclose your protected health information if you are an inmate of a correctional facility and your Healthcare Provider created or received your protected health information in the course of providing care to you.
- Required Uses and Disclosures- Under the law, we must make disclosures about you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the Privacy Rule.