NORTH FULTON SMILES

Welcome! We are pleased you've joined our dental family. We look forward to discussing and treating your dental needs. Please feel free to ask us how we can make **you** feel good about your teeth.

(Please Print)

First Name: _____ Middle Initial: ____ Last Name: _____

Address: _____ City, State, Zip_____

Home Phone: (___ _____ Work Phone: (___ _____ Cell Phone: (___) _____

Additional Contact Number: (___ _____ M/F: _____ Marital Status: _____

Birth Date: _____ SSN: _____ Email: _____ Nickname: _____

Emergency Contact: _____Relationship:_____Contact Number: (___) _____

If you are completing this form for another person, what is your relationship to that person?

Name: _____ Relationship: _____

Responsible Party (If someone other than the patient.)

First Name: _____ Last Name: _____

Address: _____City, State, Zip: _____

Home Phone: (___) _____ Work Phone: (___) _____ Cell Phone: (___) _____

(Primary Insurance Holder is considered to be the responsible party.)

Primary Insurance Information

(If you have given us this information over the phone, feel free to leave blank.)

First Name of Insured: _____ Last Name of Insured: _____

Relationship to Patient: Self Spouse Child Other Insured's Date of Birth: _____

Insured's Member ID or SSN: _____ _____ Group #: _____

Insured's Employer: _____ _____ Insurance Co.: _____

Claims Address: _____ Insurance Phone Number: (_____

The permission and presence of a parent or legal guardian is required for treatment of a minor (a child under the age of 18). No exceptions can be made to this policy.

All information obtained on this and the following forms is for our records only and will be kept confidential in accordance with all applicable laws. Please note that during your initial visit, you may be asked questions regarding your answers on this form and there may be additional questions concerning your health. This information is vital in allowing us to provide appropriate care to you. This office does not use this information to discriminate.

I hereby authorize releases of any information needed and also authorize my insurance company to pay directly to North Fulton Smiles, LLC any benefits accruing to me under my policy.

Signature of Insured: _____ Date: _____

Signature of Patient (Parent or Guardian of minor): _____

Practice Policies

Appointment Policy

We have a **2-BUSINESS DAY** cancellation policy. If you need to change or reschedule your reserved time with us, please give us at least a **2-BUSINESS DAY** notice so that we will be able to fill this time with others waiting for treatment. If you cancel or fail to show for your appointment we recover our lost opportunity and associated costs for having our staff on standby with a **BROKEN Appointment Fee** of $50.

Please understand that if you have TWO (2) broken appointments, we reserve the right to release you as a patient and ask that you seek treatment at another dental practice. Thank you for understanding this policy.

Payment Policy

We are committed to providing you with affordable and excellent dental care. Your trust is very important to us. Our goal is to make sure you fully understand your treatment needs and financial responsibility before treatment begins. We will make every effort to work with you to ensure your dental needs are be met.

PAYMENTS:

Payment is expected at the time of service unless prior financial arrangements have been made. We offer several options:

We accept Visa, MasterCard, American Express and Discover as well as HSA cards.

Patients with insurance:

Co-pays, deductibles, and/or portions not covered by insurance are due at the time of treatment.

Insurance and Payment Policy

PAYMENTS:

Payment is due at the time of service unless prior financial arrangements have been made. We offer several options:

We accept Visa, MasterCard, American Express and Discover as well as HSA cards.

Patients with insurance:

Co-pays, deductibles, and/or portions not covered by insurance are due at the time of treatment.

Insurance Policy

We strive to help you maximize your dental insurance benefits. However, we do not have the capability to go through every single insurance code and find out what each individual insurance company covers. Normally they cover according to this: Preventative: This is your dental wellness visit, cleaning and x-rays. Basic: This is *most of the time* your fillings, periodontal, and endodontics (root canals). Sometimes endo falls under your major coverage. Major: This is your crowns, bridges, and prosthodontics. Please understand that your insurance company and employer have a contract with each other. Companies are allowing your insurance company to downgrade your procedures to sub-standard care. You, as the subscriber, will be responsible for any balances remaining after insurance payments.

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE RECEIVED OR READ A COPY OF THE PRACTICE POLICIES FROM NORTH FULTON SMILES.

_____ _____

SIGNATURE DATE

NORTH FULTON SMILES

Patient Name: _____ Nickname: _____

How did you hear about our office? _____

Patient Dental History

What is the reason for your visit with us today? (e.g.: pain, checkup, etc.) _____

Previous dentist: _____ Last visit: _____ Date of last cleaning: _____

Reason for changing dentists: _____

Have you had any problems with past dental treatment? _____

Are you nervous about seeing a dentist? [ ] Yes [ ] No If yes, please tell us why: _____

How often do you brush? _____ Do you floss? [ ] Yes [ ] No How often? _____ Toothbrush: Hard Soft Electric

Do you:

[ ] Clench or grind your teeth during the day or while sleeping?

[ ] Like your smile?

[ ] Prefer tooth-colored fillings?

[ ] Have or have had orthodontics?

[ ] Want whiter teeth?

[ ] Want straighter teeth?

[ ] Any pain/ clicking of your jaw joint when opening or closing?

[ ] See bleeding when brushing or flossing?

[ ] Feel tenderness or swelling of your gums?

[ ] Have problems eating?

[ ] Avoid brushing areas due to pain?

[ ] Have or had a facial or jaw injury?

[ ] Have a dry mouth or low saliva flow?

[ ] Take antibiotics prior to dental treatment?

What are your dental priorities (e.g.: appearance, dental health, etc.)? _____

Patient Medical History

Although dental personnel primarily treat the areas of your mouth, it is part of your entire body. Health problems that you may have or medications you may be taking could have an important interrelationship with any dental care you may receive. Thank you for answering the following questions.

Are you currently under a physician's care? [ ] Yes [ ] No Condition(s) _____

Physician's Name_____

Physician's Address_____

Physician's Phone #_____

Are you taking any prescriptions or supplements? [ ] None [ ] List_____

_____

Have you ever been hospitalized or had major surgery? [ ] Yes [ ] No Details_____

Have you had any cosmetic surgery? [ ] Yes [ ] No Details _____

Have you ever had a serious head or neck injury? [ ] Yes [ ] No Details_____

Have you ever or are you currently taking Phen-Phen or Redux? [ ] Yes [ ] No

Have you ever or are you currently taking a bisphosphonate such as Fosamax or Boniva? [ ] Yes [ ] No

Are you on a special or restricted diet? [ ] Yes [ ] No

Do you use controlled substances or recreational drugs? [ ] Yes [ ] No

Do you smoke? [ ] Yes [ ] No # of packs per week_____ Do you use smokeless tobacco? [ ] Yes [ ] No

NORTH FULTON SMILES

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?

[ ] Acid Reflux	[ ] Convulsions	[ ] Heart Murmur	[ ] Psychiatric Disorders
[ ] AIDS/HIV Positive	[ ] Corticosteroids	[ ] Heart Surgery	[ ] Radiation
[ ] Alzheimer's disease	[ ] Deep Vein Thrombosis	[ ] Hemophilia	[ ] Rheumatic Fever
[ ] Anemia	[ ] Diabetes	[ ] Hepatitis A	[ ] Respiratory Problems
[ ] Angina	[ ] Dialysis	[ ] Hepatitis B or C	[ ] Scarlet Fever
[ ] Anorexia/Bulimia	[ ] Drug Addiction	[ ] Herpes	[ ] Sickle Cell Disease
[ ] Arthritis/Gout	[ ] Emphysema	[ ] High Blood Pressure	[ ] Sinus Trouble
[ ] Artificial Heart Valve	[ ] Epilepsy or Seizures	[ ] Hives or Rash	[ ] Spina Bifida
[ ] Artificial Joint(s)	[ ] Excessive Bleeding	[ ] Hypoglycemia	[ ] Stomach/Intestinal Disease
[ ] Asthma	[ ] Excessive Thirst	[ ] Irregular Heartbeat	[ ] Stroke
[ ] Blood Transfusion	[ ] Fainting Spells/Dizziness	[ ] Kidney Problems	[ ] Swelling of Limbs
Date: _____	[ ] Fibromyalgia	[ ] Leukemia	[ ] Thyroid Disease
	[ ] Frequent Cough	[ ] Liver Disease	[ ] Tonsillitis
[ ] Bruise Easily	[ ] Frequent Diarrhea		[ ] Tuberculosis
[ ] Cancer	[ ] Frequent Headaches	[ ] Lung Disease	[ ] Tumors or Growths
[ ] Chemotherapy	[ ] Genital Herpes/Warts	[ ] Measles/Mumps	[ ] Ulcers
[ ] Chest Pains	[ ] Glaucoma	[ ] Mitral Valve Prolapse	[ ] Venereal Disease
[ ] Cold Sores/Fever Blisters	[ ] Hay Fever	[ ] Neuropathy	[ ] Yellow Jaundice
[ ] Congestive Heart Failure	[ ] Heart Attack	[ ] Parathyroid Disease	

Have you had any serious illness not listed above? [ ] Yes [ ] No Explain: _____

Female Patients only Are you: [ ] Pregnant? [ ] Trying to conceive? [ ] Nursing? [ ] Taking oral contraceptives?

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

Patient Name (Please Print): _____ Date: _____

Patient/Legal Guardian Signature: _____

NORTH FULTON SMILES

Patient Consent to Receive Mail, E-mail, and /or Telephone Messages

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters) or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

I agree that the practice may communicate with me electronically at the following address:

Phone Number: _____ E-Mail Address: _____

I consent to receive calls and test messages related to my protected healthcare and other services at the phone number(s) above, including my wireless number provided. I understand I may be charged for such calls by m wireless carrier and that such calls may be generated by an automated dialing system.

I give my permission to receive:

Recall appointment reminders sent to my home. Y_____ N_____

Unsecured appointment, billing or dental information via answering machine / voice mail / e-mail: Y_____ N_____

Unsecured emails for Ads, Specials and Promotions: Y_____ N_____

Patient Name (Please Print): _____ Date: _____

Patient/Legal Guardian Signature: _____

NORTH FULTON SMILES

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AS WELL AS HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR PERSONAL INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your protected health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect on 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 to you when you first receive services from us after the date the revised notice becomes effective or 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 at the end of this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

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

> **Treatment:** We may use or disclose your health information for your treatment, For example, we may disclose to a doctor or other health care provider providing treatment to you.
>
> **Payment:** We may use or disclose your health information to obtain payment for services we provide to you.
>
> **Health Care Operations:** We may use or disclose your health information in connection with our health care operations. For example, Health care operations include quality assessment and improvement activities, reviewing competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation and certification, licensing, or credentialing activities.

Marketing or Sales: We will not use your health information for marketing communications without your written consent nor disclose your health information in exchange for remuneration, without your written authorization. .

Your Authorization: In addition to our use of your health information for the following purposes, 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.

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

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including and identifying or locating) a family member, your personal representative or another person responsible for your care, to the extent necessary to help with your health care or with payment of your health care, if you agree that we may do so. We may also advise these persons 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 and 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 the information that is directly relevant to the person's involvement in your health care. We will also use our professional judgment and our experience with common practice to make reasonable inferences on your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Public Health and Public Benefit: We may use or disclose your health information to report abuse, neglect, or domestic violence; to report disease, injury, and vital statistics; to report certain information to the Food and Drug Administration (FDA); to alert someone who may be at risk of contracting or spreading a disease; for health oversight activities; for certain judicial and administrative proceedings; for certain law enforcement purposes to avert a serious threat to health or safety; and to comply with workers' compensation or similar programs.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counter intelligence, and other national security health information of an inmate or patient under certain circumstances.

Correspondence: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters), correspondence, and missed appointment notification.

PATIENT RIGHTS

Access: You have the right to look at or obtain copies 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 the notice. You may also request access by sending us a letter to the address at the end of this notice. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying. 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 and breach notification: 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. Affected patients have a right to be notified following a breach of unsecured protected health information.

Amendment: the right to request amendments to your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

Restrictions: the right to request restrictions on our permitted uses and disclosures of your information (although we are not legally obligated to honor this request); and

Alternative Communication: You have the right to request that we communicate with you about your health information be sent by alternative means or at 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.

Electronic Notice: You may receive a paper copy of this notice upon request, even if you have agreed to receive this notice electronically on our Web Site or by electronic mail (e-mail).

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact our Office manager at the information listed below.

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 alternative locations, you may complain to us using the contact information listed at the end of the notice. You may also 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 upon request. We support your right to the privacy of your health information. We will not retaliate in any way should you choose to file a complaint either with us or the U.S. Department of Health and Human Services.

Contact: Diana Byrdsong, Office Manager

Telephone: 770-569-0613

Fax: 770-569-0614

Address: 12315 Crabapple Road, Suite # 121

Alpharetta, Ga. 30004

NORTH FULTON SMILES

North Fulton Smiles, LLC
Alpharetta, Georgia 30004

Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of North Fulton Smiles, LLC. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

North Fulton Smiles, LLC reserves the right to change the privacy practices currently described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed or otherwise transmitted to me.

ADDITIONAL DISCLOSURE AUTHORIZATION		
In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare Information to the person(s) identified below. (I understand that the default answer is "NO". Without indicating "YES" in answer to the each individual question, personal protected (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)		
Spouse only	☐ **YES**	☐ **NO**
OR		
Any Member of my immediate family: (Spouse, Children, Children's Spouses)	☐ **YES**	☐ **NO**
Any Member of my extended family: (Parents, Grandchildren)	☐ **YES**	☐ **NO**
Other: _____	☐ **YES**	☐ **NO**
Name of patient (please print): _____		
Patient signature (if 18 years old or older): _____		
Patient's personal representative: (Please Print): _____		
Personal Representative's signature: _____		
Representative's Telephone Number: _____ Date: _____		

OFFICE USE ONLY BELOW THIS LINE

Acknowledgement Not Obtained			
Provided Prior to Treatment?	☐ **YES**	☐ **NO**	**Date Statement Provided: _____**
Reason for not obtaining patient signature	☐	**Needed more time to review Statement of Privacy Practices**	
	☐	**Wanted to consult another person before signing**	
	☐	**Physically unable to sign**	
	☐	**No reason offered**	
	☐	**Other:**	