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: ____________________

I would like to receive correspondence via email: Yes No

Employment Status: Full Time Part Time Retired Unemployed

Student Status: Full Time Part Time

Emergency Contact: ____________________________ Relationship:____________________ Contact Number: (___)___________
Do we have your permission to discuss your medical health with this person? Yes No

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): ____

Dental Practice and Financial Policy (Please Read Carefully)

Dear Patient:

It is our goal to operate this office as efficiently as possible and for our staff to attend all your dental needs. To ensure this, we will try to meet each patient according to his or her need as best understood when making an appointment. Since everyone's time is very valuable, if you are more than **15 minutes late**, we may reschedule your appointment to allow the doctor and hygienist to maintain their schedules.

We must also have at least 48 hours notice if you need to cancel or reschedule your appointment to allow us to bring in another patient at that time. Failure to give a 48 hour notice will result in a **$50 per hour of scheduled time** broken appointment fee and, for longer appointments only, a **$100 per hour deposit** to reschedule. It is your responsibility to keep track of your appointments. A call to remind you is only a courtesy, not a requirement.

New patient appointments consist of a cancer screening, comprehensive exam, periodontal screening, necessary x-rays (to be determined by the doctor), and a presentation of a detailed treatment plan. Cleanings are done if time permits and depends on the condition of periodontal tissues (gums).

Our office does not alter treatment plans to accommodate insurance allowances.

Considerable care has been taken in the setting of our fees. We want to assure you that our charges accurately reflect the complexity of care rendered and the skill and expertise required. Our fees are comparable with fees of other general dentists in this area.

As such, **our practice policy requires payment at the time of service for all office visits and procedures**. Our agreement is with you, not your insurance company; therefore you are ultimately responsible for any and all charges incurred. You (and perhaps your employer) have chosen your coverage. We will assist you by filing all of your claims to your carrier and providing any documentation you may need in an effort to expedite reimbursement. This is a courtesy to you, our valued patient, not a requirement of this office. Payment to our office is not contingent or dependent upon your insurance company. Fees quoted are an estimate based on the information provided by you and your insurance company and are subject to change. In the event that your carrier has not paid their estimated portion within 60 (sixty) days after the date of service, any and all unpaid balance becomes the responsibility of the patient as does following up with the insurance company to obtain proper reimbursement. We will gladly provide you with a copy of any claim in question that we submitted to your carrier.

Insurance verification is not a guarantee of coverage. If your carrier denies a claim for any reason, we will bill you the requisite fees incurred. It will be your responsibility to file an appeal with your insurance company and receive reimbursement from them. It is also your responsibility to inform our office of any changes in carrier or coverage. This office cannot and will not render treatment on the assumption that charges will be paid by your insurance carrier.

All deductibles and co-pays are due at the time services are rendered unless other financial arrangements have been made in advance.

Some procedures require specimens to be sent to an outside laboratory for analysis. This is a separate facility and you may receive an additional statement from them.

Cosmetic procedures and services are not covered by insurance. Payment for all cosmetic services is expected at the time treatment is rendered.

In an effort to make payment for your care more convenient, we accept Visa, Mastercard, Discover, and American Express as well as personal checks and cash. We also accept Care Credit. If you are interested in learning more about Care Credit, please ask our Patient Coordinator. We do not offer any long-term, in-house payment plan.

All accounts that have a balance of more than $5.00 and are over 30 (thirty) days old will incur a $10.00 late fee that will accrue each month that the balance remains. We reserve the right to submit your personal information to any agency deemed necessary to collect the balance that is due.

All returned checks and credit card charge-backs will incur a charge of $35.00 or 5% of the face amount, whichever is greater. This includes checks that have had a stop payment placed on them.

By signing, you agree to all conditions herein and as well as the financial stipulations above.

Signed: ____ Date: ____________________

Printed : ____

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

Female Patients only Are you: [ ] Pregnant? [ ] Trying to conceive? [ ] 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?

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

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

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: ____

Acknowledgement of Receipt of Notice of Privacy Practices

You may refuse to sign this acknowledgement. Doing so will prevent us from filing any claims on your behalf with your insurance carrier.

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

Print: ____

Signature: ____

Date: ___________________________________

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but were unable to because:

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

___

___

___

Joint 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 OBLIGATIONS

We are required by law to maintain the privacy of your personal health information. We are also required to give you this notice about our privacy practices, our legal obligations, 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 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 to a physician or other health care provider who is providing treatment to you.

Payment: We may use or disclose your health information to your health insurer 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. 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. For example, we may use or disclose your health information in order to conduct an internal assessment of the quality of care that we provide.

Marketing Health –Related Services: We will not use your health information for marketing communications without your written consent.

Your Authorization: Other uses and disclosures of your health information will be made if you give us written authorization to do so. 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.

PATIENT RIGHTS

You have certain rights regarding your health information. These rights include:

1. the right to obtain a paper copy of this notice;
2. the right to inspect and copy your health information (copies are available for a reasonable fee);
3. the right to request amendments to your health information you believe to be accurate;
4. the right to obtain an accounting of North Fulton Smiles' uses and disclosures of your information, subject to certain exceptions;

5. 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
6. the right to request that communications regarding your health information be sent by alternative means or at alternative locations.

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 wish to exercise any of your rights described herein, please contact us using the contact information at the end of this 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 Officer: Heather Delgado

Telephone: 770-569-0613 **Fax:** 770-569-0614

Address: 1240 Upper Hembree Rd. Suite E, Roswell, GA 30076

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.

Disclosures Permitted or Required by Law: We are permitted, and in some cases required, by law to make certain other disclosures of health information without your consent. We may disclose your health information, if appropriate, to the following entities under the following circumstances:

1. to public health agencies to satisfy certain reporting requirements, such as births or deaths, certain communicable diseases, child abuse, and other public health issues;
2. to health oversight agencies such as governmental auditors, the Georgia Agency for Health Care Administration, the Georgia Department of Health, and other agencies when required;
3. to any individual when North Fulton Smiles is ordered by a court or other legal process to do so;
4. to law enforcement officials when necessary for law enforcement purposes and as required by law;
5. to a coroner or medical examiner when necessary to enable them to perform their duties;
6. to organ procurement organizations to enable them to make a suitability determination;
7. in cases of emergency;
8. or to researchers if their research has been approved by an institutional review board and they take certain steps to protect your privacy.

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.