NORTHWEST GEORGIA DENTISTRY

PATIENT INFORMATION

Full Legal Name _____ Preferred Name _____
First Middle Last

Address _____
Street and Number City State Zip

E-Mail Address: _____

Telephone: Home _____ Work _____ Mobile/Beeper _____
Area Code Number Area Code Number Area Code Number

Date of Birth _____ Social Security # _____ Driver's License # _____
Month/Day/Year

Employer _____ Occupation _____
Name Address

Marital Status: ___ Married ___ Single Sex: ___ Male ___ Female

SPOUSE-PARENT OR LEGAL GUARDIAN INFORMATION

Full Legal Name _____ Preferred Name _____
First Middle Last

Address _____
Street and Number City State Zip

Telephone: Home _____ Work _____ Mobile/Beeper _____
Area Code Number Area Code Number Area Code Number

Date of Birth _____ Social Security # _____ Driver's License # _____
Month/Day/Year

Employer _____ Occupation _____
Name Address

NEAREST RELATIVE *NOT* LIVING WITH YOU

Name _____ Telephone Number _____
First Middle Last Area Code Number

Address _____
Street and Number City State Zip

Relationship? _____

INSURANCE INFORMATION - ALL INFORMATION REQUIRED

Dental Insurance Co. _____ Employer _____
Name Address

Name of Insured _____ Group Number _____

Insured's mailing address (if different) _____

Insured Identification No.: _____ D.O.B.: _____

Secondary Insurance _____

DENTAL HISTORY

Reason for visit: _____

When was your last dental visit? _____ What was done? _____

Date of last cleaning _____ Where x-rays made at that time? ___ Yes ___ No

Have you ever had a Panorex or a complete set of x-rays? ___ Yes ___ No When? _____

Have you ever had an unfavorable dental experience? ___ Yes ___ No If, yes please describe _____

Do you like the appearance of your teeth? ___ Yes ___ No ..... Your Smile? ___ Yes ___ No

Are any of your teeth painful or sensitive? ..... ___ Yes ___ No

Do your gums bleed easily? ..... ___ Yes ___ No

Do your gums feel tender or swollen? ..... ___ Yes ___ No

Have you ever been told that you have Periodontal (gum) disease? ..... ___ Yes ___ No

Do you ever have any discomfort around your ear, throat, neck, or shoulders? ..... ___ Yes ___ No

Does your jaw ever pop or lock open? ..... ___ Yes ___ No

MEDICAL HISTORY

PATIENT NAME _____

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 Name: _____

Have you ever been hospitalized or had a major operation? ○ Yes ○ No List: _____

Have you ever had a serious head or neck injury? ○ Yes ○ No When: _____

Are you taking any medications, pills, or drugs? ○ Yes ○ No List: _____

Do you take, or have taken, Phen-Fen or Redux? ○ Yes ○ No

Do you use tobacco? ○ Yes ○ No

Are you on a special diet? ○ Yes ○ No

Do you use controlled substances? ○ 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 ❑ Local Anesthetics ❑ Other

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

❑ AIDS/HIV Positive	❑ Cancer	❑ Frequent Headaches	❑ Leukemia	❑ Sinus Trouble
❑ Alzheimer's Disease	❑ Chemotherapy	❑ Glaucoma	❑ Liver Disease	❑ Spina Bifida
❑ Anaphylaxis	❑ Chest Pains	❑ Hay Fever	❑ Low Blood Pressure	❑ Stomach/Intestinal Disease
❑ Anemia	❑ Cold Sores/Fever Blisters	❑ Hearing Impaired	❑ Lung Disease	❑ Stroke
❑ Angina	❑ Congenital Heart Disorder	❑ Heart Attack/Failure	❑ Mitral Valve Prolapse*	❑ Swelling of Limbs
❑ Arthritis/Gout	❑ Convulsions	❑ Heart Murmur*	❑ Nervous Disorder	❑ Thyroid Disease
❑ Artificial Heart Valve*	❑ Cortisone Medicine	❑ Heart Pace Maker*	❑ Pain in Jaw Joints	❑ Tonsillitis
❑ Artificial Joint*	❑ Diabetes	❑ Heart Trouble/Disease	❑ Parathyroid Disease	❑ Tuberculosis
❑ Asthma	❑ Drug Addiction	❑ Hemophilia	❑ Radiation Treatments	❑ Tumors or Growths
❑ Bisphosphonates for Osteoporosis	❑ Easily Winded	❑ Hepatitis A	❑ Recent Weight Loss	❑ Ulcers
	❑ Emphysema	❑ Hepatitis B or C	❑ Renal Dialysis	❑ Venereal Disease
❑ Blindness	❑ Epilepsy or Seizures	❑ High Blood Pressure	❑ Rheumatic Fever*	❑ Yellow Jaundice
❑ Blood Disease	❑ Excessive Bleeding	❑ Hives or Rash	❑ Rheumatism	
❑ Blood Transfusion	❑ Excessive Thirst	❑ Hypoglycemia	❑ Scarlet Fever	
❑ Breathing Problem	❑ Fainting Spells/Dizziness	❑ Irregular Heartbeat	❑ Shingles	
❑ Bruise Easily	❑ Frequent Cough	❑ Kidney Problems	❑ Sickle Cell Disease	

Have you ever had any serious illness not listed above ❑ Yes ❑ No ❑ N/A _____

Whom may we thank for referring you to our office? _____

CONSENT

The undersigned hereby authorizes Northwest Georgia Dental Center to take x-rays, study models, photographs, or any other diagnosis aids deemed appropriate by Northwest Georgia Dental Center to make a thorough diagnosis of my dental needs. I also authorize Northwest Georgia Dental Center to perform any and all forms of treatment, medication and therapy, that may be indicated. I understand that the use of anesthetic agents embodies a certain risk, as does any type of dental treatment.

I authorize payment directly to Northwest Georgia Dental Center of any group insurance benefits otherwise payable to me and agree to the release of information relating to this claim.

I certify that the medical and dental history information is correct to the best of my knowledge.

Signed _____ Date _____

(Patient or Legal Guardian)

NORTHWEST GEORGIA DENTAL CENTER

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, 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 4-14-03, 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 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 listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

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

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, 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.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

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

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

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

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your 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 this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.75 for each page, $20.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. 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: 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.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend 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.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concemed 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 at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may 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 with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: A. Henry

Telephone: 706-935-2206 Fax: 706-935-8247

E-Mail: nwgdentl@catt.com

Address: 7319 Nashville Street, Ringgold, Georgia 30736

Northwest Georgia Dentistry

Financial Policy

Thank you for choosing us as your dental care provider. We are absolutely committed to the success of your treatment, and we want to make every visit as comfortable and productive as possible. In order for us to maintain the superb quality of care that our patients have learned to expect, we ask you to read and adhere to the following financial guidelines:

*Payment is required at the time that services are rendered.

*Balances older than 30 days or partial monthly payments will be subject to additional finance charges.

*Broken appointments or appointments cancelled without a 24 hour notice will be charged a fee for the missed appointment.

*Concerning divorced or separated parents- the parent bringing the child in for treatment is responsible for the day of service.

Insurance

*Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.

*We will file your insurance as a COURTESY on your behalf.

*We will file your insurance only ONE time, as we are finding insurance companies are becoming less cooperative with dental offices in general. Any additional filings are to be done by the patient.

*If your insurance company has not paid us within 60 days, you are responsible for the balance in full.

*All deductibles and appropriate percentages must be paid at the time of treatment. We can only ESTIMATE what your insurance will pay; any amount that insurance does not pay is your responsibility.

I have read, understand, and agree to the provisions of this Financial Policy.

_____ _____ _____

Signature of Responsible Party Date Patient Name

Notice of Privacy Practices

* You May Refuse to Sign This Acknowledgement*

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

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

Signature_____

If patient's name differs from signature, please print patient's full name: _____