Healthy Smiles Of Georgia

Patient Name: **SSN:** **DOB:**

Name of Parent/Guardian **Patient Age:** **Sex:** ☐M ☐F

Street Address: **Email:**

City, State, Zip: **Occupation:**

Tel:(Home) **(Work)** **(Cell)** **Driver License #:**

Employer: **Position:**

Employer's Address:

In case of emergency, your nearest relative (other than spouse), neighbor or friend not living with you to contact:

Name: **Relationship:**

Address: **Phone:**

If Patient is married, please fill out this section.

Spouse's Name: **Spouse's DOB:**

Marital Status: **Spouse's Work #:** **Spouse's SSN:**

Spouse's Employer: **Position:**

Spouse's Employer's Address:

If patient is covered by dental insurance, please fill out this section.

Name of Insured:

Dental Insurance Company: **Policy / Group #:**

Release of Information / Assignment of Benefits

I authorize the release of any dental information necessary to process my claims.

Signed (Patient, or parent if Minor) Date

How were you referred to us? (check one)

☐Friend or family member ☐Yellow Pages ☐Web / Internet

☐Insurance Company ☐Our Staff Members ☐Other (please specify)

Whom may we thank for your referral?

I , the undersigned (patient or legally responsible party) authorize treatment to be rendered and assume financial reponsibility. I acknowledge that all non-current balances on accounts over thirty days will be charged a service charge of 1.5% per month (18% annually) on the unpaid balance. Any additional costs incurred in collecting this account including court costs, agency fees and attorney fees will be added to your balance due.

Signature of Person Responsible for the payment of the Account:

Visit us on the web at www.healthysmilesofgeorgia.com

MEDICAL HISTORY

Please answer **ALL** questions by circling either **YES** or **NO**. If you don't understand a question go on to the next one, the doctor will review it with you. All information is confidential.

1. When did you last receive dental treatment?
   What type of treatment?_____
2. Previous Dentist_____
   City, State_____
3. Do you have dentures, partial dentures or bridges? Y N
4. Date of last physical examination?_____
5. Have you been hospitalized during the past three years? Y N
   If so, please explain._____
6. Have you had any serious illnesses in the past three years? Y N
   If so, please explain._____
7. Are you under a physician's care? Y N
   If so, for what condition?_____
   Physician's Name _____
   Phone Number _____

Do you have or have you had any of the following conditions or diseases:

CARDIOVASCULAR

8. Rheumatic Fever Y N
9. Congenital Heart Defect Y N
10. Angina or Heart Attack Y N
11. Heart Murmurs Y N
12. Congestive Heart Failure Y N
13. Heart Surgery or Pacemaker Y N
14. High or Low Blood Pressure Y N
15. Stroke Y N

RESPIRATORY DISEASE

16. Asthma or Bronchitis Y N
17. Emphysema Y N
18. Hay Fever or Sinusitis? Y N

ENDOCRINE DISORDERS

19. Diabetes Y N
20. Hyperthyroidism (high thyroid) Y N
21. Hypothyroidism (low thyroid) Y N

BLOOD DISORDERS

22. Anemia Y N
23. Do you bleed excessively when cut? Y N

KIDNEY DISEASE

24. Have you had any kidney infections? Y N
25. Have you had kidney surgery? Y N

INFECTIOUS DISEASES

26. Hepatitus Y N
27. Venereal Disease Y N
28. Tuberculosis Y N
29. HIV Positive Y N

MISCELLANEOUS

30. Frequent Fainting Y N
31. Liver Disease/Jaundice Y N
32. Arthritis Y N
33. Ulcers Y N
34. Glaucoma Y N
35. Radiation Therapy for Cancer Y N
36. Epilepsy Y N
37. Cancer Y N
38. Do you smoke? Y N
39. Do you use any other form of tobacco? Y N
40. Do you have any implanted prosthetic devices? Y N

Are you currently taking any of the following drugs or medications?

41. Antibiotics Y N
42. Blood Thinners Y N
43. Steroids or Cortisone Y N
44. High Blood Pressure Medicine Y N
45. Tranquilizers Y N
46. Immune Suppressant Drugs Y N
47. Aspirin Y N
48. Herbs/Vitamins Y N

Please write down all the prescribed medicines you are now taking: _____

_____

_____

Do you have an **ALLERGY** or **REACTION** to any of the following medications and materials?

49. Local Anesthetics Y N
50. Penicillin Y N
51. Other Antibiotics Y N
52. Codeine Y N
53. Other Pain Medication Y N
54. Aspirin Y N
55. Barbiturates or Sedatives Y N
56. Nickel Allergy Y N
57. Latex Allergy Y N
58. Other Medicines Y N
    If so, what medicines?_____
59. Have you ever worn braces? Y N
60. Have you ever had gum surgery? Y N
61. Have you ever had any difficulty with any dental work or extractions? Y N
62. Do you have any medical problem not listed above? Y N
    If so, what is it?_____

WOMEN ONLY

63. Are you pregnant? Y N
    If so, when are you due?_____
64. Do you have any menstrual difficulty other than cramps? Y N
65. Are you taking an oral contraceptive? Y N
66. Are you taking hormonal therapy? Y N

DOCTOR'S SIGNATURE DATE

PLEASE SIGN YOUR NAME ON THE LINE ABOVE
(Parents must sign for their minor children)

Healthy Smiles of Georgia

FINANCIAL ARRANGEMENTS

- We will accept assignment of your insurance and ask that you pay any co-pays and deductibles at the time of your appointment. For your convenience we will bill your dental insurance directly and wait for insurance reimbursement. You will be asked to pay your coinsurance rate and any other fee not covered by your particular insurance company at the time services are rendered. *Co-Pays, deductibles and any cost beyond the insurance maximum is the patient's responsibility.* _____

- We deal with different dental insurance benefits. Each employer may offer many different dental and medical plans. Your employer can change benefits, co-pays and deductibles many times throughout the year. Please keep us informed of any change to your dental benefits. It is important that all information about you and your benefits is current in our system.

- We do our best to provide you with accurate coverage estimates based on information available to us. At times, it is almost impossible to accurately estimate our patients' co-payment. Many benefit providers will not disclose their reimbursement fees until after the treatment is completed. *At times, procedures which the doctor feels will benefit to the patient, may not be covered or partially covered under the group contract your employer has with your insurance company.* Until the insurance company makes its payment, we wouldn't be able to tell you your accurate patient balance for any treatment. _____

- Our assistance with dental benefit matters doesn't stop there! We will help you with any request your benefit provider might have – if they need additional information such as treatment explanatory notes, X-rays, and exam results, we will send them on your behalf at no extra charge.

Payment Options

- Pay fully at the time of Service for the planned treatment.
- For those who would prefer an extended payment plan, outside financing is available through our office. Please ask us about **Care Credit** and other forms of installment credit plans.
- For your convenience payments may be made with **cash**, **bank draft**, **Visa**, **MasterCard, Amex** or **Discover**

Patient Sign: **Date:**

Notice of Privacy Practices

Purpose: This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices. {Note: this form may need to be changed to reflect the dental practice's particular privacy policies and/or stricter state laws.}

We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient, including service delivered electronically, after April 14, 2003. We must make a good-faith attempt to obtain written acknowledgement of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them. We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the Notice. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post the revised Notice in our office as discussed above.

Healthy Smiles Of Georgia

{NAME OF PRACTICE}

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.

Healthy Smiles of Georgia

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 06/04/2009, 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.__$15.00__ for each page, $__20.00__ per hour for staff time to 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 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 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: Dr.Jai Thirumalai

Telephone: 678 762 0690 Fax: 678 762 0692

E-mail: info@healthysmilesofgeorgia.com

Address: 295 Rucker Rd, Suite 160,

Alpharetta, GA, 30004

HIPAA PRIVACY FORM 2

Acknowledgement of Receipt of Notice of Privacy Practices

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.

Healthy Smiles Of Georgia

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

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

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

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

_____

_____

_____