Southwest Georgia Dental Associates

Patient Information

Patient Name_____ Today's Date_____

Parent's Name, if Patient under 18 years old: Mother_____ Father_____

Marital Status: Single Married Divorced Widowed Gender: Male or Female

Height_____ Weight_____ DOB_____ Age_____ SS#_____

Mailing Address _____City, State,

Zip_____

Physical Address _____City, State, Zip_____

Home #_____ Cell #_____Work #_____ Text #_____

Email Address_____

*Referred by*_____

Account Information

Please indicate your Payment Method for services:

_____ Fee for Service (Cash, Check, Charge)
_____ Private Insurance
_____ Medicaid

In Event of Emergency

Whom should we contact?_____
Relation_____
Phone #_____
Who is your Medical Doctor?_____
Medical Doctor's Phone _____

Family Information

Please list name of person who is responsible for bringing patient to appointments and also permitted to give consent for treatment.

_____
_____

Please list other members of your family that are current patients of this office.

_____
_____
_____

We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient.

Dental Information

Reason for Today's Visit: ____*Dental Checkup* _____*Emergency Exam/X-ray* _____*Consultation*

Please indicate any of the following problems:

__Discomfort, clicking or popping in jaw __ Bad Breath __Teeth Grinding __Broken/Chip. Teeth
__Red, swollen or bleeding gums. __ Stained Teeth ___Locking Jaw __Lost/Broken Filling
__Sensitive tooth, teeth or gums. ___ Blisters/Sores in mouth. __Other_____

Are you in pain? Yes or No Do you require pre-medication? Yes or No or Don't Know
Date of Last Dental Exam ____/_____/_____ with Dr. _____

Medical History

Are you taking any of the following medications? *Please Check.*
___Nerve Pills ___Stimulants ___Muscle Relaxers ___Pain Killers ___ Blood Thinners ___ Tranquilizers
Others:_____

Do you have or have you had any of the following diseases, medical conditions or procedures?
Please Circle Y (yes) or N (no) for EACH CONDITION:

Y	Heart Attack Stroke	N	Y	High/Low Blood Pressure	N	Y	Frequent/Severe Headaches	N
Y	Fainting/Seizures	N	Y	Asthma	N	Y	Thyroid Problems	N
Y	Cancers/Tumors	N	Y	Alcohol/Drug Abuse	N	Y	Venereal Disease	N
Y	Heart Murmur	N	Y	Chest Pains	N	Y	HIV +/AIDS/ARC	N
Y	Diabetes	N	Y	Emphysema	N	Y	Liver Problems	N
Y	Jaw Problems (TMJ)	N	Y	ADD/ADHD	N	Y	Tuberculosis (TB)	N
Y	Congenital Heart Defect	N	Y	Heart Surgery/Pacemaker	N	Y	Hepatitis	N
Y	Stomach Problem/Ulcers	N	Y	Respiratory Problems	N	Y	Kidney Problems	N
Y	Arthritis/Rheumatism	N	Y	Psychiatric Problems	N	Y	Frequent/Severe Neck Pain	N

Please List any other surgeries and medical conditions you have or ever had: _____
_____

Are you allergic to any of the following? *(Please check all that apply.)*
___ Latex ___Aspirin ___Sulfur ___Dental Anesthetics ___Penicillin/Amoxicillin ___Tetracycline Other_____

Do you use tobacco? Yes No If Yes, for how long?_____ ***For Women***: Are you pregnant? Yes No If yes, how far

We emphasize that we are NOT a party to the contract, which exist between you and your insurance company. Consequently, the patient, not his/her insurance carrier, is responsible for any charges incurred. Fees are due at time of service. If account is not paid, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.

Guarantee of Account

I guarantee full payment of all dental charges incurred by the above patient. I give my consent to needed dental services recommended for my (my minor) benefit and accept full responsibility of payment for services performed. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand that it is my responsibility to inform this office of any changes to the information that I have provided.

Signed: _____ *Date:*_____
(Guardian must sign, if Patient under 18 years)

NOTICE OF PRIVACY AND SECURITY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY AND SECURITY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy and security of your health information. We are also required to give you this Notice about our privacy and security practices, our legal duties, and your rights concerning your health information. We must follow the privacy and security practices that are described in this Notice while it is in effect. This Notice takes effect October 21, 2002, and will remain in effect until we replace it. We reserve the right to change our privacy and security practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make changes in our privacy and security 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. As we make a significant change in our privacy and security practices, we will accordingly 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 and security practices, or for additional copies of this Notice, please contact us using the information at the top 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. We may use patient sign-in sheets and post daily schedules in individual operatories (out of the direct view of patients). We may share the necessary minimum information with the dental laboratory when prostheses are being made. **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 Patients 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 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 access 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. You may also request access by sending us a letter to the address at the top of this Notice. If you request copies more than once in a twelve month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. **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 six years, but not before April 14, 2003. If you request this accounting more than once in a twelve 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. However, 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. **Electronic Communication:** You have the right to request that we contact you through electronic mail (email). Patients should understand that while we do not employ an encryption system, we do use several methods to attempt to safeguard confidential information, including firewall and virus protection. Patients should also understand that the Practice cannot be held responsible for breaches in security via an electronic medium and use electronic methods of communication at their own risk. Additional information regarding our specific security practices may be obtained via the contact information at the top of this Notice. **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 by electronic mail, you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy or security practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy or security 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 top 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 with the U.S. Department of Health and Human Services upon request. We support your right to the privacy and security of your health information. We will not retaliate in any way if you choose to file a complaint with the U.S. Department of Health and Human Services.

Contact Person: Michael R. Carr, DMD 100 W. Chason Street, Donalsonville, GA 39845(229) 524-5772

Southwest Georgia Dental Associates

www.southwestgeorgiadental.com

100 W. Chason Street, Donalsonville, GA 39845
(229) 524-5772 Office

84 Court Street, Cuthbert, GA 39840
(229) 732-3300 Office

Acknowledgement of Receipt of Notice of Privacy and Security Practices

I, _____, have received a copy of this Office's Notice of
Name of Patient/Guardian

Privacy and Security Practices.

Patient Name (please print clearly) **Date**

Patient Signature (or Guardian Signature) **Date**

Witness **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

____ Communication barriers prohibited obtaining the acknowledgment

____Emergency situation prevented us from obtaining acknowledgement

____ Other (Please specify)

_____

_____