WELCOME TO OUR PRACTICE

Thank you for selecting our office for your dental care needs.
We are committed to providing you with the best care possible.

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

PATIENT INFORMATION

(confidential)

Date _____

Name _____
LAST FIRST MIDDLE

Home Phone(____) _____ **Cell Phone(____)**_____ **Business Phone(____)** _____
INCLUDE AREA CODE INCLUDE AREA CODE INCLUDE AREA CODE

Address _____ **City** _____ **State**_____ **Zip** _____
MAILING ADDRESS

SS# or Patient ID _____ **Date of Birth** _____ **Email**_____

Sex: M F **Status:** ❑ **Minor** ❑ **Single** ❑ **Married** ❑ **Divorced** ❑ **Widowed** ❑ **Separated**

Emergency Contact:_____ **Relationship:**_____ **Home Phone(____)** _____ **Cell Phone(____)** _____
INCLUDE AREA CODE INCLUDE AREA CODE

Patient Employer _____ **Address** _____**Phone(____)** _____

Spouse_____ **Phone (____)**_____ **Birth Date**_____ **SS#**_____

Spouse Employer_____ **Address** _____**Phone(____)** _____

Whom can we thank for referring you? _____

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

RESPONSIBLE PARTY

Name of Person Responsible for this account _____ **Relationship to patient**_____

Address _____ **City** _____ **State** _____ **Phone** _____

Birth Date_____ **Social Security #** _____

Employer _____ **Work Phone** _____

Is this Person currently a patient in our office? ____yes ____no

PLEASE COMPLETE OTHER SIDE

PRIMARY DENTAL INSURANCE INFORMATION

Name of Insured _____ **Relationship to patient** _____

Birth Date_____ **Social Security #** _____ **Work Phone** _____

Name of Employer _____

Address _____

Insurance Company _____ **Group #** _____ **Policy ID#** _____

Insurance Co. Address_____ **City**_____ **State**_____ **Zip** _____

Do you have a secondary dental insurance policy? ____yes ____no If yes, please provide card.

FINANCIAL AGREEMENT

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such dental care to third party payors and/or appropriate health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. Payment for services is due in full at the time service is provided. In the event your account is delinquent and placed with a collection agency you are responsible for the collection fee of 30% of the account balance as liquidated damages, and if an attorney is hired to collect, after maturity, 15% of unpaid principal and interest owing on said account as attorneys' fees.

Signature of patient (parent if minor) _____ **Date** _____

MEDICAL HISTORY FORM

Today's Date:_____

Patient's Name _____ Date of Birth_____

Please Check ONLY the Box for any condition you have had in the past or have now.

Cardiovascular	Box
Congestive Heart Failure	
Heart Attack/Disease	
Angina or Chest Pain	
Heart Surgery	
High Blood Pressure	
Low Blood Pressure	
Heart Murmur	
Infective Endocarditis	
Congenital Heart Defect/Disease	
Artificial/Prosthetic Heart Valve	
Arrhythmias	
Pacemaker/Defibrillator	
Heart Transplant	
Other Heart Problems	
Blood Thinners	
Aneurysm	
Shortness of Breath	
Swollen Ankles	
Sleep Disorder	
Hematologic	
Blood Transfusion	
Anemia	
Hemophilia	
Leukemia	
Sickle Cell Disease	
Bleeding Tendencies	
Neurologic	
Glaucoma	
Hearing Loss	
Severe Headaches	
Fainting Spells	
Stroke/CVA	
Seizures/Epilepsy	
Psychiatric Treatment	
Paralysis	
Alzheimer's / Dementia	
Gastrointestinal	
Stomach Ulcers	
Gastritis/Colitis	
Hepatitis	
Liver Disease	
Yellow Jaundice	
Cirrhosis	
Eating Disorders	
Diet Suppressants	

Women Only	Box
Currently or Possibly Pregnant	
Currently Breast Feeding	
Use of Oral Contraceptives	
Respiratory	
Hay Fever	
Sinus Trouble	
Allergy/Hives	
Asthma	
COPD	
Emphysema	
Chronic Bronchitis	
Tuberculosis	
Breathing Difficulties	
Dermatologic	
Skin Rash	
Fever Blisters	
Canker Sores	
Endocrine	
Diabetes	
Thyroid Disease	
Steroid Use	
Genitourinary	
Kidney Problems	
Dialysis	
Sexually Transmitted Disease	
Musculoskeletal	
Arthritis	
Osteoporosis	
Joint Replacement	
Bone Disorders	
Muscle Disorders	
Other	
Prostate Problems (Male)	
HIV Positive	
Drug Addiction	
Do you Drink Alcohol	
Tumor or Cancer	
Radiation Treatment	
Chemotherapy	
Organ Transplant	
Tobacco Use	
Unexplained Weight Loss or Gain	
Reaction to General Anesthesia	

ARE YOU ALLERGIC TO:	Box
Local Anesthetics	
Codeine/Narcotics	
Aspirin/NSAIDS	
Barbiturates	
Sedatives	
Sleeping Pills	
Sulfa Drugs	
Iodine	
Metals	
Latex	
Food	
Other	

Are You Allergic to Penicillin, or any Other Antibiotics? ❑ Yes ❑ No

_____
_____
_____
_____
_____
_____

Any conditions not mentioned here? _____
_____
_____
_____
_____

Bisphosphonate Derivatives are medications use to strengthen bones and they are used in cancer chemotherapy.

Common Bisphosphonate Derivatives include: Fosamax, Aredia, Actonel, Boniva, Reclast, Zometa, and Didronel.

Are you taking or have you ever taken Bisphosphonate Derivatives ❑ Yes ❑ No

OFFICE USE ONLY

BP _____

Pulse _____

Med Alert _____

PLEASE COMPLETE OTHER SIDE

MEDICAL HX FORM CONT'D.

Today's Date: _____

Patient's Name _____

Please Provide the following information about your Primary Care Physician:

Physician's Name _____

Address _____

Phone Number _____ Fax _____

Date of Last Visit _____

2. Have you been hospitalized or had any operations in the past 5 years? Yes___ No___

If yes, please list:

Year **Reason**

_____

_____

_____

_____

3. Are you Currently taking any Prescribed Medications, Herbals or Over-the-Counter drugs? Yes___ No___

If yes, please list:

Current Medication **Dose** **Dentist Medication Notes Only**

_____

_____

_____

_____

_____

_____

_____

_____

_____

CONSENT TO TREAT

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. **It is my responsibility to inform this office of any changes in my health status.** I authorize the dentist to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. I also authorize the dentist to perform any and all forms of dental procedures that may be indicated in connection with my treatment. I also understand the use of local anesthetic agents have the potential for complications including but not limited to infection, allergic reaction, persistent and/or partial numbness, and hematoma.

Signature of patient _____ Date _____

DENTAL HISTORY

For the following questions, please mark (X) your responses to the following questions.

Name:_____

	Yes	No
Are you currently experiencing dental pain or discomfort?	❑	❑
Do your gums bleed when you brush or floss?	❑	❑
Are your teeth sensitive to cold, hot, sweets or pressure?	❑	❑
Does food or floss catch between your teeth?	❑	❑
Is your mouth dry?	❑	❑
Have you had any periodontal (gum) treatments?	❑	❑
Have you ever had orthodontic (braces) treatment?	❑	❑
Is your home water supply fluoridated?	❑	❑

What is your reason for your visit today?_____

_____

_____

How do you feel about your smile? _____

_____

_____

	Yes	No
Do you have earaches or neck pains?	❑	❑
Do you have any clicking, popping or discomfort in the jaw?	❑	❑

	Yes	No
Do you clench or grind your teeth?	❑	❑
Do you have sores or ulcers in your mouth?	❑	❑
Do you wear dentures or partials?	❑	❑

How many partials/dentures have you had? _____

When was your last partial/denture made? _____

Have you ever had a serious injury to your head or mouth? ❑ ❑

_____

_____

Have you had any problems associated with previous dental treatment? ❑ ❑

_____

_____

Date of your last dental exam: _____

What was done at that time? _____

_____

Date of last dental x-rays: _____

Signature _____ Date_____

PATIENT CONSENT TO RECEIVE COMMUNICATIONS / MESSAGES

Patient Name: _____

D.O.B.: _____

I give authorization to be contacted or leave information pertaining to my care by the following methods, I assume responsibility to update this information whenever it may change.

Check all that apply:

_____ Home Phone and/or Voicemail # _____

_____ Cell Phone and/or Voicemail # _____

_____ Work Phone and/or Voicemail # _____

_____ Email: _____

_____ Other – Please Indicate: _____

List the names of people we can discuss your dental care with:

_____

NAME RELATIONSHIP PHONE NUMBER

_____

NAME RELATIONSHIP PHONE NUMBER

_____

NAME RELATIONSHIP PHONE NUMBER

_____

PLEASE PRINT NAME OF PERSON COMPLETING FORM

_____

RELATIONSHIP TO PATIENT

_____

SIGNATURE DATE

Jeffrey A. Houston, D.M.D.
John P. Robison, D.M.D.
1625 Broadrick Dr.
Dalton, Ga. 30720

Acknowledgment of our Appointment Policy

We want to thank you for choosing us as your dental health care provider. In order to provide you and our other patients with the best care possible, we request that you follow our guidelines regarding broken and/or cancelled appointments.

You are the only one scheduled for your appointment time. Your appointment time is important to you, your dentist and to others who are in need of our services.

If you cannot keep your appointment for any reason, please call us 24 hours prior to your appointment time. If you cancel with less than 24 hours notice, do not show for your appointment, or arrive too late for your procedure to be completed, **a fee could be charged to your account.** You will be personally responsible for this charge. This charge will not be billed to nor paid by your insurance company. Future appointments will not be scheduled until this fee is paid. Please make us aware of any unforeseen circumstances you feel we should know about.

Additionally, we reserve the right to dismiss any patients with multiple broken appointments.

Please help us keep the scheduling of appointments fair for everyone.

Thank you.

_____ _____
Signature Date

_____
Printed Name

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 April 1, 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 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._____ for each page, $_____ 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 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: LYNN SWEENY

Telephone: 706-226-3334 Fax: 706-277-0689

E-mail: _____

Address: 1625 BROADRICK DR. DALTON, GA. 30720

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

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)

_____

_____

_____