Welcome

Today's Date _____

Name _____ I like to be called _____
Street Address _____
City, State, and Zip _____
Social Security No. _____ Date of Birth _____ Sex: Male /Female
Marital Status: Single ____ Married ____ Divorced ____ Widowed_____
If married what is your spouse's name? _____
Employer _____ Occupation _____

If this information pertains to a child, please list responsible party _____
Address _____
Telephone Number _____ Date of Birth _____
Whom may we thank for referring you? _____

Telephone Information

Home Phone _____ Work Phone _____
Pager or Cell Phone _____ E-mail Address _____
In the case of an emergency, is there someone we can contact?
Name _____ Phone Number _____

Medical History

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 If yes, please explain: _____

Have you ever been hospitalized or had major operations? __ Yes __ No If yes, please explain: _____

Have you ever had a serious head or neck injury? __ Yes __ No If yes, please explain: _____

Are you taking any medications, pills or drugs? __ Yes __ No If yes, please explain: _____

Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates? __ Yes __ No If yes, please explain: _____

Do you use tobacco? __ Yes __ No

Do you use controlled substances? __ Yes __ No

Women: Are you: ___ ***Pregnant/Trying to get pregnant?*** ___ ***Nursing?*** ___ ***Taking oral contraceptives?***

*****DO YOU TAKE ANTIBIOTICS BEFORE DENTAL TREATMENT DUE TO JOINT REPLACEMENT/HEART CONDITIONS? Y____ N____**

Are you allergic to any of the following?
__ Aspirin __ Penicillin __ Codeine __ Acrylic __ Metal __ Latex __ Local Anesthetic

___ Other If yes, please explain: _____

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

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

Have you ever had any serious illness not listed above? __ Yes __ No If yes, please explain:

_____

Dental History

Why have you come to the dentist today? _____

Date of your last dental visit _____ Previous dentist's name_____

How would you describe the health of your teeth and gums? Good___ Fair ___ Poor ___

Have you seen another dentist for your dental needs? Y___N___ If yes, please explain: _____

Are you in pain or discomfort? Y___N___ If yes, please explain: _____

Have you been treated for TMD Symptoms? Y___N___ If yes, please explain: _____

Do your gums bleed when you brush & floss? Y___N___ How often do you brush & floss? _____

Do you have pain in your jaw joint? Y___N___ Do you grind your teeth? Y___ N___

If you could easily and safely whiten your teeth, would you? Y ___ N ___

If you could wave a magic wand and change anything you could about the appearance of your smile, what would you like to do? _____

Insurance Information

Primary insurance subscriber's name _____ Relation to patient _____

SSN/Member ID# _____ Date of birth _____ Employer _____

Insurance co. _____ Insurance co. phone _____ Group # _____

Insurance mailing address _____

I understand that the information is correct to the best of my knowledge. I understand it will be held in strictest confidence and only be used to improve communication between the doctor and myself. I also give permission for the doctor or his staff to use any photos he may take to be used for lecturing or educational purposes.

Signature _____ **Date** _____

Vanident

General & Cosmetic Dentistry
1600 Mall of Georgia Blvd Ste 1203
Buford, Ga 30519

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 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 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 on April14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the same 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 or 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, and 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 this 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 the authorized federal officials of 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.

Vanident

1600 Mall of Georgia Blvd
Suite 1203
Buford, Ga 30519

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

Print Name _____

Signature _____

Date _____

Vanident General & Cosmetic Dentistry

OFFICE FINANCIAL AGREEMENT

At ***Vanident General & Cosmetic Dentistry*** we are committed to providing you with quality dental care. A clear understanding of your financial responsibility is important to our professional relationship. (Please note that all office fees are subject to change).

FULL PAYMENT is due at the time of service. For your convenience we accept **Cash**, **Visa**, **MasterCard**, **American Express**, **Discover**, **Debit Cards** and **CareCredit**.

We accept most major insurance plans. After providing us with your insurance cars and related insurance information, we will contact your insurance company to verify your benefits. We will explain your coverage on or before the day of your visit. It would be impossible to know policies for all insurance companies; therefore, if we provide dental services which will be considered non-covered and will not be paid by insurance company, it will be the patient's responsibility for those charges.

You will be responsible for paying your *estimated* portion at the time services are provided. Please note that most insurance companies only provide *estimates* of your financial portion prior to receiving the actual claim form.

As a courtesy, we will file your insurance claim promptly and we agree to wait 30 days for reimbursement. If after 30 days we have not received payment from your insurance company, we will contact you and you will have 15 days to settle your account. Overdue accounts may be subject to a periodic finance charge (in an amount permissible under the laws of the State of Georgia) and/or collection agency fees, including but not limited to attorney's fees, interest and court costs in addition to the balance due.

Insurance is a contract between you and your insurance company; **WE ARE NOT A PARTY IN THAT CONTRACT**. We will not become involves in disputes between charges, secondary insurance, usual and customary charges, etc. other than supply factual information as necessary.

RESCHEDULING APPOINTMENTS

Since we reserve time just for you, we kindly request at least a 48 hour notice when rescheduling an appointment. Failure to contact our office at least 24 hours before your scheduled appointment will result in a charge of $50. You must speak with a staff person directly in order to reschedule your appointment; messages left on the machine will result in a $50 charge.

******I have read and fully understand the above office policy******

_____ _____

Signature of Patient (Guardian or Responsible Party) Date

Vanident
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Tel (678) 606 - 0166 Fax (678) 606 - 0167
patient@vani-dent.com
www.vani-dent.com

Vanident
General & Cosmetic Dentistry

Informed Consent for Treatment

I understand that I have the following conditions requiring dental treatment in the opinion of my dentist_____

_____

_____

All dental and anesthetic procedures have associated risks. These may be, but are not limited to:

- Drug reactions and side effects
- Damage to adjacent teeth or fillings
- Postoperative infection
- Postoperative bleeding that may require additional treatment
- Delayed healing of an extraction site ("dry socket"), necessitating additional care
- Sinus involvement during removal of upper molars, which may require additional treatment or surgical repair at a later date
- Involvement of the nerves during the removal of teeth, resulting in temporary or possibly permanent numbness or tingling of the lip, chin, tongue, or other areas
- Bruising, swelling, sensitivity, or pain
- Failure of the dental procedure, necessitating additional treatment
- Breakage of dental instruments inside tooth canals, making additional treatment necessary
- Complications during treatment, necessitating referral to a specialist

I understand the recommended treatment for my conditions, the risks of such treatment, and any alternatives and risks, as well as the consequences of doing nothing. Fees involved also have been explained. I have had the opportunity to speak with the dentist and have all of my questions answered. I have not been offered any guarantees.

Patient Full Name (Please print) _____

Patient Signature _____ **Date**_____

Parent/Guardian Signature _____ **Date**_____
(if patient is unable to sign or is a minor)

Witness Signature _____ **Date**_____