ATHENS ADVANCED DENTAL

Welcome and thank you for choosing our office for your dental needs! Please complete fully and accurately, sign, and provide us with any Insurance Card and Driver's License.

Name:____Birth Date:_____________
First Last Nickname

Address____City______________ State_____ Zip__________

Drivers License #_______________________________ Social Security # _________________________________

Gender: (Circle) M / F Marital Status: (Circle) Married Single Divorced Other

Preferred method of communication: (Circle) Cell Home Text Email

Cell Phone: ( ) ______________________________ Home Phone: ( )______________________________

Email:____

Employer______________________________________ Occupation____________________________________

Work Address____ Work Phone: ( )______________________

Person to Contact in case of Emergency:

Name__________________________________ Relationship __________________ Phone: ( )__________________

How did you find out about us? (Circle)

Newspaper Insurance Website Drive by Friend/Current Patient __________________________________
Name

Person Responsible for this Account____
Relationship to Patient

Address (Responsible Party)_______________________________________ Phone: ( )_________________________

Drivers Lic #:__________________________ Social Security #:__________________________ Birth Date:______________

Employer:_____________________________________ Work Phone: ( )___________________________

OFFICE CANCELLATION AND FINANCIAL POLICIES

- As a courtesy to you we may accept assignment of insurance after verification of your coverage. Please understand that as your dental provider, our relationship is with you and not your insurance company. It is your responsibility to know and understand the services covered by your insurance company.
- Please be aware that some or even all of the services provided may not be covered in full by your insurance and that YOU ARE FINANANCIALLY RESPONSIBLE for all services NOT COVERED by your insurance.
- All payments, including insurance co-pay and deductibles, are due at the time of service. If insurance denies an estimated claim, you will be held responsible for payment. Any past due balances (30 days after statement issued), may be subject to late fees, monthly finance charges and may be referred to professional collection activity. If this action occurs, you will no longer be able to receive any dental services at Athens Advanced Dental.
- PLEASE give **48 hours** notice if unable to keep your scheduled appointment. All appointments **not cancelled 24 hours** prior to appointment time will be subject to a **$50.00 "No Show" fee**
- All returned checks are subject to a **$50.00 return check fee**
- You must provide current billing address and all phone numbers. It is your responsibility to supply office with any changes. (insurance, name, address, phone number)

I have read and understand this Financial Policy.

____
Signature of Responsible Party Date

Medical History

Physician's Name:______________________________________ Phone: ( )______________________

Physician's Address:____ Date of Last Visit ________________

Are you currently taking any medications (prescription or non-prescription)? Y / N If yes, please list _____________________

____

Are you taking Aspirin or blood thinners? Y / N If yes, why?____

Do you require ANTIBIOTIC PRE-MEDICATION for dental appointments ? Y / N

Do you have any ARTIFICIAL JOINT REPLACEMENTS (Hip, Knee, Other) ? Y / N ___________________________

Are you ALLERGIC to or ever had REACTIONS to :

Penicillin Tetracycline Latex Aspirin Dental Anesthetics

Erythromycin Codeine Other____

Please indicate any medical conditions that apply to you: (Circle any that apply)

Allergies	Epilepsy/Seizures	Kidney Problems	Respiratory Problems
Asthma	Fainting	Leukemia	Stroke
Anemia/ Excessive bleeding	Heart Attack	Liver Problems	Stomach Problems
Artificial Prosthesis	Heart Disease	Lung Problems	Thyroid Problems
Blood Disease/Disorder	High Blood Pressure	Pacemaker	Tuberculosis
Cancer	Low Blood Pressure	Radiation/Chemo Treatment	Tumor
Dizziness	Glaucoma	Rheumatism	Ulcers

Artificial Heart Valves when placed?________________________

AIDS/HIV when diagnosed?_____________________

Diabetes when diagnosed?_____________________ What type?__________________________

Hepatitis when diagnosed?_____________________ What type?__________________________

Do you smoke or use any other tobacco products? Y / N How long?___________________________________

Have you ever had any major illness, surgery, or hospitalization? Y / N If yes, please explain ____________________________

____

WOMEN ONLY: Are you pregnant or suspect that you may be? Y / N If yes, how far along_____________________________

Do you use any birth control medications? Y / N

I CERTIFY THAT ALL OF THE INFORMATION ABOVE IS COMPLETE AND ACCURATE.

____

Signature of Patient or Legal Guardian

Dental History

Reason for today's visit:____

Date of you last Dental Exam:__________________ Cleaning___________________ Xrays__________________

Name of previous Dentist:____ Location:___________________________

Please check any of following problems if they apply to you:

___ Pain ___ Headaches, earaches ___ Sensitivity (Hot Cold Sweets Chewing)

___ Bleeding gums ___ Grinding or clenching teeth ___ Loose or shifting teeth

___ Bad breath or bad taste in mouth ___ Jaw joint pain (TMJ)

Have you ever been diagnosed with periodontal disease (gum disease)? Y / N

Do you wish your teeth were whiter? Y / N

Do you wish your teeth were straighter? Y / N Have you ever had braces before? Y / N

Do you get very nervous with dental treatment? Y / N Would you like to know about Sedation Dentistry? Y / N

Are you happy with your smile? Y / N If no, what changes would you like made? ____________________________________

____

AUTHORIZATION/RELEASE:
I certify that I have read, understood, and answered the above information accurately and to the best of my knowledge. I authorize the dentist to release my information (including the diagnosis and records of any treatment or examination given to me or my child/dependent) to third party payers and/or other health practitioners. I give my consent for using email notifications. I authorize and request my insurance company to pay directly to the dentist the insurance benefits otherwise payable to me. I understand that my dental insurance my pay less than the actual bill for service, and that I agree to be held responsible for payment of all services rendered on my behalf or dependents.

____ Date ____________________
Signature of Patient or Legal Guardian

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ____, have received a copy of this office's Notice of Privacy Practices.
Print Patients Name

____
Signature of Patient or Legal Guardian

Medical information is private and confidential and is only released with your permission.

Release to:____ Relationship: ________________________________
Birth Date

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us, whether electronically, written, or oral, are kept confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used.

We are required by federal and state law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices concerning your protected health information. This notice is effective as of April 14, 2003, and will remain in effect until we replace it. We reserve the right to change the terms of our Notice of Privacy Practices and to make new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

As required by HIPAA, we have prepared an explanation of how we are required to maintain the privacy of your health information and how we my use and disclose your health information.
Treatment: using your health information for treatment or disclose it to a dentist, physician, or other health care provider providing treatment to you.
Payment: use and disclose health information to obtain payment for services we provide, to confirm coverage, billing, or any other collection activities
Health Care Operations: use and disclose health information for our health care operations. This includes all business aspects of operating our practice, such as quality assessment and improvement activities, training programs, credentialing activities, auditing functions, detecting health care fraud, cost analysis, and customer service.
Your Authorization: you may give us authorization to use or disclose your health information to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time, and we will honor that request, except if we have already taken action based on your authorization.
Appointment Reminders: we may use or disclose your health information to provide you with appointment reminders

We may also create and distribute de-identified health information by removing all references to individual identifiable information. We may use a sign in sheet at registration. We may call you by name in the waiting area when your healthcare provider is ready to see you.

You have the following rights with respect to your protected health information.
Access: you may look at or get copies of your health information. If copies are requested, we will charge a cost-based fee
Disclosure Accounting: you may receive a list of instances in which we disclosed your health information
Restriction: you may request additional restrictions on certain uses or disclosures of health information. We are not required to agree to any additional restrictions, but if we do, we will abide by our agreement (unless in an emergency). Your request is not binding unless in writing.
Alternative Communication: you may request, in writing, that we communicate with you about your health information by alternative means or to alternative locations. Must provide explanation, including how you will handle payment.
Amendment: you may request, in writing, that we amend your health information. You must explain why and we may deny.

If you feel that your privacy protections have been violated, you have the right to file a written complaint with our office, or with the Dept. of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

If you would like additional information or have any questions or concerns, please contact our office:

Athens Advanced Dental
800 S. Palestine St.
Athens, TX 75751
(903) 675-9118

To file a complaint:

The U.S. Department of Health and Human Services
Office of Civil Rights
200 Independence Ave., S.W.
Washington, D.C. 20201