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

Athens Advanced Dental

Date 11/2/2021

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

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
Have you ever been hospitalized or had a major operation?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Are you taking any medications, pills, or drugs?	Yes No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Are you on a special diet?	Yes No	
Do you use tobacco?	Yes No	
Do you use controlled substances?	Yes No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

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

AIDS/HIV Positive	Yes No	Cortisone Medicine	Yes No	Hemophilia	Yes No	Radiation Treatments	Yes No
Alzheimer's Disease	Yes No	Diabetes	Yes No	Hepatitis A	Yes No	Recent Weight Loss	Yes No
Anaphylaxis	Yes No	Drug Addiction	Yes No	Hepatitis B or C	Yes No	Renal Dialysis	Yes No
Anemia	Yes No	Easily Winded	Yes No	Herpes	Yes No	Rheumatic Fever	Yes No
Angina	Yes No	Emphysema	Yes No	High Blood Pressure	Yes No	Rheumatism	Yes No
Arthritis/Gout	Yes No	Epilepsy or Seizures	Yes No	High Cholesterol	Yes No	Scarlet Fever	Yes No
Artificial Heart Valve	Yes No	Excessive Bleeding	Yes No	Hives or Rash	Yes No	Shingles	Yes No
Artificial Joint	Yes No	Excessive Thirst	Yes No	Hypoglycemia	Yes No	Sickle Cell Disease	Yes No
Asthma	Yes No	Fainting Spells/Dizziness	Yes No	Irregular Heartbeat	Yes No	Sinus Trouble	Yes No
Blood Disease	Yes No	Frequent Cough	Yes No	Kidney Problems	Yes No	Spina Bifida	Yes No
Blood Transfusion	Yes No	Frequent Diarrhea	Yes No	Leukemia	Yes No	Stomach/Intestinal Disease	Yes No
Breathing Problems	Yes No	Frequent Headaches	Yes No	Liver Disease	Yes No	Stroke	Yes No
Bruise Easily	Yes No	Genital Herpes	Yes No	Low Blood Pressure	Yes No	Swelling of Limbs	Yes No
Cancer	Yes No	Glaucoma	Yes No	Lung Disease	Yes No	Thyroid Disease	Yes No
Chemotherapy	Yes No	Hay Fever	Yes No	Mitral Valve Prolapse	Yes No	Tonsilitis	Yes No
Chest Pains	Yes No	Heart Attack/Failure	Yes No	Osteoporosis	Yes No	Tuberculosis	Yes No
Cold Sores/Fever Blisters	Yes No	Heart Murmur	Yes No	Pain in Jaw Joints	Yes No	Tumors or Growths	Yes No
Congenital Heart Disorder	Yes No	Heart Pacemaker	Yes No	Parathyroid Disease	Yes No	Ulcers	Yes No
Convulsions	Yes No	Heart Trouble/Disease	Yes No	Psychiatric Care	Yes No	Venereal Disease	Yes No
						Yellow Jaundice	Yes No

Have you ever had any serious illness not listed above? Yes No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date:_____

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