Welcome!

Patient Information

*Patient Name*_____ *Nickname*_____ *SS#*_____

*Birthday*_____ *Sex: M*___ *F*___ *Single*____ *Married*____ *Widowed*____ *Divorced*____ *Separated*____

*Patient Address*_____ Apt# _____ *City*_____ *State*_____ *Zip*_____

Cell Phone _____ *Parents Names (if minor)* _____

Work Phone _____ *Best Phone Number & Time of Day to Call* _____

Home Phone _____ *Email Address* _____

Patient Employer _____ *Position* _____

Spouse Name _____ *Spouse Birthday* _____ *SS#* _____

Spouse Employer _____ *Spouse Work Phone* _____

Spouse's Cell Phone _____ *Email*_____

How did you hear about our office? _____

Responsible Party, if other than self

Name of Person Responsible for this Account _____ *Relationship to Patient* _____

Address _____ *City* _____ *State* _____ *Zip* _____

SS# _____ *Birthday* _____ *Employer* _____ *Work Phone Number* _____

Is this Person Currently a Patient in our office? _____ *Home Number*_____ *Cell Number*_____

Dental History

Name and address of former Dentist _____ *Date last seen* _____

What was done? _____ *Date of last FULL MOUTH X-Rays* _____

*Reason for today's visit*_____

Has your experience of dental treatment in the past been: good □ *bad* □ *Describe* _____

_____

Have you noticed:

□ *Gums bleed or hurt while brushing*
□ *Loosening of permanent teeth*
□ *Food gets caught between teeth*
□ *Teeth sensitive to hot, cold, or sweets*
□ *Grinding teeth while asleep*
□ *Squeezing or clenching teeth*
□ *Frequent headaches*
□ *Pain in jaw joint*
□ *Popping or Clicking of Jaw Joint*
□ *Sores or lumps in or near the mouth*
□ *Other, Describe* _____

Are you satisfied with the appearance of your teeth and smile? _____

Have you been told you Snore? _____
Do you fall asleep at inappropriate times (at work, driving, etc)? _____
Do you frequently fall asleep while sitting in a chair, or watching TV, or reading? _____
Would you like to know more about Anti-Snoring Mouthpieces for yourself or another person? _____

Please check which are most important to you

□ *Your appearance*
□ *Most economical*
□ *Comfort (free from mouth pain)*
□ *Saving time*
□ *Other* _____

Medical History

Physician's Name _____ Phone _____

Physician's Address _____ City _____ State _____ ZIP _____

Currently under a Physician's care? No ❑ Yes ❑ If so, why? _____

_____

Please check the appropriate items. A blank box indicates you have never had that specific problem or condition.

Has patient ever had a problem with, treatment for, or diagnosed with the following:

❑Osteoporosis	❑Hepatitis or Jaundice	❑HPV	❑Tuberculosis
❑Joint replacement	❑Liver disease	❑Diabetes	❑Asthma
❑Artificial Heart Valves	❑Bleeding disorder	❑Kidney	❑Thyroid problems
❑Congenital Heart Disease	❑Anemia	❑Tumor or Growth	❑Arthritis or Rheumatism
❑Stroke	❑Leukemia	❑Cancer	❑Back Problems
❑Infective Endocarditis	❑Ulcers/Reflux	❑Chemotherapy	❑Glaucoma
❑Pacemaker	❑HIV positive	❑Hives or severe rash	❑Sinus trouble
❑Heart Problems(describe below)	❑High Blood Pressure	❑Skin problems	❑Chemical dependency
❑Abnormal bleeding after extraction or surgery	❑Cortisone treatments	❑Epilepsy	❑Seizures
	❑Tobacco	❑Daily Alcohol	❑Other_____

Please describe checked items:

_____

_____

Allergies to:

❑Penicillin	❑Iodine	❑Tetracycline
❑Codeine	❑Nickel	
❑Aspirin	❑Sulfa drugs	
❑Local Anesthetics	❑Other _____	

Women:

Are you pregnant? _____ due date ___/___/___-

Taking Birth Control Pills?_____

Preferred Pharmacy _____

Please list all medications you are currently taking (include dose and frequency):

_____

_____

_____

List operations that you have had:

_____

_____

_____

The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I will not hold my dentist or any member of his/her staff responsible for any error or omissions that I have made in the completion of this form. _____**initial**

I authorize the dentist to release any information, including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers (e.g. insurance co.) and/or health practitioners. _____**initial**

I understand that my dental insurance carrier may pay less than the estimated amount for services. _____**initial**

I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Date _____ Signature: _____

FINANCIAL PROTOCOLS

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of the Financial Policy that is required you read and sign prior to any treatment.

- **FULL PAYMENT IS DUE AT TIME OF SERVICE.** **(First New Patient on a New Account and Uninsured Patients)**
- **WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, DISCOVER, DEBIT CARDS, AND CARE CREDIT.**
- **WE DO OFFER AN EXTENDED PAYMENT PLAN WITH PRIOR CREDIT APPROVAL THROUGH CARE CREDIT.**

Regarding Insurance
We may accept assignment of insurance benefits after the second visit. However, we do require deductibles and estimated co-payments to be paid at time of service. The balance is your responsibility whether your insurance company pays or not. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Initial

If your insurance company has not paid your account in full within 60 days, you will be required to pay the balance. It is then your responsibility to contact your insurance company about the unpaid claim. If your bill is not paid in full within the next 30 days your account can be turned over to a collection agency and permanently affect your credit record. Please be aware that some, and perhaps all, of the services provided may be non-covered services. Initial

We accept assignment of benefits from only one dental insurance company per patient. It is your responsibility to file claims to your secondary insurance company. This is easily done by requesting a dental claim form from your secondary insurance company, fill out the patient portion, and attach to it the Explanation of Benefits letter that you receive from your primary dental insurance company. Initial

Read and sign here only if you want our office to receive benefits from your insurance company.

I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

X _____ Date _____

Signature of Patient or Responsible Party

Usual and Customary Rates
You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our practice.

Adult Patients
Adult Patients are responsible for full payment at time of service.

Minor Patients
The adult accompanying a minor is responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to a credit card, debit card, or Care Credit; or if payment by cash or check at time of service is verified. Initial

Appointment Reservations
Unless canceled at least 2 working days in advance, our policy is to charge for missed appointment reservations at the rate of a normal office visit when this occurs more than twice in a six month period.

Patients who arrive over 15 minutes late for a reserved appointment may be rescheduled so as not to inconvenience other scheduled patients. Initial

Interest
Interest of 1.5% per month is charged on accounts 30 days after treatment or after receipt of insurance payment.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns. I have read the Financial Policy. I understand and agree to the Financial Policy:

X _____ Date _____

Signature of Patient or Responsible Party

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 **01/01/2003**, 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 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 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 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 wiring 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 $0.00 for each page, $0.00 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 you 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 address to file your complaint with 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 the U.S. Department and Human Services.

Contact Officer: Dr. Sheila Shah

Telephone: 478-757-8714 Fax: 478-757-0253

E-mail: info@maconsmiles.com

Address: 4929 Forsyth Rd. Macon GA 31210

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

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)