Dalton Family & Cosmetic Dentistry
1006 Professional Blvd, Suite B
Dalton, GA 30720

Medical Alert For Office Use

***THANK YOU* for visiting Dalton Family and Cosmetic Dentistry! It is our optimal goal to provide you and your family with the highest quality of dental care while maintaining a friendly and relaxing environment. Please help us by completing this form.**

Patient Information

Name _____
LAST FIRST MIDDLE INITIAL NICKNAME

Address _____
STREET

_____
CITY STATE ZIP

Employer _____ Drivers License _____

Birth date _____ Height _____ Weight _____

θ Male θ Female

Phone: Home (____) _____ Social Security # _____

Work (____) _____ May we contact you at work? θ Yes θ No

Mobile (____) _____

Email Address _____

Emergency contact: Name _____ Phone (____) _____

If Patient is under 18

All minors must be accompanied by an adult during the ENTIRE length of the Minor's appointment.

Responsible Party _____ Relation to Patient _____

Address _____
STREET

_____
CITY STATE ZIP

Other Information:

How did you hear about us? (circle) **Yellow Pages** **Magazine Ad** **Mailer** **Movie Theater** **Friends/Family**
Internet **Newspaper** **Other**_____

What was the MAIN reason for today's visit? _____

Do you love your smile? _____

Is there anything you would like to change about your smile? _____

Why did you leave your last dentist? _____

What did you like *MOST* about your last dentist? _____

What did you like LEAST about your last dentist? _____

Level of Fear coming to the dentist? **1 2 3 4 5 6 7 8 9 10**
Least Fearful **Extremely Fearful**

Medical History and Information

Conditions

- θ Abnormal Bleeding
- θ Alcohol Abuse
- θ Allergies
- θ Anemia
- θ Angina Pectoris
- θ Arthritis
- θ Artificial Heart Valve
- θ Asthma
- θ Blood Transfusion
- θ Cancer
- θ Chemotherapy
- θ Colitis
- θ Congenital Heart Defect
- θ Diabetes
- θ Difficulty Breathing
- θ Drug Abuse
- θ Emphysema
- θ Epilepsy
- θ Facial Surgery
- θ Fainting Spells
- θ Fever Blisters
- θ Frequent Headaches
- θ Glaucoma
- θ HIV+ AIDS
- θ Heart Attack
- θ Heart Murmur
- θ Heart Surgery
- θ Hemophilia
- θ Hepatitis A
- θ Hepatitis B
- θ Hepatitis C
- θ High Blood Pressure
- θ Joint Replacement
- θ Kidney Problems
- θ Liver Disease
- θ Low Blood Pressure
- θ Mitral Valve Prolapse
- θ Pace Maker
- θ Psychiatric Problems
- θ Radiation Therapy
- θ Rheumatic Fever
- θ Seizures
- θ Sexually Transmitted Disease
- θ Shingles
- θ Sickle Cell Disease
- θ Sinus Problems
- θ Stroke
- θ Thyroid Problems
- θ Tuberculosis
- θ Ulcers

Allergies

- θ Aspirin
- θ Codeine
- θ Dental Anesthetics
- θ Erythromycin
- θ Latex
- θ Metals
- θ Penicillin/Amoxicillin
- θ Sulfa
- θ Tetracycline

Other _____

_____

Y N

θ θ Do you Smoke or use any Tobacco Products?

Y N

θ θ Do you use any type of recreational drugs?
If so, what kind? _____

If Female

Y N

θ θ Are you taking Birth Control Pills?

θ θ Are you pregnant?
If yes, # of weeks _____

θ θ Are you Nursing?

IMPORTANT! Are you taking or have you EVER taken BISPHOSPHANATES either Orally or IV, which is commonly used to treat osteoporosis or other bone related diseases. Examples: *etidronate (Didronel), pamidronate (Aredia), alendronate (Fosamax), risedronate (Actonel), zoledronate (Zometa or Reclast), ibandronate (Boniva)*

Circle YES NO

Please List **ALL Medications** *you are currently taking.*

_____

_____

Financial Policy:

Unless arrangements have been made, payment is due prior to the completion of treatment. For your convenience, we offer several payment options: We accept Cash, Checks, and Credit Cards. We also have other financing options available such as Care Credit and extended payment plans with prior approval. Failure of payment may result in your account being sent to collections. You will be responsible for all of the fees involved.

Cancellation Policy:

We value your time and the time of other patients. In order for us to stay on schedule and to give our patients the best care possible, please let us know 48 hours in advance (during working hours) to cancel or change an appointment. If there is no notice before 48 hours, you will be charged a cancellation fee of **$50 per hour** that was reserved on your behalf. If the policy is violated more than 2 times, you will be required to prepay for all subsequent appointments or may be referred to another office.

Treatment Authorization:

I hereby authorize the Dalton Family and Cosmetic Dentistry to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. I also authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary or advisable including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my medical conditions are correct to the best of my knowledge. I also understand that payment for all treatment and services rendered are my responsibility.

_____ _____

PATIENTS SIGNATURE / GUARDIAN SIGNATURE IF UNDER 18 Date

Dalton Family and Cosmetic Dentistry
1006 Professional Blvd, Suite B
Dalton, GA 30720
Tel: (706) 226-2228 Fax: (706) 226-1881

INSURANCE INFORMATION FORM

We accept assignment of dental insurance benefits; however we do require your co-payment for deductibles to be paid at the time of service. Unfortunately there are times where a claim may be denied for whatever reason, some out of our control. As a courtesy to you, we will do our best to ensure that all claims will be processed in a timely and accurate manner.

Please keep in mind that your insurance policy is between **you** and **your insurance company**. We are not a part of that contract. We do **NOT** know what they will pay. We can only **ESTIMATE** what they will cover. If your insurance company has not paid their estimated portion, the balance is your responsibility. All accounts over 90 days will be subject to a finance charge of 2% per month (annual rate of 24%). Any unpaid balances after 90 days may be sent to a collection agency and all fees associated with this will be your responsibility.

Please Initial here _____ that you have read and understood the statement above.

Primary Dental Carrier

Subscriber Name _____ Social Security # _____ DOB _____

Employer _____ Insurance Co. _____

Insurance Co. Phone # _____ Group # _____

Relation to patient _____

Secondary Dental Carrier

Subscriber Name _____ Social Security # _____ DOB _____

Employer _____ Insurance Co. _____

Insurance Co. Phone # _____ Group # _____

Relation to patient _____

Insurance Authorization Statement

I hereby authorize payment directly to the Dalton Family and Cosmetic Dentistry of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs associated to my dental treatment. I have read the above policies and understand my responsibilities as a patient.

Signature_____ **Date**_____

Dalton Family and Cosmetic Dentistry
1006 Professional Blvd, Suite B
Dalton, GA 30720
Tel: (706) 226-2228 Fax: (706) 226-1881

Authorization for Treatment, Disclosure and Filing Insurance

The undersigned hereby authorizes Dalton Family and Cosmetic Dentistry/Lee-Voegele, LLC, to take x-rays or any other diagnostic aids deemed appropriate to make a thorough diagnosis to my medical/dental needs. I also authorize Dalton Family and Cosmetic Dentistry/Lee-Voegele, LLC to perform any and all forms of treatment, medication, and therapy that may be indicated. I understand that the use of anesthetic agents embodies a certain risk. I certify that the medical/dental history information is correct to the best of my knowledge.

I give authorization to release any and all necessary information to my insurance company, managed care organization, state agencies, federal agencies, health care financing administration and/or third party administrator or its agents, any information needed to process my claim and/or determine benefits payable for related services. I also authorize that payment be made directly to the dentist. I also authorize Dalton Family and Cosmetic Dentistry/Lee-Voegele, LLC, to utilize the fax machine or the internet to transmit any or all of the above medical/dental records pertaining to medical/dental care or insurance reimbursement. I acknowledge that faxing or electronically transmitting medical/dental records may increase the risk of accidental disclosure of my records. This authorization remains valid and effective from the date of signing until revoked in writing. A photocopy of this authorization will be valid as the original.

I have read or have read to me the financial policy. I understand that I am financially responsible for all charges incurred, including but not limited to, deductible amounts, co-payments, co-insurance amounts, non-covered charges and any and all balances not covered by the insurance company.

Our Staff may occasionally place calls to verify your appointment. May we do this by leaving a message on your answering machine, voicemail, email, fax, with a family member, or with a co-worker?

_____YES _____ NO _____ Initial

Patient Signature_____ Date_____

Witness_____

Dalton Family and Cosmetic Dentistry

1006 Professional Blvd, Suite B
Dalton, GA 30720
Tel: (706) 226-2228 Fax: (706) 226-1881

Patient Agreement and Release Form

I _____ hereby authorize Dalton Family and Cosmetic Dentistry to use material, including but not limited to visual aids, pertaining to this case for teaching and printing publications. I also authorize photographs to be taken of me for educational purposes and understand that they may be shown to other dentists and their staffs as well as patients contemplating similar treatments.

I authorize and agree to the statement above.

_____ _____
Signature of Patient Date

I decline and do not agree to the statement above.

_____ _____
Signature of Patient Date

_____ _____
Signature of Witness Date

Dalton Family and Cosmetic Dentistry
1006 Professional Blvd, Suite B
Dalton, GA 30720
Tel: (706) 226-2228 Fax: (706) 226-1881

Effective Date: August 1, 2005

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we usually will not ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;

disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
uses or disclosures for health related research;
uses and disclosures to prevent a serious threat to health or safety;
uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
disclosures of de-identified information;
disclosures relating to worker's compensation programs;
disclosures of a "limited data set" for research, public health, or health care operations;
incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.

If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:
ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this Notice.
ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part,

however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

- ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

Dalton Family and Cosmetic Dentistry
1006 Professional Blvd, Suite B
Dalton, GA 30720
Tel: (706) 226-2228 Fax: (706) 226-1881

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

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please specify)