

# Patient Dental & Medical Health History Information

**To our patients:** Please know that we may ask follow-up questions to make sure we have all of the information we need in order to treat you.

PATIENT INFORMATION			
Last Name:		First Name:	
Home Phone:		Cell Phone:	
Email Address:		Work Phone:	
Mailing Address:		City:	State: Zip:
Date of Birth:        /        /		Gender:	
Occupation:			
Emergency Contact: Name:		Relationship:	Phone:
If you are completing this form for another person, what is your name and relationship to that person? Name: _____ Relationship: _____ If executing this form as the patient's personal representative, I represent and warrant that I have full legal right and authority to consent to the performance of any procedure(s) on this patient. If for any reason I no longer have such legal right and authority, I will immediately notify the practice in writing.			
DENTAL HISTORY & SYMPTOMS			
What is the reason for your visit today?			
Are you currently experiencing any dental pain or discomfort? <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, where?			
When was your last dental exam?        /        /		What was done at that appointment?	
When was the last time you had dental x-rays taken?			
Please mark an "X" in the box ONLY if this applies to you.			
Is it hard to open your mouth? .....		<input type="checkbox"/> Have you ever had a serious injury to your head or mouth? .....	
Does it hurt to chew, bite or swallow? .....		<input type="checkbox"/> If yes, please describe what happened and when it happened: _____	
Do your gums bleed when you brush or floss your teeth? .....		<input type="checkbox"/> Have you ever had problems with dental treatment in the past? .....	
Have you ever had periodontal (gum) treatments like scaling and root planing? .....		<input type="checkbox"/> If yes, please describe what happened: _____	
Do you have, or have you ever had, any sores or growths in your mouth? .....		<input type="checkbox"/> Have you ever had a reaction to, or problem with, dental anesthesia? .....	
Do you clench or grind your teeth? .....		<input type="checkbox"/> If yes, please describe what happened: _____	
Does your jaw click, pop or hurt? .....		<input type="checkbox"/> Are you unhappy with your smile? .....	
Do you have earaches or neck pains? .....		<input type="checkbox"/> If yes, why? Please mark all that apply:	
Does dental treatment make you nervous? .....		<input type="checkbox"/> <input type="checkbox"/> The color of your teeth <input type="checkbox"/> The shape of your teeth <input type="checkbox"/> The position of your teeth	
Have you ever experienced any of these sleep-related breathing disorders? .....		<input type="checkbox"/> <input type="checkbox"/> Other. Please describe: _____	
<input type="checkbox"/> Mouth breathing <input type="checkbox"/> Snoring <input type="checkbox"/> Trouble breathing during sleep			
MEDICATIONS & OTHER PRODUCTS/SUBSTANCES			
Please use an "X" to mark your answers to the following questions. <span style="float: right;">Yes No ?</span>			
Are you taking any <b>blood thinners</b> (such as Coumadin, Warfarin, rivaroxaban (Xarelto®), dabigatran (Pradaxa®), clopidogrel (Plavix®), heparin or aspirin)? .....			
If yes, what medication are you taking? _____			
Are you taking any medication to treat <b>osteoporosis</b> or Paget's disease? .....			
Some commonly-prescribed drugs include alendronate (Fosamax®), risedronate (Actonel®), ibandronate (Boniva®), zoledronate (Reclast®), and denosumab (Prolia®).			
If yes, what medication are you taking? _____			
Are you taking, or scheduled to take, an <b>IV medication</b> to treat bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? .....			
Some commonly-prescribed drugs include denosumab (Xgeva®), pamidronate (Aredia®) or zoledronate (Zometa®).			
If yes, what medication are you taking? _____ How many years have you been taking it? _____			
Are you taking <b>hormonal replacements</b> ? .....			
Do you use any form of <b>tobacco or nicotine products</b> (cigarettes, cigars, snuff, chew, bidis)? .....			
Do you use <b>vaping products</b> ? .....			
How many <b>alcoholic beverages</b> do you have per week? _____			
Do you use <b>controlled substances</b> (drugs), including marijuana, for either medicinal or recreational reasons? .....			
If yes, what substances? _____ If yes, how often is your use? <input type="checkbox"/> Daily <input type="checkbox"/> Several times per week <input type="checkbox"/> Weekly <input type="checkbox"/> Occasionally			
Was the substance prescribed by a doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, for what reason(s)? _____			
Do you take any other <b>prescriptions and/or over-the-counter medicine(s), vitamins, herbs and/or supplements</b> ? .....			
If yes, please list them here and include information about how much and how often you use each one. _____			
<b>WOMEN ONLY:</b> Are you:			
Taking <b>birth control pills</b> ? .....			
<b>Pregnant?</b> If yes, number of weeks: _____			
<b>Nursing?</b> If yes, number of weeks: _____			

ALLERGIES Please use an "X" to mark your answers to the following questions.			
Are you allergic to or have you had an allergic reaction to:		Yes No ?	Yes No ?
Aspirin .....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Sulfa drugs such as sulfamethoxazole-trimethoprim (Septra, Bactrim), erythromycin-sulfisoxazole, sulfasalazine (Azulfidine), erythromycin-sulfisoxazole (Eryzole, Pediazole) glyburide (Diabeta, Glynase PresTabs), dapsone, sumatriptan (Imitrex), celecoxib (Celebrex), hydrochlorothiazide (Microzide) and furosemide (Lasix)..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Barbiturates, sedatives or sleeping pills .....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Codeine or other narcotics .....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Hay fever/seasonal allergies .....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Iodine .....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Latex (rubber) .....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Other ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Local anesthetics.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Please describe any "Yes" answers and include information about your experience. _____
Metals .....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Penicillin or other antibiotics.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
MEDICAL & SURGICAL HISTORY			
Date of last physical exam:        /        /		What is your normal blood pressure (systolic, diastolic)?	
Doctor's Name:		Phone:	
Please use an "X" to mark your answers to the following questions. Yes No ?			
Are you in good physical health? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
Are you currently being seen or treated by a physician? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
Has a physician or previous dentist recommended that you take <b>antibiotics</b> before having dental work done? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
Have you had a <b>serious illness, operation or been hospitalized</b> in the past 5 years? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
Have you had any type (either total or partial) of <b>joint replacement</b> surgery (such as for a hip, knee, shoulder, elbow, finger, etc.)? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
Have you had a <b>heart valve replacement or heart surgery</b> ? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
Have you had an <b>organ or bone marrow/stem cell transplant</b> ? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
Have you traveled internationally within the last 30 days ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
Have you had a fever (100.4°F or above) in the last 72 hours? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
If you answered yes to any of the above, please explain: _____			
MEDICAL HISTORY SPECIFIC Please use an "X" to mark your answers to the following questions.			
Do you have, or have you been diagnosed with, any of the following conditions? Yes No ? Yes No ?			
<b>Heart (Cardiac) Health</b>		<b>Cancer</b> ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<b>Digestive Health</b>
Pacemaker/implanted defibrillator ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		Type: _____	Gastrointestinal disease ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Artificial (prosthetic) heart valve ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		Date of diagnosis: _____	G.E. reflux/persistent heartburn (GERD)..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Previous infective endocarditis ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		Chemotherapy: _____	Stomach ulcers..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Congenital heart disease (CHD) ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		Radiation treatment: _____	<b>Eye (Vision) Health</b>
Unrepaired, cyanotic CHD..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<b>Blood (Circulatory) Health</b>	Glaucoma..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Repaired (completely) in last 6 months ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		Anemia..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<b>Other</b>
Repaired CHD with residual defects ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		Blood transfusion..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Arthritis..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Arteriosclerosis..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		If yes, date: _____	Chronic pain ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Coronary artery disease ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		Hemophilia..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Diabetes (type I or II) ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Congestive heart failure ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		High or low blood pressure..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Eating disorder ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Damaged heart valves ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<b>Brain (Neurological)/Mental Health</b>	Frequent infections..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Heart attack ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		Anxiety..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Type of infection: _____
Heart murmur/rhythm disorder ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		Depression..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Hepatitis, jaundice or liver disease ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Rheumatic heart disease..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		Epilepsy..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Immune deficiency..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Stroke..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		Mental health disorders ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Kidney problems..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<b>Breathing (Respiratory) Health</b>		Neurological disorders..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Malnutrition ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Asthma (COPD) ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		Post-traumatic stress disorder ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Osteoporosis..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Bronchitis..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		Traumatic brain injury or concussion..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Rheumatoid arthritis ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Emphysema..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<b>Autoimmune Disease</b>	Sexually transmitted infection (STI)..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Sinus trouble..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		AIDS or HIV Infection ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Thyroid problems..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Tuberculosis..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		Lupus..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Do you have any disease, condition, or problem that's not listed here? If so, please explain. _____			
MEDICAL SYMPTOMS/GENERAL Please use an "X" to mark your answers to the following questions.			
In the past 30 days, have you: Yes No ?		Yes No ?	Yes No ?
had pain or tightness in the chest?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		found it hard to catch your breath? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	experienced vomiting, diarrhea, chills, night sweats or bleeding?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
coughed up blood or had a cough that lasted longer than 3 weeks? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		had a high fever (greater than 101.5°F) for no reason?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	had migraines or severe headaches? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
been exposed to anyone with tuberculosis?.. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		noticed a change in your vision? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
had a rapid or irregular heart beat? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		fainted for no reason?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<b>NOTE: It's important for both the doctor and patient to talk honestly about the patient's health before dental treatment starts.</b>			
I have answered the above questions completely, accurately and to the best of my ability.			
Signature of Patient/Legal Guardian: _____		Date: _____	
FOR COMPLETION BY DENTIST			
Comments: _____			
<b>Office Use Only:</b> <input type="checkbox"/> Medical Alert <input type="checkbox"/> Premedication <input type="checkbox"/> Allergies <input type="checkbox"/> Anesthesia			
Reviewed by: _____		Date: _____	



DOUGLAS DENTAL  
*Studio*

Patient Name: \_\_\_\_\_

## Patient Screening Form

	PRE-APPOINTMENT	IN-OFFICE
<b>Please use an "X" to mark your answers to the following questions.</b>		
	Date: ____/____/____	Date: ____/____/____
1. Do you/the patient have fever or have you/the patient felt hot or feverish recently (14–21 days)? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Are you/the patient having shortness of breath or other difficulties breathing? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Do you/the patient have a cough? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have you/the patient experienced recent loss of taste or smell? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Are you/the patient in contact with any confirmed COVID-19 positive patients? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.</i>		
7. Is your/the patient's age over 60? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Do you/the patient have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Have you/the patient traveled in the past 14 days? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment.**

For testing, see the Centers for Disease Control and Prevention (CDC)'s list of State and Territorial Health Department Websites for your specific area's information: <https://www.cdc.gov/publichealthgateway/healthdirectories/healthdepartments.html>.

**Dental Insurance:** \_\_\_\_\_

**Who is responsible for this account?** \_\_\_\_\_

**Relationship to patient:** \_\_\_\_\_

**Insurance co.:** \_\_\_\_\_

**Group #:** \_\_\_\_\_

**Is the patient covered by additional insurance?** \_\_\_\_\_ **YES** \_\_\_\_\_ **NO**

**Subscriber Name:** \_\_\_\_\_

**Birthdate** \_\_\_\_\_ **SS#** \_\_\_\_\_

**Relationship To Patient** \_\_\_\_\_

**Insurance Co.** \_\_\_\_\_

**Group #** \_\_\_\_\_

## **ASSIGNMENT AND RELEASE OF BENEFITS**

**I certify that I, and/or my dependent(s) have insurance coverage with \_\_\_\_\_ and assign directly to Dr. \_\_\_\_\_**

**all insurance benefits, If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.**

**The above named dentist may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.**

\_\_\_\_\_  
**Signature of Patient, Parent, Guardian, or Personal Representative**

\_\_\_\_\_  
**Printed Name of Patient, Parent, Guardian, or Personal Representative**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Relationship to Patient**



## Consent Form – Oral Cancer Screening

Our office strives to bring its patients state-of-the-art technology to provide you with the latest advancements in oral health. We have recently introduced the OralID™ screening device into our office. The OralID examination will allow us to visualize any oral mucosal abnormalities including cancer and dysplasia (pre-cancer) before they can be detected with the naked eye. The procedure is quick, painless and no rinses or dyes are used.

Similar to other cancers, early detection of Oral Cancer is critical. Studies have shown that early detection of oral cancer with technologies like the OralID™ dramatically improves the survivability of the disease. If oral cancer is detected in its later stages, which typically occurs during a conventional oral cancer exam, the chances of survival are dramatically reduced.

### Who is at Risk?

- Age - 17+ years
- Tobacco Use
- Alcohol Use
- HPV infection

If you have any questions about risk factors, please feel free to talk to our hygiene staff. We recommend all of our patients be screened with the OralID™ to reduce the mortality of late stage detection.

**\$20 FEE**

☐ Yes, I request that your staff perform an examination with the OralID.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name

\_\_\_\_\_  
Date

☐ No, I prefer to not have this examination at this visit.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name

\_\_\_\_\_  
Date





## OFFICE POLICIES

**Please read and initial each policy below**

### **Cancellation & No Show**

Our office hours are by appointment and we do value your time. This office is a private practice and not a dental "clinic." Appointment times are reserved for you alone. Therefore, if you cannot make an appointment as scheduled, we ask that you please notify the office within **48 hrs to avoid a broken appointment fee.**

### **Financial Policy**

Our office offers simple financial arrangements in order to avoid possible misunderstandings. **Unless prior arrangements are made, payment in full is expected at the time treatment is provided.** For your convenience, we accept all major credit cards, cash, checks, and care credit. There is a fee charged for returned checks.

### **Dental Insurance**

We are happy to assist you in receiving your maximum dental insurance benefits. Our office will accept assignment of dental insurance benefits directly to our office. As courtesy, we will provide **estimates** for dental insurance based upon the most current information given to us by your dental insurance. Therefore, you are responsible for all dental fees (charges) that your insurance company has not paid, within a 60-day period from when treatment has begun. You will be expected to pay the full amount.

### **Overdue Balances**

If your balance becomes 60-days or more overdue, our office reserves the right to interrupt or discontinue treatment and/or send your account to an attorney for collection. In the event that your account is sent to collection, you will be responsible for all cost and fees, including reasonable attorney's fees incurred.

### **Treatment Fee**

The estimate fees we provided for dental services are guaranteed for 90- days. If treatment is not begun within 90-days of the estimate date, cost of treatment could vary. Once dental treatment has begun, changes in the anticipated treatment plan may be required, depending on oral conditions encountered. You will be informed if this occurs and given the option of continuing treatment, changing treatment, or cancelling treatment.

\_\_\_\_\_  
Signature of Patient/Guardian

\_\_\_\_\_  
Date





# NOTICE OF PRIVACY PRACTICES

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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.

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## 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 (08/01/2009), 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.

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## 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 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 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 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 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).

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#### **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 writing 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 \$0.40 for each page, \$12.00 per hour for staff time to 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 your 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.

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#### **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 the address to file your complaint with the 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 with the U.S. Department of Health and Human Services.

**Contact Officer:** Dr. Cassandra Lichkay

**Telephone:** 770-942-8288

**Address:** 3009 Chapel Hill Rd Ste A, Douglasville

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This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002; April 30, 2009).

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Signature of Patient/Guardian

Date



# FINANCIAL POLICY ACKNOWLEDGEMENT

**Douglas Dental Studio  
3009 Chapel Hill Rd Suite A  
Douglasville, GA 30135  
Phone: 770-942-8288**

## **FINANCIAL POLICY ACKNOWLEDGEMENT**

The following information is to inform you of our financial policy. If, at any time, you have questions regarding this policy, please do not hesitate to ask any member of our business team.

We are committed to providing you with the highest quality of care. Our fees are a reflection of the quality of care we provide. We continue our commitment by offering a variety of financial options to enable you to receive the dental care you need. We accept cash, check, VISA, Mastercard, Discover, and American Express. We have also partnered with a third-party company CareCredit to offer flexibility of deferred interest and extended payment options. Check policy: If your check is returned for any reason, we will charge you a returned check fee of \$35 plus a processing fee.

We will communicate all recommended treatment options and associated fees prior to the start of treatment. A delinquent account impedes our ability to provide you with the quality dental care that you deserve. It is our policy that the parent or guardian who accompanies a child to our office for treatment is responsible for payment of all services rendered. We are committed to respecting your time and ask that you make every effort to keep the appointment time reserved exclusively for you. We understand there may be times when you are unable to keep your scheduled appointment, however, any appointment missed may be subject to a missed appointment fee of \$57. Should you find it necessary to reschedule an appointment, please provide us with a notice of 2 business days to avoid being charged a missed appointment fee.

As a courtesy to our patients with dental insurance benefits, we will submit your claim and provide any necessary information to assist you in receiving your dental benefits. We require that any applicable deductibles and estimated patient portion be paid at the time treatment is rendered. We do accept assignment of insurance benefits as a form of payment to help reduce your immediate out-of-pocket expense. We are participating providers for Delta Dental, Cigna, United Healthcare, and Metlife. However, we **DO NOT** participate in any DMO, HMO, Medicare, Medicaid, or Discount plans. We accept MOST PPO policies but are only in network for those listed above.

Please contact your insurance carrier prior to your visit to obtain essential information which will accurately reflect your coverage. Providing us with this information will expedite the processing of claims. If you have a direct reimbursement policy, payment in full is expected on the day of service and your dental plan will reimburse you.

### **Important Facts About Your Dental Insurance**

- **Dental Insurance is a contract between the patient and the insurance company. It is a benefit to assist you with the cost of dental care. At no time should insurance benefits compromise your doctor's diagnosis or affect your choice of treatment.**
- **It is your responsibility to understand the type of dental insurance you have and benefits selected by you and/or your employer.**
- **You (NOT THE INSURANCE COMPANY) are responsible for the fees of services rendered.**

Patient/Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_