Patient Information

Patient Name: _____ Preferred Name: _____
Last First MI

Address: _____
Street Apartment #

_____
City State Zip Code

Phone (Home): _____ (Work): _____ Ext: _____ Cell: _____

Email Address: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____ Height: _____

Social Security #: _____ Date of Birth: _____ Weight: _____

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

Reason for visit today: _____

Name of general dentist referring you to our practice: _____

Have we treated any of your friends or family? _____ Who? _____

Health Information

Have you ever had or do you now have any of the following? Please check those that apply:

- ☐ Anxiety / Depression
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Thinner Use
- ☐ Bone Density Meds
- ☐ Cancer
- ☐ Dementia
- ☐ Developmental Delay
- ☐ Diabetes
- ☐ Drug / Alcohol Dependency
- ☐ Epilepsy
- ☐ Fainting
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis / Liver Disease
- ☐ High Blood Pressure
- ☐ HIV / AIDS
- ☐ Kidney Disease
- ☐ Osteoporosis
- ☐ Pacemaker/Defibrillator
- ☐ **Current Pregnancy**
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ TMJ
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease

List current medications: (attach list, if necessary)

1. _____
2. _____
3. _____
4. _____

Note adverse reactions to:

☐ Penicillin ☐ Codeine ☐ Local Anesth.
☐ Erythromycin ☐ Demerol ☐ Antihistamines
☐ Tetracycline ☐ Aspirin ☐ Barbiturates
☐ Other: _____

IN CASE OF EMERGENCY, WHOM MAY WE CONTACT? _____ **phone** _____

- Do you smoke? ☐ Yes ☐ No If yes, how much? _____
- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

(CONTINUED ON BACK)

Dental Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
(Last / First / MI)

Insured's Birth Date: _____ SS #: _____ Group #: _____

Insured's Address: _____
(Street / City / State / Zip Code)

Insured's Employer Name: _____

Address: _____
(Street / City / State / Zip Code)

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name, Address & Phone: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
(Last / First / MI)

Insured's Birth Date: _____ SS #: _____ Group #: _____

Insured's Address: _____
(Street / City / State / Zip Code)

Insured's Employer Name: _____

Address: _____
(Street / City / State / Zip Code)

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name, Address & Phone: _____

I hereby instruct _____ Insurance Company and/or _____

Insurance Company to pay by check made out and mailed to: Macon Periodontics and Implant Dentistry, LLC
6076 Lakeside Commons Dr
Macon, GA 31210

If my current policy prohibits direct payment to doctor, I hereby also instruct and direct you to make out the check to me and mail it to: Macon Periodontics and Implant Dentistry, LLC
6076 Lakeside Commons Dr
Macon, GA 31210

for the professional or medical expenses benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. This is a direct assignment of my benefits under this policy. This payment may not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this agreement shall be considered as effective and valid as the original.

_____ _____
Signature Date

MACON PERIODONTICS AND IMPLANT DENTISTRY, LLC

6076 Lakeside Commons Dr
Macon, GA 31210

FINANCIAL POLICY

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your responsibility.

- Please read and sign prior to seeing the doctor.
- We accept cash, checks, Visa, MasterCard, American Express, and Discover.
- We do not accept insurance for your initial exam. Payment for this visit is due at the time service is rendered. However, we will help you complete the claim forms so that you can be reimbursed by your insurance company to the extent of your coverage.

On subsequent visits, we will accept your insurance if you obtain approval from our office staff prior to the date of service. When we accept your insurance, we require at least 30% of the total charges at the time of service (some procedures require 50% payment). If your insurance company has not paid the full balance within 45 days, arrangements will need to be made with our office to satisfy this balance within 15 days. If your insurance company pays more than the balance due, we will send a refund check to you.

Insurance is a contract between you and your insurance company. We are not a party to this contract. We file insurance claims as a courtesy to our patients. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual & customary" charges, etc., other than to supply factual information as necessary. You are responsible for the timely payment on your account.

Regarding Minors: The adult accompanying a minor will be held responsible for payment of services.

Missed Appointments: Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments. Please help us serve you better by keeping your scheduled appointments.

Thank you for understanding our financial policy. Please let us know if you any questions or concerns.

There will be a $25 service charge on all returned checks.

_____ _____

Responsible Party Signature Date

MACON PERIODONTICS AND IMPLANT DENTISTRY, LLC

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 April 14, 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 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).

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 may 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 may charge you for each page and 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 may 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.

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: Kay Willis Telephone: 478-742-4254 Fax: 478-742-1457

Address: 6076 Lakeside Commons Drive, Macon, Georgia 31210

MACON PERIODONTICS AND IMPLANT DENTISTRY, LLC

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)

_____

_____

Macon Periodontics & Implant Dentistry, LLC
6076 Lakeside Commons Drive
Macon, Georgia 31210

Driving from the **SOUTH**:

1. Take Exit 172 (Bass Road) off I-75
2. Turn **LEFT** on Bass Road
3. Turn left on Bowman Rd at traffic light
4. Turn right on Lakeside Commons Drive
5. Keep to the left and go to the end of the drive
6. Turn left into parking lot

Driving from the **NORTH**:

1. Take Exit 172 (Bass Road) off I-75
2. Turn **RIGHT** on Bass Road
3. Turn left on Bowman Rd at traffic light
4. Turn right on Lakeside Commons Drive
5. Keep to the left and go to the end of the drive
6. Turn left into parking lot.

(478) 742-4254