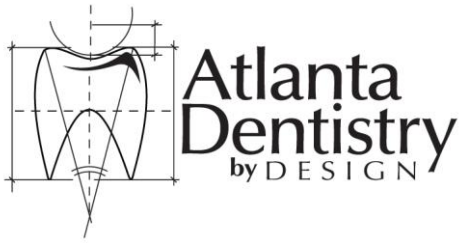


Dr. Paul H. Freeman DDS

Phone: 404-355-2001 | Fax: 404-355-6490
Email: Randi@atlantadentistrybydesign.com
Website: www.atlantadentistrybydesign.com

Today's Date:

PATIENT INFORMATION

☐ Mr. ☐ Ms ☐ Miss ☐ Mrs. ☐ Dr.

Last Name:	First:	Middle:
Home Address:		
City:	State:	Zip:
Home #	Work #	Cell #
Email:	Social Security #	
Birth Date:	☐ Single ☐ Married	☐ Male ☐ Female
Spouse Name:	Contact #	
Referral Source/ Name:		
Employer Name:		

RESPONSIBLE PARTY
IF OTHER THAN PATIENT

Relationship to Patient: ☐ Husband ☐ Wife ☐ Father ☐ Mother

Last Name:	First:	Middle
Home Address:		
City:	State:	Zip:
Home #	Work #	
Email:		

EMERGENCY CONTACT

Name:
Contact #
Relationship to Patient:

DENTAL INSURANCE

Insurance Company:
Insured's Name:
Member ID #:
Insured's Birth Date:
Insured's Social Security:
Relationship: ☐ Husband ☐ Wife ☐ Father ☐ Mother
Insured's Employer:
Policy / Group Number:

NOTES

- **We Gladly Accept Assignment From Your Primary Carrier Only**
- **Please Provide Copy of Drivers License/ ID at Appointment**

INFORMED CONSENT

The information I have given today is correct to the best of my knowledge. This information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my personal and dental insurance status. I authorize the dental staff to perform any necessary dental services with the information provided that I may need during diagnosis and treatment with my informed consent.

I understand that my deductible should be met based on my policy. Co-payments are due at the time of service. Payment is due in full at the time of treatment unless prior arrangements have been approved. Additionally, if insurance does not pay the balance in full or any pre-determined portion of the agreed upon fee, I understand that I am responsible for any remaining balance within 30 days.

Patient's Signature:	Date:

MEDICAL AND DENTAL QUESTIONNAIRE

Last Name:	First:	Birth Date:

Main Concern for Today's Appointment?

Are you currently under the care of a physician?	☐ YES	☐ NO	If yes, please explain:
Are you taking any prescription/OTC drugs?	☐ YES	☐ NO	If yes, please list all below

MEDICATION	DOSAGE	FREQUENCY

Physician's Name:	Office #	Date of Last Visit:

PLEASE CHECK EACH CATEGORY INDIVIDUALLY

☐ Y	☐ N	Alcoholism	☐ Y	☐ N	Eating Disorder	☐ Y	☐ N	Lupus
☐ Y	☐ N	Anemia	☐ Y	☐ N	Epilepsy/ seizures	☐ Y	☐ N	Measles
☐ Y	☐ N	Anxiety Disorder	☐ Y	☐ N	Heart Disease	☐ Y	☐ N	Fever Blisters/ Herpes
☐ Y	☐ N	Arthritis	☐ Y	☐ N	Heart Problems	☐ Y	☐ N	Osteoporosis
☐ Y	☐ N	Asthma	☐ Y	☐ N	Hepatitis – A,B,C	☐ Y	☐ N	Pacemaker
☐ Y	☐ N	AIDS/ HIV	☐ Y	☐ N	High Blood Pressure	☐ Y	☐ N	Sinus Problems
☐ Y	☐ N	Bleeding Disorder	☐ Y	☐ N	High Cholesterol	☐ Y	☐ N	Stroke
☐ Y	☐ N	Blood Disease	☐ Y	☐ N	Joint Disorder	☐ Y	☐ N	Stomach Ulcer
☐ Y	☐ N	Blood Transfusion	☐ Y	☐ N	Kidney Disorder	☐ Y	☐ N	Substance Abuse
☐ Y	☐ N	Cancer/ Chemotherapy	☐ Y	☐ N	Liver Disorder	☐ Y	☐ N	Thyroid Disorder
☐ Y	☐ N	Diabetes	☐ Y	☐ N	Lung Disease	☐ Y	☐ N	Tuberculosis
☐ Y	☐ N	Are You Required to Pre-Medicate for Medical/Dental Procedures? If so, Condition:						

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING

☐ Y	☐ N	Adhesive Tape	☐ Y	☐ N	Dental Anesthetics	☐ Y	☐ N	Penicillin
☐ Y	☐ N	Aspirin	☐ Y	☐ N	Erythromycin	☐ Y	☐ N	Sulfa
☐ Y	☐ N	Barbiturates (sleeping pills)	☐ Y	☐ N	Latex	☐ Y	☐ N	Tetracycline
☐ Y	☐ N	Codeine	☐ Y	☐ N	Other:			

FOR WOMEN ONLY

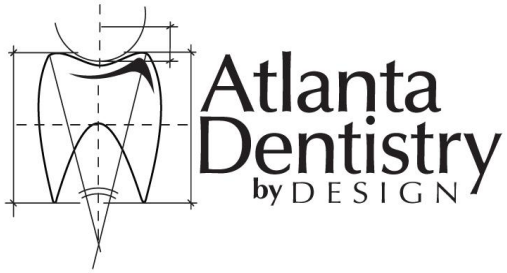
☐ Y	☐ N	Are you taking Birth Control Pills?	☐ Y	☐ N	Pregnant, # of weeks	☐ Y	☐ N	Nursing

PLEASE ANSWER QUESTIONS BELOW

☐ Y	☐ N	Are you currently in pain? Where?	☐ Y	☐ N	Are you aware of clenching, grinding or jaw joint issues? Explain:
☐ Y	☐ N	Do your gums ever bleed?	☐ Y	☐ N	Do you smoke or chew tobacco? ☐ Smoke ☐ Chew How often:
☐ Y	☐ N	Do you use a CPAP?	☐ Y	☐ N	Do you/ have you been told you snore?
☐ Y	☐ N	Does your family have a history of periodontal/gum disease? ☐ Father ☐ Mother ☐ Both			

The information I have given today is correct to the best of my knowledge. This information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical/dental status. Based on my medical/dental history, I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Patient's Signature:	Today's Date:
Dr. Freeman's Signature:	Date Reviewed:



Acknowledgement of Office Policy

Dr. Paul H. Freeman DDS

Dental Insurance

- Dental insurance is not meant to be a "pay all", it is intended as assistance or a supplement to help with dental expenses. The yearly maximum allowable has not changed in most plans since 1967.

- You may receive correspondence from your insurance company stating that our dental fees are different than their fee schedule offering. An insurance company's "fee schedule" is completely arbitrary and is typically not based on any survey of area fees. In fact, an insurance company's "fee schedule" will change from one plan to another depending on what you or your employer have paid for the plan. The primary tool the insurance companies use to determine a plan's "fees" is your premium payment. The more you pay for the plan, the higher the "fee allowance".

- Most insurance plans tell their insured they will be covered "80%-100%" but do not disclose the specific fee schedule allowance, frequency limitations, annual maximums, or any restrictions on pre-existing conditions. At times, it can be a guessing game. For that reason, we cannot guarantee insurance benefit. We have no control over what decisions they make. Our concern is your health.

- The amount your plan pays is determined by how much your employer paid for the plan. The less paid for the insurance, the less you will receive in dental coverage. Remember you get back only what your employer puts in, less the profits of the insurance company.

- Many routine dental services are not covered by insurance carriers. Although you have dental insurance, you are completely responsible for payment of your account.

- Our office will file insurance as a courtesy with your primary insurance company only. If you have secondary insurance it will be your responsibility to file. We can assist with claim forms.

- We do ask that you familiarize yourself with your dental plan coverage.

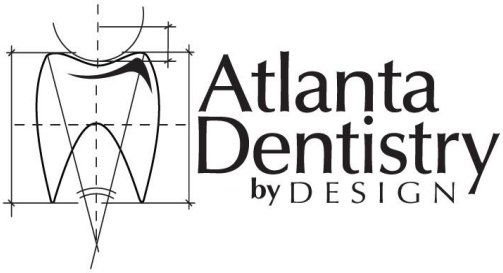
No-Show Appointments

Our office takes special care to remind all of our patients of their upcoming scheduled appointments through mail, email and telephone calls. While we make sure every patient is contacted and aware of their appointments, we would like to remind you that YOU are responsible for keeping track of your appointments. While we understand that unforeseen events can arise, preventing you from keeping your appointment, we have a very forgiving cancellation policy that allows you up to 24 hours before the appointment to cancel or reschedule. If we do not hear from you, you will be considered a "no-show" and you will be charged a fee of $25.00 per hour broken.

It is not our intent to charge our patients additional money but it is very costly to miss your appointment without warning. It is also very difficult to keep the schedule running smoothly when there are no-shows. This policy enables us to maintain a high level of service for all of our patients.

Thank you for your confidence in our office and do not hesitate to ask us for assistance.

PLEASE INITIAL: _____ **DATE**:_____



Acknowledgement of Receipt of Privacy Practices

Dr. Paul H. Freeman DDS

I acknowledge I have had the opportunity to review Dr. Paul H. Freeman's Notice of Privacy Practices.

Patient Name: _____ Date: _____

Signature of Patient, Legal Guardian,
or Authorized Representative: _____

Notice of Privacy Practices

Dr. Paul H. Freeman DDS

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 understand that medical information about you and your health is personal "Protected Health Information" ("PHI") and we are committed to protecting your medical information. PHI includes individually identifiable information about your past, present, or future health or condition, the provision of health care to you, or payment for such health care. We use and disclose PHI about you for treatment, payment, and health care operations.

Treatment:
We may disclose PHI to your insurance provider, our dentist(s), and other dental care providers for treatment purposes. For example, your dentist may wish to provide a dental service to you but first seeks information from your insurance provider as to whether the service has been previously provided.

Payment:
We disclose your PHI in order to fulfill our duty to check your coverage, determine your benefits, and secure payment for services provided to you. For example, we use your PHI in order to request process of your claims by your insurance provider.

Health Care Operations:
We disclose your PHI as a part of certain operations, such as quality improvement. For example, we may use your PHI to evaluate the quality of dental services that were performed.
We may be asked by the sponsor of your health plan to provide your PHI to the sponsor. If we are asked to do so, we intend to honor such requests unless we are prohibited by law.

Uses and Disclosures for Other Reasons without Permission:
We may use or disclose your PHI without your authorization for several other reasons. Subject to certain requirements, we may give out PHI without your authorization for public health purposes, auditing purposes, research studies, and emergencies. We provide PHI when otherwise required by law, such as for law enforcement in specific circumstances, or for judicial or administrative proceedings. In any other situation, we will ask for your written authorization before using or disclosing your PHI. If you choose to sign an authorization to allow disclosure of your PHI, you can later revoke that authorization to stop any future uses and disclosures (other than for treatment, payment, and health care operations).We may change our policies at any time. Before we make a significant change in our policies, we will update our notice and send the new notice to you. You can also request a copy of our notice at any time. We may contact you for appointment reminders via text, phone, mail, or email. We may also contact you to notify you of other treatments or services available at our office. Furthermore, unless you object we may also share relevant information about your care with your family or friends who are helping you with your dental care.

Individual Rights
In most cases, you have the right to view or get a copy of your PHI within 30 days of a written request. We reserve the right to charge a reasonable fee if your request incurs cost to us. You also have the right to receive a list of instances where we have disclosed your PHI without your written authorization for reasons other than treatment, payment, or health care operations. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information. You may request in writing that we not use or disclose your PHI for treatment, payment, and health care operations except when specifically authorized by you, when required by law, or in emergency circumstances. We will consider your request but are not legally required to accept it. You also have the right to receive confidential communications of PHI by alternative means or at alternative locations if you clearly state that disclosure of all or part of your PHI could endanger you.

Our Legal Duty
We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we alter our privacy practices we will post the new notice in our office, have copies available in our office and post it to our website. If you wish to inspect your records, receive a listing of disclosures, or correct or add to the information in your record, or if you have any questions, complaints, or concerns, please contact our office.

Complaints
If you are concerned that we have violated your privacy rights, or you disagree with a decision we have made about access to your records, please contact us. You may also send a written complaint to the U.S. Department of Health and Human Services. Customer Service can provide you with the appropriate address upon request.