Buckhead Dental Care
caring · gentle

Deborah L King, DDS
2964 Peachtree Road NW
Buckhead Centre, Suite 340
Atlanta, GA 30305
404.239.9566

Caring Professionals with a Gentle Touch!

Dear Patient,
We welcome you to the office. The following information is requested to assist the doctor in administering the proper dental service. Please answer the questions to the best of your ability. Thank you in advance for your cooperation.

PATIENT INFORMATION

(Please circle one): Dr. Mr. Mrs. Ms. Miss DATE

NAME: (Last) (First) (Middle)

HOME ADDRESS:

CITY: STATE: ZIP:

BUSINESS NAME AND ADDRESS:

PHONE: (Home) (Business) (Cell)

OCCUPATION:

DATE OF BIRTH: SEX: MARITAL STATUS: (circle) SINGLE MARRIED WIDOWED DIVORCE

SPOUSE'S NAME: TYPE OF DENTAL INSURANCE:

SOCIAL SECURITY NUMBER: REFERRED BY:

REASON FOR YOUR VISIT:

WHOM SHOULD WE NOTIFY IN CASE OF AN EMERGENCY? PHONE:

EMAIL ADDRESS: _____

WOULD YOU PREFER OFFICE CORRESPONDENCE THROUGH EMAIL OR MAIL (PLEASE CIRCLE)?

MEDICAL HEALTH

GENERAL HEALTH: (CIRCLE) EXCELLENT GOOD FAIR POOR

NAME AND ADDRESS OF YOUR PHYSICIAN:

ARE YOU TAKING ANY MEDICATIONS NOW? YES NO PLEASE LIST ALL MEDICATIONS AND EACH PURPOSE:

ARE YOU ALLERGIC TO: ANTIBIOTICS CODEINE ASPIRIN LOCAL ANESTHETIC OTHER (SPECIFY):

HAVE YOU EVER BEEN HOSPITALIZED? YES NO IF YES, REASON AND DATES:

HAVE YOU HAD ANY BLOOD TRANSFUSIONS? YES NO

DO YOU USE TOBACCO? IF YES, HOW MANY PER DAY: YES NO IS YOUR BLOOD PRESSURE NORMAL?

(CIRCLE) NORMAL LOW HIGH

WOMEN: ARE YOU PREGNANT? YES NO IF YES, HOW LONG?

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

Chest pains . . . . . Yes__ No___

Comments_____

Heart disease. . . . . Yes__ No___
Rheumatic fever. . . . . Yes__ No___
Congenital heart defects . . . . . Yes__ No___
Prosthetic Valves or joints, hips, knees, etc. . . . Yes__ No___
Heart murmur / mitral valve prolapse . . . . . Yes__ No___
Has your physician told you that you need antibiotics prior to dental treatment? . . Yes__ No_____

Postural Hypotension (Fainting spells). . . . . Yes__ No___
Hypertension (high blood pressure). . . . . Yes__ No___
Kidney problems . . . . . Yes No__
Stroke. . . . . Yes__ No___
Auto Immune Problems . . . . . Yes __No___
Multiple Sclerosis . . . . . Yes__ No___
Thyroid problems . . . . . Yes__ No___
Hormonal problems . . . . . Yes __ No__
Ulcers. . . . . Yes__ No___
Tuberculosis or lung disease . . . . . Yes __ No__
Diabetes. . . . . Yes__ No__
Epilepsy or seizures . . . . . Yes__ No__
Anemia. . . . . Yes __ No__
Cancer or Leukemia. . . . . Yes __ No__
Psychiatric problems . . . . . Yes __ No__

Sickle cell disease . . . . . Yes __ No__
Glaucoma. . . . . Yes__No__
Bruise easily. . . . . Yes__ No__
Jaundice. . . . . Yes__ No__
Asthma or hay fever. . . . . Yes__ No__
Allergies or hives . . . . . Yes__No__
Sinus trouble . . . . . Yes__No__
Arthritis . . . . . Yes__ No__
Excessive urination and/or thirst . . . . . Yes__ No__
Persistent cough . . . . . Yes__No __

Prolonged bleeding problems . . . . . Yes__ No__
Sexually transmitted disease . . . . . Yes__ No__
HIV Positive / AIDS . . . . . Yes__No__
Have you ever been tested positive for hepatitis? . Yes__ No___
Circle A B C
Are you being treated with immunosuppressive drugs? Yes__ No___
Prolonged sore throat. . . . . Yes__ No____
Enlarged lymph nodes . . . . . Yes__ No ____
Night sweats. . . . . Yes__ No____
Persistent diarrhea . . . . . Yes__ No____
Fatigue . . . . . Yes__ No_____
Do you have a history of cold sores, fever blisters, or canker sores? . . . . . Yes__ No____
Have you ever used drugs for recreational purposes? Yes No___

DENTAL HEALTH

When was your last dental visit?_____
How often do you floss?_____
Do your gums feel tender or swollen? . . . . . Yes___ No___
Does food catch between your teeth? . . . . . Yes___ No___
Do your gums bleed while brushing or flossing? . Yes___ No____
Do you have spaces between your teeth that bother you? . . . . . .Yes___ No___
Have you ever had periodontal treatment?. . . Yes___ No__
Do you gag easily? . . . . . Yes___ No___
Does the shape of your teeth bother you? . . . . . Yes___ No__

How often do you brush your teeth?_____

Do you feel that your teeth are too crowded? .....Yes__ No___
Are your teeth "notched" at the gum line? .....Yes__ No___
Do your facial muscles ever feel tired? ..... Yes__ No___
Do you get headaches? ..... Yes__ No___
Are your teeth too short?.....Yes__ No____
Have you ever had orthodontic treatment? .....Yes__ No_____
Do you chew on only one side of your mouth? .....Yes__ No_____
Do you get a metallic taste in your mouth? .....Yes__ No_____

Do you experience dry mouth? ……Yes____ No____ How often?_____
Are any of your teeth sensitive to air or during chewing? ..... Yes__ No_____
Do you clench or grind your teeth while sleeping or during the day? ..... Yes__ No_____
Do you have chips or uneven edges on your teeth?..... Yes__ No_____
Have you ever had professional advice in dental home care? ..... Yes__ No_____
Have you ever had any serious problems associated with previous dental treatment? ..... Yes__ No_____
If yes, explain._____
Are you apprehensive about your dental treatment? ..... Yes__ No_____
If yes, have you had: medication during or prior to treatment?..... Yes__ No_____
If your smile were improved, would you feel more confident? ..... Yes__ No_____
Do you dislike the color of your teeth?.....Yes__No___ (circle) too light too dark too various
Do you wear full dentures? .....Yes__No___ (circle) Upper Lower
Do you wear a partial denture? .....Yes__No___ (circle) Upper Lower
Do you sleep with a partial denture or denture in your mouth? .....Yes__ No_____
Do you have retention problems with full or partial denture?..... Yes__ No_____
Do you avoid brushing any part of your mouth because of sensitivity? ..... Yes__ No___
Do you feel twinges of pain when your teeth come in contact with hot, cold, sweet or sour? (circle the one that applies)..... Yes__ No___
In general, how do you feel about your smile? _____
Would you change anything?_____
Is there anything else that you would like to tell us that would help us render dental care to you?_____
_____

I, _____, acknowledge that the information provided above is to the best of my knowledge.
please print name

_____ _____
Signature (Patient) ***Date***

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APPOINTMENT, FINANCIAL AND INSURANCE GUIDELINES

We believe that our patients would like to know and understand our appointment, financial, and insurance guidelines in advance of their treatment. You will find these guidelines outlined below; however, we are always happy to discuss your proposed treatment and any of our practice guidelines with you personally.

APPOINTMENT GUIDELINES:

Rescheduling Your Appointment:
We pre-plan and prepare for your visit and hope you have done the same. Your appointment time has been reserved especially for you and we strongly encourage all patients to keep their appointments. When time is lost due to last-minute appointment changes, other patients in need of treatment cannot be seen and your treatment is delayed.

- Should any scheduling changes be required, **we require at least 24 hours advance notice to avoid a $45 cancellation fee.**
Courtesy Reminders:

We consider all appointments confirmed when they are made. As a courtesy, we make every effort to remind patients by telephone or email prior to their appointment but please do not depend on this courtesy. We have found that with the recent popular use of answering machines, cell phones, pagers, and voice mail, some of our patients may not receive these reminder calls.

- **If we are unable to speak with you directly, your appointment card will serve as confirmation and implies your obligation to be present at that prearranged date and time.**

By initialing this section and signing below, you indicate that you understand and agree to these appointment guidelines.

Please initial here: _____

FINANCIAL GUIDELINES:

We accept Cash, Check, Visa, Mastercard and Discover for payment. We will file your insurance claim after each visit. However, our agreement is with You and Not your insurance company. We feel this allows our practice to provide the comprehensive care you deserve by not allowing insurance companies to dictate the treatment you need. Although you will ultimately be financially responsible for the services you receive, we will be happy to assist you with any questions concerning your insurance. Thank you for taking the time to complete this questionnaire. The information that we gain will be most helpful in providing you proper dental treatment. I have read and understand my financial responsibilities under this policy.

Please initial here: _____

INSURANCE GUIDELINES:

We are glad you have dental insurance to help you with partial assistance in affording your dental care. As a courtesy, we are happy to assist you in filing the necessary forms to help you receive the full benefits of your dental insurance coverage at no additional cost. Dental insurance is different than most medical insurance plans and it is important to be aware of the following:

- **Insurance is an agreement between you and your insurance company.** The insurance relationship constitutes an agreement between the carrier, the employer, and the patient. Our dental office is not a party to that contract. As such, we can make no guarantee of estimated coverage or payment.
- **Full dental fees are not always covered.** Insurance companies base the amounts they pay on restrictive fee schedules, regardless of what the actual fee may be. Our fees are often, but not necessarily, covered in full by the maximum allowance determined by your carrier.
- **Not all your care may be covered.** Not all dental services that are necessary for proper dental health are a covered benefit in all contracts. This depends on the kind of plan your employer has purchased.
- **Deductibles and Co-payments must be collected.** Deductibles and co-payments are built into most plans and their required payment is strictly regulated by state law. Your Employee Benefits Director can usually help you become familiar with your plan and its restrictions.

Your Responsibilities Will Be:

1. To pay all fees at the time of treatment or as otherwise arranged.
2. To provide our office with necessary information concerning your insurance coverage to allow correct filing of claims.
3. To understand that your plan is a contract between you, your employer, and the insurance carrier. Our office will do all we can to facilitate claims payment, but we do not have the power to force your insurance company to pay.

Here's What We Promise To Do:

1. Complete insurance claim forms and submit to your carrier within 24 hours of treatment to ensure a timely reimbursement from your carrier to you.
2.
3. Use current American Dental Association coding for correct reporting of procedures.
4. If necessary, re-file your insurance a second time within a 30-60 day period.
5. Refund any payment from your insurance company incorrectly mailed to our practice.

Please initial here: _____

Thank you for choosing our office for your dental needs. Please know that we will do everything possible to see that you receive the full benefits of your insurance policy.

I, _____ *please print name* ***, understand that any insurance coverage estimate given to me by this office is not a guarantee of actual insurance payment. I also understand that I am responsible for all charges incurred for dentistry performed upon myself or my dependents in this dental office, and that I will be reimbursed directly from my insurance carrier. I authorize release of my dental/medical histories and other information about my dental treatment to third party payers.***

_____ _____

Signature (Patient or Insured) ***Date***

_____ _____

Dental Office Representative ***Date***

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OUR LEGAL DUTY UNDER HIPAA
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

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), which became effective on April 14, 2003, 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 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 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. If 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, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURE OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use and 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 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 other than 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 and disclose health information to notify, or assist in the notification of (including identifying and 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 Purposes: We will not use or sell your information for marketing purposes without your signed authorization. We will inform you of any financial conflicts of interest with our office and any products or services utilized within our practice as part of your treatment.

YOUR RIGHT TO BE NOTIFIED OF A BREACH:

"You have a right to be notified following a breach of unsecured medical information. You have a right to, and will receive, notifications of breaches affecting you, or your child's, medical information. A breach is defined as the unauthorized access, use or disclosure of you, or your child's, protected health information in a manner not permitted under HIPAA. If this occurs, you will be provided information about the breach, information about the steps that Buckhead Dental Care has taken to minimize any potential harm caused by the breach, and how you as a patient or on behalf of your child can lessen any harm as a result of the breach."

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 may also 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: Anne Seamans
Telephone: 404-239-9566 Fax: 404-262-1744
Email: contactus@buckheaddentalcare.com
Address: 2964 Peachtree Road, Suite 340, Atlanta, Georgia 30305

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 (Patient) ***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)