BUCKHEAD DENTAL
- ASSOCIATES, P.C. -

Welcome to our office. We will do our best to make your appointments as convenient and pleasant as possible. If at any time you have any questions regarding your treatment, your appointments, or fees, please feel free to ask. Please complete both pages of the following "Get Acquainted Questionnaire" so that we may better serve you.

PATIENT INFORMATION

Today's Date: _____

Patient's Name: _____ SSN: _____

First Name You Prefer: _____ Date Birth: _____

Address: _____ Single: ☐ Married: ☐

_____ Divorced: ☐ Widowed: ☐

Home Telephone: _____ Spouse's Name: _____

Cell Telephone: _____ Spouse's D.O.B. _____

Work Telephone: _____ Spouse's SSN: _____

Employer: _____ Spouse's Employer: _____

Email Address: _____ Spouse's Work Tel: _____

Nearest Relative: _____ Relative's Tel: _____

When and where is the best time/place to reach you? _____

Person responsible for payment of account? _____

Telephone: _____

Address: _____

_____

Whom may we thank for referring you to our office? _____

INSURANCE INFORMATION

Do you have dental insurance? Yes: ☐ No: ☐

Insurance Co. Name: _____

Employer: _____

Group #: _____ Subscriber ID #: _____

Insurance Address: _____ Telephone: _____

_____

We are happy to assist you in obtaining the maximum benefits specified in your insurance contract. Your dental benefit program is a contract between you, your employer, and the insurance company. We are not a party to that contract. You are responsible for all fees for services rendered to you.

I, the patient or guardian, certify that all information is correct and authorize any information to be released regarding medical or dental history, treatment, or credit reference to Buckhead Dental Associates, P.C.

Signature: _____

MEDICAL HISTORY

Physician's Name: _____ Date of Last Physical: _____

1.	Do you consider yourself to be in good health?	Yes	___	No	___	Unsure	___
2.	Are you presently receiving treatment under a physician?	Yes	___	No	___	Unsure	___
3.	Are you taking any medication at this time?	Yes	___	No	___	Unsure	___
	If yes, please list:						
4.	Do you have diabetes?	Yes	___	No	___	Unsure	___
5.	Has anyone in your family had diabetes?	Yes	___	No	___	Unsure	___
6.	Have you ever been told you have high or low blood pressure?	Yes	___	No	___	Unsure	___
7.	Have you ever had any heart ailments?	Yes	___	No	___	Unsure	___
8.	Have you ever had any kidney or bladder problems?	Yes	___	No	___	Unsure	___
9.	Have you ever had any liver problems or hepatitis?	Yes	___	No	___	Unsure	___
10.	Have you ever had a sexually transmitted disease (syphilis, gonorrhea, herpes, etc.)?	Yes	___	No	___	Unsure	___
	If yes, when?						
11.	Have you ever been tested for the HIV Virus?	Yes	___	No	___	Unsure	___
12.	Are you HIV-positive?	Yes	___	No	___	Unsure	___
13.	Do you have AIDS?	Yes	___	No	___	Unsure	___
14.	Have you ever had Rheumatic fever, Rheumatic heart disease, or a heart murmur?	Yes	___	No	___	Unsure	___
15.	Do you require antibiotics before dental treatment?	Yes	___	No	___	Unsure	___
16.	Have you ever had excessive bleeding, anemia, or other blood problems?	Yes	___	No	___	Unsure	___
17.	Have you ever had breathing problems, tuberculosis, asthma or emphysema?	Yes	___	No	___	Unsure	___
18.	Have you ever undergone chemotherapy?	Yes	___	No	___	Unsure	___
19.	Are you pregnant?	Yes	___	No	___	Unsure	___
20.	Are you allergic to any medications or latex?	Yes	___	No	___	Unsure	___
	If yes, please list:						
21.	Do you smoke?	Yes	___	No	___	Unsure	___
22.	Have you had any major surgery?	Yes	___	No	___	Unsure	___
	If yes, please list with date:						
23.	Please list any other condition that you feel we need to know.						
24.	Do you fear dentistry?	Yes	___	No	___		
25.	Are you presently having any problems in connection with your mouth?	Yes	___	No	___		
26.	Are you pleased with the appearance of your teeth?	Yes	___	No	___		
27.	When did you last have a dental treatment? _____	X-Rays?	_____				
28.	Have you ever experienced pain or discomfort in your jaw joint?	Yes	___	No	___		

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At Buckhead Dental Associates we are committed to providing you with optimal dental care and exemplary service. To accomplish this we ask for your cooperation in complying with our office policies.

Financial Policy

1) Payment for professional services is due at the time services are performed. For your convenience we accept Visa, Mastercard, American Express, Discover, cash, and personal checks.

2) If you have dental insurance coverage we are happy to file your claim as a courtesy. We are not contracted with any insurance and are considered an out-of-network provider. Therefore, patients will be responsible for any portion not covered by the insurance. By supplying us with your most recent information, we can expedite your reimbursement from the insurance company.

3) Since insurance coverage varies from plan to plan, should you have any questions regarding your covered benefits, we encourage you to contact your insurance carrier or your employer for details. Please note that your insurance policy is a contract between you and your insurance company; therefore, your balance is your responsibility.

4) Should you wish to inquire about our financial payment options, we will be happy to assist you. We do offer financing through CareCredit. Failure to resolve any past due account will result in referral to a collection agency.

Cancellation /No-Show Policy

If you need to change your reserved appointment time, we request that you notify us during regular business hours, at least 24 hours in advance of your appointment. Failure to keep your scheduled appointment without appropriate notification will result in a cancellation fee of **$75** to offset the lost time that was reserved for you.

Late Arrival

Any patient who is more than 15 minutes late will be considered a no show. Patients who miss more than 2 scheduled appointments without the required 24 hours cancellation notice, may be dismissed from the practice.

Thank you for your assistance with our policies. We appreciate your trust and look forward to serving you for many years to come.

Patient/Guardian Signature:_____ Date:_____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY AND SECURITY PRACTICES

I, _____ have received a copy of this
PRINT NAME OF PATIENT

office's Notice of Privacy and Security Practices.

_____
SIGNATURE OF PATIENT OR PARENT/ GUARDIAN

_____
DATE

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy and Security Practices, but acknowledgement could not be obtained because:

- **Individual refused to sign**
- **Communication barriers prohibited obtaining acknowledgement**
- **An emergency situation prevented us from obtaining acknowledgement**
- **Other (please specify)**

_____
_____
_____
_____

Buckhead Dental Associates, P.C.

NOTICE OF PRIVACY AND SECURITY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY AND SECURITY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy and security of your health information. We are also required to give you this Notice about our privacy and security practices, our legal duties, and your rights concerning your health information. We must follow the privacy and security practices that are described in this Notice while it is in effect. This Notice takes effect October 21, 2002, and will remain in effect until we replace it.

We reserve the right to change our privacy and security 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 and security 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. As we make a significant change in our privacy and security practices, we will accordingly 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 and security 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. We may use patient sign-in sheets and post daily schedules in individual operatories (out of the direct view of patients). We may share the necessary minimum information with the dental laboratory when prostheses are being made.

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 Patients 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 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 judgement 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 access 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. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies more than once in a twelve month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format.

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 six years, but not before April 14, 2003. If you request this accounting more than once in a twelve 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. However, 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.

Electronic Communication: You have the right to request that we contact you through electronic mail (email). Patients should understand that while we do not employ an encryption system, we do use several methods to attempt to safeguard confidential information, including firewall and virus protection. Patients should also understand that the Practice cannot be held responsible for breaches in security via an electronic medium and use electronic methods of communication at their own risk. Additional information regarding our specific security practices may be obtained via the contact information at the end of this Notice.

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 by electronic mail, you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy or security practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy or security 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 and security of your health information. We will not retaliate in any way if you choose to file a complaint with the U.S. Department of Health and Human Services.

CONTACT OFFICER: Tiara Robinson **TELEPHONE:** (404)266-1300

ADDRESS: 3490 Piedmont Rd NE, Suite 110 Atlanta, GA 30305 **EMAIL:** Info@BuckheadDentalAssociates.com