NAME

HOME PHONE

WORK PHONE

SOCIAL SECURITY NUMBER

DATE OF BIRTH

SEX

MARITAL STATUS:

PHYSICIAN'S NAME

PHONE

YOUR EMPLOYER

ADDRESS

CITY

STATE ZIP

PHONE

NAME OF A PERSON NOT LIVING WITH YOU

PHONE

REFERRED BY:

E-Mail

ADDRESS

CITY

STATE ZIP

SPOUSE'S NAME

SPOUSE'S EMPLOYER

SPOUSE'S WORK PHONE

SPOUSE'S SOCIAL SECURITY NUMBER

LAST PHYSICAL EXAM

LAST DENTAL EXAM

YOUR INSURANCE COMPANY

ADDRESS

CITY

STATE ZIP

PHONE

GROUP NUMBER

GROUP NAME

PERSON TO CONTACT

COVERAGE TYPE

In order to minimize bookkeeping costs, payment is required at time of treatment.

- ☐ PAYMENT BY CASH OR CHECK
- ☐ PAYMENT BY VISA OR MASTERCARD
- ☐ DENTAL INSURANCE - DEDUCTABLE AND CO PAYMENT REQUIRED AT TIME OF TREATMENT.

I authorize Dr Jeffrey Smith and delegates to perform the dental procedures advisable for myself/child including the use of local anesthetics and/or nitrous oxide analgesia.

SIGNATURE OF PATIENT,PARENT OR GUARDIAN

DATE

Thank you for completing the following
confidential information.

PLEASE ANSWER ALL QUESTIONS.

MEDICAL /DENTAL HISTORY

REASON FOR TODAY'S VISIT_____

Please state whether you have suffered any of the following

YES	NO		YES	NO		YES	NO	
☐	☐	RHEUMATIC FEVER	☐	☐	RESPIRATORY PROBLEMS	☐	☐	DIABETES
☐	☐	HEART MURMUR	☐	☐	KIDNEY DISEASE	☐	☐	SEIZURES
☐	☐	CONGENITAL HEART DISORDER	☐	☐	VENEREAL DISEASE	☐	☐	MALIGNANCY
☐	☐	HEART SURGERY	☐	☐	AIDS	☐	☐	HEPATITIS
☐	☐	PROSTHETIC VALVES	☐	☐	HIGH BLOOD PRESSURE	☐	☐	PREGNANT?
☐	☐	OTHER HEART CONDITON	☐	☐	TUBERCULOSIS	☐	☐	ASPIRIN ALLERGY
☐	☐	PENNICILLIN ALLERGY	☐	☐	CODEINE ALLERGY			

☐ ☐ BLOOD TRANSFUSION, date_____

☐ ☐ ARE YOU ALLERGIC TO ANY MEDICATION NOT LISTED ABOVE? PLEASE LIST:_____

_____

☐ ☐ ARE YOU TAKING ANY MEDICATION AT THIS TIME? PLEASE LIST:_____

_____

Please describe any symptoms.

☐	☐	BLEEDING,SORE GUMS	☐	☐	BAD TASTE /BREATH	☐	☐	LOOSE TEETH
☐	☐	BURNING TONGUE, LIPS	☐	☐	FREQUENT BLISTERS	☐	☐	SWELLING/LUMPS
☐	☐	ORTHO TREATMENT(BRACES)	☐	☐	BITING LIPS/CHEEKS	☐	☐	FILLINGS

YES	NO		YES	NO	
☐	☐	FOOD IMPACTION	☐	☐	CLENCHING /GRINDING
☐	☐	DIFFICULTY OPENING OR CLOSING JAW	☐	☐	PAIN IN OR AROUND EARS
☐	☐	CLICKING/POPPING JAW	☐	☐	HAVE YOU LOST ANY TEETH?
☐	☐	ARE YOUR TEETH SENSITIVE TO HOT?	☐	☐	ARE YOUR TEETH SENSITIVE TO SWEETS
☐	☐	ARE YOUR TEETH SENSITIVE TO COLD?	☐	☐	ARE YOUR TEETH SENSITIVE TO BITING?

☐ ☐ ARE YOU UNHAPPY WITH THE APPEARANCE OF YOUR TEETH?

☐ ☐ DO YOU HAVE DISCOLORED TEETH THAT BOTHER YOU?

☐ ☐ WOULD YOU LIKE TO KNOW MORE ABOUT PERMANENT REPLACEMENT?

☐ ☐ ARE YOU INTERESTED IN TOOTH-COLORED FILLINGS?

☐ ☐ ARE YOU INTERESTED IN IMPLANTS?

Do you use the following and how often?

☐ ☐ TOOTH BRUSH_____

☐ ☐ DENTAL FLOSS_____

☐ ☐ FLUORIDE RINSE_____

IS YOUR TOOTH BRUSH : SOFT ☐ MEDIUM ☐ HARD ☐

Patients Name _____ Date _____

Are You a Candidate For Cosmetic Dentistry?

self-analysis:

Why change your smile? Don't if you're happy with it, but ask yourself the following questions:	*Yes*	*No*
1. Does your self-confidence lessen when smiling in front of other people?	___	___
2. Do you ever put your hand up to cover your smile?	___	___
3. Do you feel you photograph better from one side of your face?	___	___
4. Is there someone you think has a better smile than you?	___	___
5. Do you look at magazines and wish you had a smile as pretty as the model's?	___	___
6. When you read a fashion magazine, are your eyes drawn to the model's smile?	___	___
7. When you look at your smile in the mirror, do you see a minor defect in your gums or in any of your teeth?	___	___
8. Do you wish your teeth were whiter?	___	___
9. Do you wish your gums looked better?	___	___
10. Do you wish you showed more or fewer teeth when smiling?	___	___
11. Do you think you show too much or too little gum tissue when you smile?	___	___
12. Do you wish you had longer or shorter teeth?	___	___
13. Would you prefer wider or narrower teeth?	___	___
14. Are your teeth too square or too round?	___	___
15. Do you wish your teeth were shaped differently?	___	___

If you answered "NO" to every question except #1, #9 and #15, you are apparently content with your smile.

TMD *Screening Questionnaire*

(Temporomandibular joint/jaw joint)

	Yes	*No*		Degree of Discomfort *mild–1–2–3–4–5–> severe*
16.	___	___	Do you suffer from frequent headaches (e.g. more than once a week)?	_____
17.	___	___	Do you ever have pain, discomfort, or other sensations (ringing, roaring, stuffiness, etc.), in front of or behind the ear?	
18.	___	___	Do you ever have pain, discomfort, or other sensations (tiredness, pulling, weakness, burning, etc.) about the ears, temples, neck or cheek?	_____
19.	___	___	Does it ever hurt to chew or is your bite ever uncomfortable or unusual?	_____
20	___	___	Does it ever hurt to open wide, take a big bite or yawn?	_____
21.	___	___	Does your jaw ever make noise (popping, cracking, grating, etc.) or does your jaw ever lock?	_____
22.	___	___	Have you had any serious trouble associated with any previous dental treatment? If so, explain.	_____
			_____	_____
			_____	
23.	___	___	Have you ever had an injury to your head, neck or jaw (e.g. due to an auto accident)?	
24.	___	___	Have you previously been treated for jaw or joint problems? If so, when? _____	_____
			_____	_____
25	___	___	Are you wearing removable dental appliances (e.g. bite plane, retainer, nightguard, etc.)?	

Chief Dental Complaint? _____

_____

_____

Dental management considerations: _____

_____

DR. SMITH'S MESSAGE TO PATIENTS REGARDING DENTAL INSURANCE COVERAGE

We would like to clarify the relationship between our office, our patients, and dental insurance providers.

When we file dental insurance claims for our patients, we are attempting to assist our patients in receiving the benefit of their dental insurance coverage. **However, our efforts do not effect the patient's ultimate responsibility for full payment of fees.**

Generally, insurance policies will state that they pay a percentage of the cost of services based on what they consider to be the "usual and customary fee" for such services. Usually, an insurance company will not disclose in advance the amount that they consider to be the "usual and customary fee" for a service. It has often been our experience a "usual and customary fee" for a service is very different from one dental insurance company to another, and even by the same dental insurance company from one claim to the next.

As an example, when a patient's dental insurance policy states that the insurance company will pay 100% of the cost of preventative services, that means that the company will pay 100% of what that particular company considers to be "usual and customary fee" for preventative services. In some cases, this amount is less than 100% of the fees charged by our office. When this happens, the patient remains responsible for the difference between the amount paid by the insurance company and the amount charged by this office.

Any fees for dental treatment received in our office where a dental insurance claim is to be filed by our office is due in full within 30 days after the date of service, whether paid in full by the insurance company or by a combination of payments by the insurance company and the patient.

If you have any questions about our policy regarding dental insurance coverage and patient responsibility for fees, please feel free to ask any one of us.

Please keep this page for your records, and return the attached acknowledgment of receipt of this information.

I acknowledge receipt of Dr. Smith's Message to Patients Regarding Dental Insurance Coverage. I understand that Dr. Smith's office will file my claim for dental insurance coverage. I also understand that if my dental insurance provider does not pay for 100% of the fees charged by Dr. Smith's office, then I will be responsible for the difference. Both payment by the my insurance provider and payment by me of any remaining balance are due within 30 days of the date of services.

_____

Sign Above
Print Name:

Date:_____

POLICIES REGARDING TREATMENT

1. APPOINTMENTS:

   Appointment times are "reserved." This means that we do not "double book" our appointments. This is an advantage to you because it allows you to be seen at a specific time. We respect your time and we make a special effort to be on time.

2. CANCELLATIONS AND BROKEN APPOINTMENTS:

   24 hour notice is required when canceling or rescheduling an appointment. If an appointment is canceled with less than 24 hour notice, a $75 charge will be made. Failure to show up for an appointment does not release the obligation for the time. We are understanding with regard to unusual circumstances bur chronic failure of appointments is not compatible to our type of practice where times are reserved.

3. CONFIRMATION OF APPOINTMENTS:

   We will make every effort to reach our patients to remind them of their appointments. This is usually done the week before the appointment. Failure to reach an individual does not remove the financial obligation for the time. Scheduled appointments are the patient's responsibility.

4. INSURANCE:

   If you have insurance, we will gladly process your forms, but we request that you pay your portion when services are rendered. Please have your portion of the forms filled out. If your insurance company has not paid after 30 days, you are responsible for any remaining balance.

5. PAST DUE BILLS:

   If an account is past due for more than 60 days, a 1.5% per month finance charge will be added unless other arrangements have been made. If you are delinquent in payment, you will be responsible for payment of all costs of collection, including costs of a collection agency if your account is turned over to a collection agency.

By signing below, I acknowledge that I have read, understand and agree to the policies of this office.

PRINT NAME OF PATIENT: _____

_____

Signature of Patient (or parent/guardian if patient is a minor)

Date:_____

Please scroll down to see all pages - 4 pages total.

Acknowledgement of Receipt of Notice of Privacy Practices

Jeffrey M. Smith, DMD

* You May Refuse to Sign This Acknowledgment*

I have received a copy of this office's Notice of Privacy Practices.

Print Name of Patient/Guardian:_____

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)

Jeffrey M. Smith, DMD

Notice of Privacy Practices

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 9/04/2013, 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;

- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

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 the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. 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 information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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 the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. **We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment** or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

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 if 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.

Our Privacy Official: Katrina Carlton

Telephone: (404) 876-7979 Fax: (404) 872-1945

Address: 999 Peachtree Street NE Suite 720 Atlanta, GA 30309

E-mail: privacy@smilemidtown.com

Jeffrey M. Smith, DMD

Agreement to Receive Electronic Communication

Patient Name: _____ Date of Birth:_____

I agree that the dental practice may communicate with me electronically at the email address below.

I am aware that there is some level of risk that third parties might be able to read unencrypted emails.

I am responsible for providing the dental practice any updates to my email address.

I can withdraw my consent to electronic communications by calling:

(404)885-1441

Email Address (PLEASE PRINT CLEARLY):

_____@_____

Patient Signature:_____

Date:_____