Lifetime Dentistry

Cosmetic Dentistry, Braces and Implant Therapy

Patient Name _____ Today's Date:_____

Birth date: _____

Name of Parent/Guardian
if patient is under 18: _____ Patient Age _____ Sex: M F

Street Address: _____ Email Address:_ _____

City, State, Zip + 4: _____ Occupation:_____

Telephone Number: (home) _____(work) _____ (cell)_____

Social Security #: _____GA Driver's License #: _____

Employer: _____Position: _____

Employer's Address: _____

In case of emergency, your nearest relative (other than spouse), neighbor or friend not living with you to contact:

Name: _____ Relationship: _____

Address: _____Phone: _____

If Patient is married, please fill out this section.

Marital Status: _____ Spouse's Work #:_____

Spouse's Name: _____

Spouse's Social Security #: _____ Spouse's Birth date: _____

Spouse's Employer: _____ Position: _____

Spouse Employer's Address: _____

If patient is covered by dental insurance, please fill out this section.

Name of Insured: _____

Dental Insurance Company: _____ Policy / Group#: _____

Release of Information / Assignment of Benefits
I authorize the release of any dental information necessary to process my claims.

_____

Signed (Patient, or parent if Minor) Date

How were you referred to us? (Check one) _____ Friend or family member _____ Yellow Pages _____ Web / Internet
_____ Insurance Company _____ Our Staff Members _____ Other (please specify) _____

Whom may we thank for your referral?_____

I , the undersigned (patient or legally responsible party) authorize treatment to be rendered and assume financial responsibility. I acknowledge that all non-current balances on accounts over thirty days will be charged a service charge of 1.5% per month (18% annually) on the unpaid balance. Any additional costs incurred in collecting this account including court costs, agency fees and attorney fees will be added to your balance due.
Signature of Person Responsible for the payment of the Account: _____

Visit us on the web at www.lifetimedentistryofga.com

PATIENT NAME _____

MEDICAL HISTORY

Please answer **ALL** questions by circling either **YES** or **NO**. If you don't understand a question go on to the next one, the doctor will review it with you. All information is confidential.

1. When did you last receive dental treatment?
What type of treatment? _____
2. Previous Dentist_____
City, State_____
3. Do you have dentures, partial dentures or bridges? Y N
4. Date of last physical examination? _____
5. Have you been hospitalized during the past three years? Y N
If so, please explain. _____
6. Have you had any serious illnesses in the past three years? Y N
If so, please explain. _____
7. Are you under a physician's care? Y N
If so, for what condition? _____
Physician's Name _____
Phone Number_____

Do you have or have you had any of the following conditions or diseases:

CARDIOVASCULAR

8. Rheumatic Fever Y N
9. Congenital Hear t Defect Y N
10. Angina or Heart Attack Y N
11. Heart Murmurs Y N
12. Congestive Heart Failure Y N
13. Heart Surgery or Pacemaker Y N
14. High or Low Blood Pressure Y N
15. Stroke Y N

RESPIRATORY DISEASE

16. Asthma or Bronchitis Y N
17. Emphysema Y N
18. Hay Fever or Sinusitis? Y N

ENDOCRINE DISORDERS

19. Diabetes Y N
20. Hyperthyroidism (high thyroid) Y N
21. Hypothyroidism (low thyroid) Y N

BLOOD DISORDERS

22. Anemia Y N
23. Do you bleed excessively when cut? Y N

KIDNEY DISEASE

24. Have you had any kidney infections? Y N
25. Have you had kidney surgery? Y N

INFECTIOUS DISEASES

26. Hepatitis Y N
27. Venereal Disease Y N
28. Tuberculosis Y N
29. HIV Positive Y N

MISCELLANEOUS

30. Frequent Fainting Y N
31. Liver Disease/Jaundice Y N
32. Arthritis Y N
33. Ulcers Y N
34. Glaucoma Y N
35. Radiation Therapy of cancer Y N
36. Epilepsy Y N
37. Cancer Y N
38. Do you smoke Y N
39. Do you use any other form of tobacco? Y N
40. Do you have any implanted prosthetic devices? Y N

Are you currently taking any of the following drugs or medications?

41. Antibiotics Y N
42. Blood Thinners Y N
43. Steroids or Cortisone Y N
44. High Blood Pressure Medicine Y N
45. Tranquilizers Y N
46. Immune Suppressant Drugs Y N
47. Aspirin Y N
48.Herbs/Vitamins Y N

Please write down all the prescribed medicines you are now taking: _____

_____

_____

Do you have an **ALLERGY** or **REACTION** to any of the following medications and materials?

49. Local Anesthetics Y N
50. Penicillin Y N
51. Other antibiotics Y N
52. Codeine Y N
53. Other pain medication Y N
54. Aspirin Y N
55. Barbiturates or sedatives Y N
56. Nickel Allergy Y N
57. Latex Allergy Y N
58. Other medicines Y N
If so, what medicines? _____

59. Have you ever worn braces? Y N
60. Have you ever had gum surgery Y N
61. Have you ever had any difficulty with Any dental work or extractions? Y N
62. Do you have any medical problem not listed above? Y N
if so, what is it?

WOMEN ONLY

63. Are you pregnant Y N
if so, when are you due? _____
64. Do you have any menstrual difficulty other than cramps? Y N
65. Are you taking an oral contraceptive? Y N
66. Are you taking hormonal therapy? Y N

_____
DOCTOR'S SIGNATURE **DATE**

_____
PLEASE SIGN YOUR NAME ON THE LINE ABOVE
(Parents must sign for their minor children)

HIPPA Consent Form

The Health Insurance and Accountability Act of 1996 (HIPPA) provides protections to your medical records. Our office may sometimes need to disclose dental information or payment information protected by HIPPA in relation to your chart to your family members or close friends involved in your dental care. For example, your spouse may want to contact us regarding your dental health. Under HIPPA, unless you specifically object, we are allowed to use our professional judgment in deciding whether to discuss dental and payment information with your family members or close friends. However, we would like to provide you with the opportunity to tell us with whom we may discuss your dental and payment information.

[ ] You may discuss my dental information with the following person(s):

_____

_____

[ ] Please do not discuss my dental information with the following person(s):

_____

_____

[ ] Please do not discuss my dental information with anyone

Patient Name: _____ Patient signature _____

Date _____

Return all forms via mail, e-mail, or facsimile

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Facts You Should Know About Dental Insurance

• You may receive a letter from your insurance company stating that our dental fees are higher than usual and customary. An insurance company surveys a geographic area, finds the average fee, and then takes 90% of the average.

Any doctor in private practice will have fees that are considered higher than average.

• Dental insurance is not meant to be a **pay all**, it is meant to be assistance or supplement to help with dental expenses. Most plans tell their insured that they will be covered "Up to 80% or up to 100%" , but do not clearly specify the plan fee schedule allowance, annual maximum, or any limitations such as frequency, pre-existing conditions, or alternate benefit clauses.

• It has been the experience of many dentists that some insurance companies tell their insured that "fees are above the usual and customary fees" rather than saying "Our insurance benefit plan is too low or outdated with pricing of today's dental procedure fees".

****The amount your plan pays is determined by how much your employer paid for the plan. The less your employer 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.

• **Our office will file insurance as a courtesy with your primary insurance only. If you have secondary insurance it will be your responsibility to file yourself. Although, you have dental insurance, you are completely responsible for payment of your account.**

****IF YOU HAVE ANY QUESTIONS PLEASE ASK THE FRONT OFFICE STAFF AND THEY WILL HELP AS MUCH AS POSSIBLE.****

We do ask that you contact your insurance company regarding the specifics and details of the plan which it is conducted for you!

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

PLEASE INITIAL: _____ DATE: _____

Office Policy

Payment in full is expected at the time services are rendered unless other arrangements are made in advance. For your convenience, we do accept the following:

Visa, Mastercard, Discover, & American Express

A wide variety of services are available in this office; therefore, we have no uniform policy that covers all procedures and treatments. An insurance policy is a contract between the insured and the insurance company. However, we will assist you by filing your Primary insurance as a courtesy to you. You will need to pay your deductible and co-payment on the services rendered. You will be responsible for filing your secondary insurance if you have any. The receipt that we will give you will assist you in filing secondary insurance

Time is valuable for both you and us. If a confirmed appointment is broken, there will be a $50.00 broken appointment fee. Every effort is to assist you in making a convenient appointment has been made; if you must cancel please notify us 48 hours PRIOR to your scheduled appointment. If an appointment has been scheduled, please be on time, since ample time has been set for your treatment. If you are TEN minutes late, your appointment may be rescheduled.

Minors under the age of 18 with scheduled appointments must be accompanied by a parent or legal guardian.

A finance charge will be added to all accounts 30-days past due. A service charge for RETURNED checks will be added to the account in the amount of $50.00 for each occurrence. Any outstanding account balance 90 days or older with no activity will be turned over to a collection agency or Magistrate court. It will be your responsibility to pay for any and all collection fees or court costs.

Any outstanding account not covered by your insurance company will be your responsibility.

If you have any questions we will be glad to answer them for you. We will be glad to make a financial arrangement if necessary prior to initiation of treatment.

THANK YOU,

By signature, I have read and understand the office policy of this practice. In cases where payments are being accepted directly from the insurance company, I authorize payment to the provider.

_____ _____

Patient or Guardian signature Date

PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received the Notice of Privacy Practices and I have been provided an opportunity to review its content in the total form mandated by HIPPA and the compliance requirements.

Name: _____

Birth date: _____

Signature: _____

Date: _____

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 anytime. 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 bylaw.

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 will 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 will charge you $0.25 for each page, $25.00 per hour 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 will 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.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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 heath 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 US 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: Dr. Ketan Patel

Telephone: 678-762-1613

Fax: 678-762-1689

Email: info@lifetimedentistryofga.com

Address: 342 North Main Street; Suite 110; Alpharetta, GA 30009