



SUWANEE FAMILY DENTISTRY

Dr. Tina Heil and
Dr. Ashley Starnes

Date: _____ How did you hear about our office? _____

Patient: _____
Last Name First Name MI Preferred Name

Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____

Cell/Other phone: _____ SSN: _____

Email: _____ How would you like to receive courtesy notifications? Home # Cell # Email
(Circle One)

Sex: Male Female Age: _____ Birthdate: _____ Marital Status: Single Married Other

Employer: _____ Occupation: _____

Name of person responsible for account: _____

**If you have insurance and have not yet provided insurance information, please complete this section
Dental Insurance**

Policyholder's Name: _____ Group Number: _____
Relationship to patient: _____

Policyholder's Address: _____

Policyholder's Employer: _____ Policyholder's Work Phone: _____

Policyholder's SSN: _____ Policyholder's Birthdate: _____

Please read and sign below:

Assignment/Release: I, the undersigned, assign directly to Suwanee Family Dentistry, PC all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Suwanee Family Dentistry, PC to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

Date: _____ Signature: _____

Minor/Child Consent: I, being the parent or guardian of the patient listed above do hereby request and authorize the dental staff to perform necessary dental services for my child, including but not limited to x-rays and the administration of fluoride, local anesthetics or nitrous oxide as deemed advisable by Dr. Heil or Dr. Starnes, whether or not I am present at the actual appointment when the treatment is rendered.

Date: _____ Signature of Parent or Guardian: _____

Patient Medical History

Are you currently under the care of a physician? yes no If yes, for what conditions? _____

Are you taking any prescription or over the counter medications? yes no
If yes, please list: _____

Do you smoke? yes no How often? _____

Do you use smokeless tobacco? yes no How often? _____

Do you drink alcohol? yes no How often? _____

Women: Are you pregnant? yes no Taking birth control pills? yes no Are you nursing? yes no

Are you allergic to any of the following? Aspirin Penicillin Codeine Acrylic Metals
 Latex Other _____

Do you have, or have you had, any of the following?

- | | | | |
|--|--|--|---|
| AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No | Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No | Hemophilia <input type="radio"/> Yes <input type="radio"/> No | Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No |
| Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No | Diabetes <input type="radio"/> Yes <input type="radio"/> No | Hepatitis A <input type="radio"/> Yes <input type="radio"/> No | Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No |
| Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No | Drug Addiction <input type="radio"/> Yes <input type="radio"/> No | Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No | Rheumatism <input type="radio"/> Yes <input type="radio"/> No |
| Anemia <input type="radio"/> Yes <input type="radio"/> No | Easily Winded <input type="radio"/> Yes <input type="radio"/> No | Herpes <input type="radio"/> Yes <input type="radio"/> No | Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No |
| Angina <input type="radio"/> Yes <input type="radio"/> No | Emphysema <input type="radio"/> Yes <input type="radio"/> No | High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No | Shingles <input type="radio"/> Yes <input type="radio"/> No |
| Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No | Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No | Hives or Rash <input type="radio"/> Yes <input type="radio"/> No | Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No | Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No | Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No | Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Joint <input type="radio"/> Yes <input type="radio"/> No | Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No | Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No | Spina Bifida <input type="radio"/> Yes <input type="radio"/> No |
| Asthma <input type="radio"/> Yes <input type="radio"/> No | Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No | Kidney Problems <input type="radio"/> Yes <input type="radio"/> No | Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No |
| Blood Disease <input type="radio"/> Yes <input type="radio"/> No | Frequent Cough <input type="radio"/> Yes <input type="radio"/> No | Leukemia <input type="radio"/> Yes <input type="radio"/> No | Stroke <input type="radio"/> Yes <input type="radio"/> No |
| Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No | Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No | Liver Disease <input type="radio"/> Yes <input type="radio"/> No | Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No |
| Breathing Problem <input type="radio"/> Yes <input type="radio"/> No | Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No | Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No | Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No |
| Bruise Easily <input type="radio"/> Yes <input type="radio"/> No | Genital Herpes <input type="radio"/> Yes <input type="radio"/> No | Lung Disease <input type="radio"/> Yes <input type="radio"/> No | Tonsillitis <input type="radio"/> Yes <input type="radio"/> No |
| Cancer <input type="radio"/> Yes <input type="radio"/> No | Glaucoma <input type="radio"/> Yes <input type="radio"/> No | Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No | Tuberculosis <input type="radio"/> Yes <input type="radio"/> No |
| Chemotherapy <input type="radio"/> Yes <input type="radio"/> No | Hay Fever <input type="radio"/> Yes <input type="radio"/> No | Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No | Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No |
| Chest Pains <input type="radio"/> Yes <input type="radio"/> No | Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No | Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No | Ulcers <input type="radio"/> Yes <input type="radio"/> No |
| Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No | Heart Murmur <input type="radio"/> Yes <input type="radio"/> No | Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No | Venereal Disease <input type="radio"/> Yes <input type="radio"/> No |
| Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No | Heart Pace Maker <input type="radio"/> Yes <input type="radio"/> No | Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No | Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No |
| Convulsions <input type="radio"/> Yes <input type="radio"/> No | Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No | Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No | |

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

The following questions relate to the need for antibiotic prophylaxis to prevent a potentially serious heart infection:

Have you ever been advised to premed (take an antibiotic) before routine dental appointments? yes no

- Artificial heart valves Artificial joints Previous bacterial endocarditis

*****If you have had any of the above conditions, but you know that you are not required to premedicate, we will require a letter from your physician indicating that you do not need to premedicate.**

Additional Comments: _____

I certify that the above information is accurate and complete to the best of my knowledge. I understand that any errors or omissions could harm my dental treatment and/or my overall health. I will not hold Dr. Tina Heil, Dr. Ashley Starnes, or their staff responsible for the results of any errors or omissions in the information I have provided on this form.

Date: _____

Signature: _____

Office and Financial Guidelines

In order for us to provide high quality dental care in a relaxed environment, we follow these guidelines. If you have any questions please do not hesitate to ask.

Scheduling

We manage our schedule so that we can provide individualized attention to each patient. This means that your appointment time is reserved exclusively for you. Should the need arise to cancel or reschedule your reserved time, a 24 hour advance notice is required. A 48 hour advance notice may be required for reservations of more than 2 hours. Insufficient notices to cancel or reschedule may result in additional charges. In consideration of other patients, your appointment will not be extended if you arrive after your appointment time. Delayed arrival may result in the need to reschedule your appointment.

Safety

For safety and liability reasons, only the patient may be present in the room during treatment. This allows the doctor and the clinical team to focus full attention on the patient. Allowing a child in the room while the parent is being seen puts the child at risk for injury from sharp instruments and chemicals present in the room. Adults should make appointments at times when child care will not be an issue. Likewise, we ask that parents wait in the reception room while their children are being treated. We will not hesitate to call parents back when necessary, and all findings will be reviewed with the parent.

Insurance

If you have a dental benefit plan, we will make every effort to help you maximize your benefits. We will be happy to assist you by submitting claim forms to your insurance company. However, please understand that we deal with many different insurance plans in an effort to accommodate our patients. It is impossible for our office staff to be aware of the unique requirements of each and every plan. Your plan may have limitations on the number of visits, x-rays and procedures considered for payment. If you have any questions about whether a procedure will be considered for payment, please contact your insurance carrier before beginning the procedure. Any outstanding balance not paid by insurance is the responsibility of the patient.

Payments

We are committed to the success of your treatment, and we charge what is usual and customary for our area. Payment is expected at the time of service unless other arrangements have been made in advance. We accept cash, check, credit cards and we offer Capital One financing. If you are interested in financing treatment, please ask our front office staff for details.

In order to keep our fees reasonable, we do not extend patient accounts beyond 60 days. If your insurance does not pay within 60 days, the balance will become your responsibility to pay or transfer to our financing company. In the rare event that it is necessary to turn your account over to our collections agency, you will be responsible for additional collections fees.

I have read and understand the Office Policies and Financial Guidelines above, and all my questions have been answered to my satisfaction. I understand that payment is due at the time of service unless other arrangements have been made in advance. I will accept responsibility for all charges not paid by my insurance within 60 days of my visit.

Signature _____ Date _____

We are required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to explain to you the ways in which we will use and disclose the information about your health that we obtain in the course of your treatment. The privacy of your health information is very important to us, and we will only use that information in ways that we feel are beneficial to your health. Besides using your health information to treat you, we would also like to communicate with you to confirm your appointments, send holiday greetings and newsletters about our practice. We will not sell your information or use it for any marketing purposes. The full notice of our privacy practices is posted in the office for your review. If you would like a paper copy of the full notice please ask and one will be provided for you. If you have any questions please ask and we will be happy to explain our policies.

Abbreviated Description of Privacy Practices

*****This is not the full description of this office's privacy practices. A full description is available in the office.****

Suwanee Family Dentistry, PC

Effective Date of this Notice: September 15, 2003

A. Our commitment to your privacy – Our practice is dedicated to maintaining the privacy of your identifiable health information (PHI). In conducting our business, we must create records regarding you and the treatment services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you.

C. We may use and disclose your individually identifiable health information (PHI) in the following ways.

1. Treatment – The information in your medical records will be used to determine which treatment option best addresses your health needs. The treatment selected will be documented in your medical records so that other health care professionals can make informed decisions about your care. For example, we may ask you to have an x-ray, and we may use the results to help us reach a diagnosis. Many of the people who work for our practice, including but not limited to the doctors and staff – may use or disclose your PHI in order to treat you or to assist others in your treatment, such as a dental specialist. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children, or parents.

2. Payment – Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer or dental plan to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as a family member. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers to assist in their billing and collection efforts.

3. Appointments and Reminders – Our practice may use and disclose your PHI to contact you and remind you of an appointment or as a follow up on treatment. For example, we may send appointment reminders and recall cards to remind you of an upcoming office visit by mail, phone, or email.

4. Non-medical communications – Our practice may use your PHI to contact you for non-medical reasons. For example we may send you a birthday card or holiday greeting via mail.

5. Treatment options – Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives. Open Areas and Shared Office Space – There are areas within our practice that may be shared with other health care providers or are open areas where conversations with you regarding your care may be overheard by others. Every attempt will be made to minimize the exposure of your PHI, and if requested we will locate a private area in our offices for our conversations with you.

6. Release of information to family and friends – Our practice may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask a grandparent to take their child to our office for treatment. In that case, the grandparent may have access to this child's medical information.

Acknowledgement of Receipt of Notice of Privacy Practices

**** You may refuse to sign this acknowledgement.****

I have read the above privacy practices of this office. I understand that the full notice of privacy practices is posted in the office, and that I may request a paper copy of the full notice. All of my questions about the privacy of my health information have been answered to my satisfaction.

Signature _____ Date _____