Bryan Family Dentistry, P.C.

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Date of last dental appointment _____

Previous Dentist _____

City & State _____

Are you under a physician's care now? ◯ Yes ◯ No ◯ N/A _____

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No ◯ N/A _____

Have you ever had a serious head or neck injury? ◯ Yes ◯ No ◯ N/A _____

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No ◯ N/A _____

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No ◯ N/A Do you use tobacco? ◯ Yes ◯ No ◯ N/A

Are you on a special diet? ◯ Yes ◯ No ◯ N/A Do you use controlled substances? ◯ Yes ◯ No ◯ N/A

Women: Are you

Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: _____

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

- ☐ AIDS/HIV Positive
- ☐ Alzheimer's Disease
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Angina
- ☐ Anorexia
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve*
- ☐ Artificial Joint*
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Bloody Sputum
- ☐ Breathing Problem
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Cold Sores/Fever Blisters
- ☐ Congenital Heart Disorder
- ☐ Convulsions
- ☐ Cortisone Medicine
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Easily Winded
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Excessive Thirst
- ☐ Fainting Spells/Dizziness
- ☐ Fever
- ☐ Frequent Cough
- ☐ Frequent Diarrhea
- ☐ Frequent Headaches
- ☐ Genital Herpes
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack/Failure
- ☐ Heart Murmur*
- ☐ Heart Pacemaker*
- ☐ Heart Trouble/Disease
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Hives or Rash
- ☐ Hypoglycemia
- ☐ Irregular Heartbeat
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Mitral Valve Prolapse*
- ☐ Night Sweats
- ☐ Pain in Jaw Joints
- ☐ Parathyroid Disease
- ☐ Persistent Cough lasting 3 or more weeks
- ☐ Psychiatric Care
- ☐ Radiation Treatments
- ☐ Recent Weight Loss
- ☐ Renal Dialysis
- ☐ Rheumatic Fever*
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Spina Bifida
- ☐ Stomach/Intestinal Disease
- ☐ Stroke
- ☐ Swelling of Limbs
- ☐ Thyroid Disease
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors or Growths
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Yellow Jaundice

Have you ever had any serious illness not listed above? ◯ Yes ◯ No ◯ N/A _____

Comments: _____

_____

_____

_____

*Condition may require medication N/A - Not answered by patient

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Bryan Family Dentistry, P.C.

Patient Information

Name: First _____Middle _____Last _____

Address: _____

City: _____ State/Zip: _____

Home Phone: _____ Work Phone:_____ Mobile: _____

Sex: ○ Male ○ Female Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth Date: _____ Soc. Sec.: _____ Drivers Lic#_____

Email: _____ ☐ I would like to receive correspondences via email.

Employer's Name/Address:_____

Responsible Party (if someone other than the patient)

Name: First _____Middle _____Last _____

Address: _____

City: _____ State/Zip: _____

Home Phone: _____ Work Phone:_____ Mobile: _____

Birth Date: _____ Soc. Sec.: _____ Drivers Lic#_____

Employer's Name/Address: _____

Spouse's Name: _____ Social Security # _____

Spouse's Birthday: _____ Employer: _____

Employer's Address: _____ Telephone: _____

If Patient is covered by Insurance, please complete this section:

Name of Insured: _____ Social Security # _____

Dental Insurance Company Name: _____ Policy # _____

Other Dental Insurance Coverage? Y N Name of Insured: _____

Secondary Insurance Company Name: _____ Policy # _____

Medical Insurance Company Name: _____

In case of emergency, your nearest relative (other than spouse) neighbor or friend to contact:

Name: _____ Relationship: _____

Address: _____ Phone: _____

How were you referred to us? _____

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 understand that I am responsible for the remaining balance after insurance has been filed and payment has been received. 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. At this time any professional courtesy and/or budget account balances will be added back to the account. Any additional costs incurred in collecting this account including court cost, agency fees will be added to your balance due. **AN OFFICE FEE WILL BE CHARGED FOR ALL BROKEN APPOINTMENTS NOT CANCELLED WITHIN 48 HOURS.**

Person Responsible for the Payment of the Account:

_____ _____

Signature Date

403 East Maple Street • Cumming, Georgia 30040 • 770.887.3223

Bryan Family Dentistry, P.C.

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 health care 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 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 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 to 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, xrays, 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.

APPPOINTMENT REMINDERS: We may use or disclose your health information to provide you with appointment reminders (such as voicemail or text messages, emails, 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 can not 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 expenses 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 per page, $ 0 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 a 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 bide 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 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 e-mail, you are entitled to receive this notice in written form.

QUESTIONS AND COMPLAINTS

I 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 in 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 their address 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. REBECCA BRYAN
TELEPHONE: (770) 887-3223 FAX (770) 887-2383
EMAIL: bryanfamily@bellsouth.net
ADDRESS: 403 East Maple Street, Cumming, Georgia 30040

Bryan Family Dentistry, P.C.

FINANCIAL AGREEMENT

By signing below I acknowledge my responsibility to pay for the service received from Bryan Family Dentistry in accordance with their regular fees and terms. My responsibility is not modified by any third party (Insurance) that pays for all, or part of the charges.

In cases of divorce, the parent that accompanies the minor receiving treatment is the responsible party and is expected to pay at the time services are rendered; regardless of divorce decree or insurance policy holder.

PAYMENT POLICY

PATIENTS WITHOUT DENTAL INSURANCE
FULL payment is due at the time service is rendered.

PATIENTS WITH DENTAL INSURANCE
Patient pays estimated percentage of fee not covered by insurance at the time of service.

- Patient understands our office tries to verify benefits from insurance companies, but it is never a guarantee of payment (ex: insurance may quote incorrectly). Patient understands it is their responsibility to know their individual policy and will not hold Bryan Family Dentistry responsible for discrepancies in payment.

I authorize Bryan Family Dentistry to keep my signature on file and to charge my credit card account for the balance not paid by my insurance within 30 days. I also understand that this amount becomes delinquent if not paid in full within 30 days after billing. At this time a finance charge of 1.5% of the unpaid balance will be charged monthly until paid. I also understand that I am responsible to pay reasonable attorney's fees and collection expenses incurred and expended in the event should my account be referred to an attorney or agency for collection.

Assignment and Release: I authorize payment to be made directly to the dentist by my insurance company. I accept financial responsibility for all services not covered by my insurance company. I authorize release of any medical care information requested by my insurance carrier.

A $20.00 service charge will be applied for a returned check.

A charge will be applied for all broken appointments not cancelled within 48 hours.

Patient/Parent Signature Date

Bryan Family Dentistry, P.C.

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

_____
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.

( ) Communication barriers prohibited obtaining the acknowledgement.

( ) An emergency situation prevented us from obtaining acknowledgement.

( ) Other (please specify):

_____

_____

_____

_____

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ Email: _____

Patient #: _____ Social Security #: _____

SECTION B: TO THE PATIENT -- PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time, by contacting:

Contact Person:	Dr. Rebecca Bryan
Telephone:	(770) 887-3223 Fax: (770) 887-2383
Email:	Bryanfamily@bellsouth.net
Address:	403 East Maple Street, Cumming, GA 30040

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Include completed Consent in the patient's chart.