Welcome To Our Office

Patient Information Date_____

Full Name _____ Preferred Name _____ Birthdate _____

Social Security Number _____ M ___ F ___ Married ____ Single ____ Widow _____

Street _____ City _____ State_____ Zip _____

Home _____ Cell _____

E-mail _____

Employed By / Occupation : _____ / _____

Work Phone _____ Whom may we thank for referring you? _____Website _____Google _____Sign

_____Friend/Family(_____) _____Other Dr. (_____) _____Other (_____)

In the event of an emergency, whom should we contact?_____Phone_____

*If the above named patient is a minor, please indicate who is responsible for the account?

Name_____Social Security No._____Birthdate_____

Relationship_____Home Phone_____Work Phone_____

Address (if different from the patient's)_____

Medical History

1. Do you have a personal physician? Y / N - If yes, Doctor's Name & Phone _____

2. Are you currently under a physician's care? Y / N

If yes, please explain _____

3. Are you presently taking any drugs prescribed by a physician or dentist? Y / N

If yes, please list _____

4. Have you ever been told to premedicate before dental appointments? Y / N - If Yes, reason? _____

Reason for visit: (please circle)

1. Relief of Pain
2. Fillings
3. Improve Smile
4. Replacement of missing teeth (implants or bridges)
5. Routine Cleaning
6. Other _____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING:

Y N Ibuprofen	Y N Local Anesthesia	Y N Keflex	Y N Codeine	Y N Sulfa
Y N Latex	Y N Penicillin	Y N Tetracycline	Y N Erythromycin	Y N Aspirin
Y N Ceclor	Y N Cleocin	Other _____		

For Women Only: Are you pregnant? Y N If yes, how many weeks: _____ Nursing? Y N

PLEASE CIRCLE YES OR NO TO EACH OF THE FOLLOWING:

Y N Mitral Valve Prolapse	Y N Heart Murmur	Y N Rheumatic Fever	Y N Joint Replacement
Y N Cancer/Chemotherapy	Y N Hepatitis	Y N Diabetes	Y N Congenital Heart Defect
Y N Epilepsy/Seizure/Fainting	Y N Heart Attack	Y N Venereal Disease	Y N Hemophilia/Abdominal Bleeding
Y N High Blood Pressure	Y N Jaundice	Y N HIV/Aids	Y N Artificial Heart Valves
Y N Blood Disease	Y N Anemia	Y N Pacemaker	Y N Severe Headaches / Neckaches
Y N Sinus Problems	Y N Stroke	Y N Sickle Cell Disease	Y N Fever Blisters

Have you taken or are you taking Medications for loss of bone mass, (ie.; Actonel, Risedronate, Boniva, Ibandronate, Didronel, Etidronate, Fosamax, Fosamax Plus D, Alendronate, Skelid, Tiludronate, Aredia, Pamidronate, Bonefos, Clodronate, Zometa, Zoledronic Acid Atevia, Reclast, Dkelid, or Prolia) Yes No

DENTAL HISTORY

Are your teeth sensitive to: Heat : Y N Cold: Y N Sweets: Y N Biting Pressure: Y N

Do you catch food between your teeth? Y N

Have you ever had periodontal or gum disease? Y N

Do your gums bleed when brushing? Y N

Do you clinch or grind your teeth? Y N

Has fear kept you from regular Dental visits? Y N

When was your last Dental appointment? _____

How long since your last full exam and x-rays? _____

Dental Insurance Information

Primary Insurance:

Name of Insured _____ Social Security No. _____ Birthdate _____

Employer Name _____ Phone _____ Ins. Company _____

City, _____, State _____ Phone _____ Group/Policy No. _____

Secondary Insurance:

Name of Insured _____ Social Security No. _____ Birthdate _____

Employer Name _____ Phone _____ Ins. Company _____

City, _____, State _____ Phone _____ Group/Policy No. _____

OUR OFFICE FINANCIAL POLICY:

- Notice of Privacy Practices (please read)

Thank you for choosing us as your health care provider. We are committed to providing you the best care available. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment. All patients who do not pay in full at the time of service must complete our information and insurance form before services are rendered

Initial here_____ PAYMENT POLICY:

- WE ACCEPT CASH, CHECK, VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER, AND CARE CREDIT
- WE CHARGE A 1.5% MONTHLY INTEREST RATE ON ALL BALANCES OVER 60 DAYS PAST DUE.
- WE CHARGE A $35.00 FEE FOR RETURNED CHECKS.

Initial here _____ REGARDING INSURANCE:

FULL PAYMENT OF ESTIMATED DEDUCTIBLE AND CO-PAYMENT ARE EXPECTED AT THE TIME OF SERVICE. We may accept assignment of insurance benefits for your visit. However, we do require that any unmet deductible and/or co-payments be paid at the time of service. The balance is your responsibility, whether your insurance company pays or not. We will bill your insurance company at the time of service, if you give us the required insurance information. Your contract is between you and your Insurance Carrier. Although we will assist you with your claim by a courtesy filing, you should contact your insurance regarding payment of a claim. If your insurance company has not paid your account in full within thirty (30) days, we require that you remit the full balance due yourself. **Should your insurance pay less than you expected, or not at all, it is your responsibility to confer with your carrier should you wish to dispute your claim. However, you are still obligated to remit your balance immediately.**

Initial here _____ USUAL AND CUSTOMARY RATES:

Our practice is committed to providing the best treatment for our patients and our fees are based on the quality of service we provide. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Initial here _____ ACCOUNTS REFERRED FOR COLLECTION:

In the event your account is referred to a collection agency and /or attorney, you will be responsible for any additional expense incurred by Heritage Dental Associates, P.C. in the course of obtaining payment on your account including, but not limited to, court costs, accrued interest, collection agency and / or attorney fees. Any such costs will be added to your unpaid debt.

Initial here _____ FINANCIAL POLICY:

I permit a copy of this authorization to be used in place of the original and request payment of benefits to Heritage Dental Associates, P.C. moreover, I have read the financial policy. I understand and agree to all of the terms of these documents.

Initial here _____ CANCELLATION POLICY: I understand that I will be charged a LATE CANCELLATION fee of $75 if I fail to give at least a 48 hour notice prior to cancelling my appointment. No future appointments can be scheduled nor can records be transferred without the payment of this fee.

_____ Date: _____

Patient's Signature (or Parent/Guardian if applicable)

PRIVACY PRACTICE:

I AUTHORIZE, Heritage Dental Associates, P.C. to release any information required in the course of my examination or treatment. I authorize any physician or hospital to provide details of my medical history to Heritage Dental Associates, P.C. I permit a copy of this authorization to be used in place of the original. Moreover, I have read the Notice of Privacy Practices. I understand that the office will provide me with a copy of the privacy practices should I request one. I also understand and agree to all of the terms of these documents.

_____ Date: _____

Patient's Signature (or Parent/Guardian if applicable)

PO Box 38 Fayetteville, Georgia 30214

To All Patients:

In order to ensure your privacy, please answer the following questions and inform the Front Desk Staff of any changes that apply to you:

1. Do we have your permission to leave a voice message, text or emails to confirm your appointments on the phone number (s) and the email (s) you have provided to us?

   YES or NO

2. May we discuss your medical information with family and friends?

   YES or NO

3. If someone should call for or ask for you while you are here at the office, do we have permission to tell them you are here?

   YES or NO

Signature _____ Date _____

Dr. Jeff Kendrick, DMD

NOTICE OF PRIVATE 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 04/13/03), and will remain in effect until we replace it.

We reserve the right to change our privacy practices and applicable law permits the terms of this Notice at any time, provided such changes. 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

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 effect 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 of 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 by law.

Abuse or Neglect: 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 resonable cost-based fee for expense 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 $.75 for each page $20.00 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. 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.

Restrictions: 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