New Patient Form

Welcome! Please complete these confidential medical/dental forms so that we can provide you with dental care in a safe & efficient manner.

Patient Name _____ Date of Birth _____ M F

Home Address _____ City _____ State ____ Zip _____

Phone: Home _____ Business _____ Cell _____

Email _____

Social Security Number _____

Employer _____

Primary Insurance Company _____ Group _____ Subscriber _____

Secondary Insurance _____ Group _____ Subscriber _____

Marital status: ____ single ____ married ____ divorced Spouse's name _____

Responsible Party (if patient is minor) _____

In case of emergency, contact _____

Whom may we thank for referring you? _____

I authorize the release of any dental or medical records to aid in my dental treatment.

Patient/Guardian Signature _____ Date _____

I understand that dental services furnished to me are charged directly to me and that I am responsible for payment. If I carry insurance, I understand that the office will help prepare my insurance forms to assist me in obtaining my benefits but the fee is ultimately my responsibility. Financial arrangements must be made in advance. All emergency dental services, or any dental service performed without prior financial arrangements must be paid for at the time of service.

Assignment of Insurance: I hereby authorize release of any information needed/requested by my insurance carrier. I authorize my insurance company benefits to be paid directly to this office.

Signature _____ **Date** _____

Bradley K. Greenway, DDS
6175 Crooked Creek Rd
Peachtree Corners, GA 30092

Phone: (770) 449-5901
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Bradley K. Greenway, DDS

New Patient Form

PATIENT'S DENTAL HEALTH

Why have you come in to see us today? (pain, checkup, etc.) _____

Are you having any pain or discomfort? _____ When was your last dental visit? _____

How often do you brush? _____ Do you floss? ___Y ___N How often? _____

My gums bleed while brushing or flossing ___Y ___N My gums feel tender or swollen ___Y ___N

Have you ever had gum treatment? ___Y ___N When? _____ Procedure/treatment? _____

Have you ever worn braces for straightening your teeth? ___Y ___N When? _____

Have you ever bleached your teeth? ___Y ___N When & how? _____

Do you clench or grind your teeth day or night? ___Y ___N Do you wear a nightguard? ___Y ___N

Comments or questions: _____

PATIENT'S MEDICAL HISTORY

I consider my health to be (please check one) ___Excellent ___Good ___Fair ___Poor

Do you or have you had any of the following? *Please circle Y for yes or N for no*

1.	Y	N	Heart Disease (surgery, attack)	19.	Y	N	Liver Disease
2.	Y	N	Heart Murmur/Mitral Valve Prolapsed	20.	Y	N	Jaundice
3.	Y	N	Stroke	21.	Y	N	Hepatitis Type_____
4.	Y	N	Congenital Heart Disease	22.	Y	N	Diabetes
5.	Y	N	Artificial Heart Valve	23.	Y	N	Kidney Disease
6.	Y	N	Heart Pacemaker	24.	Y	N	Herpes
7.	Y	N	High Blood Pressure	25.	Y	N	Arthritis
8.	Y	N	Anemia	26.	Y	N	Glaucoma
9.	Y	N	Prolonged Bleeding Disorder	27.	Y	N	Sexually Transmitted/Venereal Disease
10.	Y	N	Tuberculosis or Lung Disease	28.	Y	N	AIDS/H.I.V. positive
11.	Y	N	Asthma	29.	Y	N	Cancer/Chemotherapy
12.	Y	N	Hay Fever	30.	Y	N	Radiation Treatment
13.	Y	N	Sinus Trouble	31.	Y	N	History of Drug Addiction
14.	Y	N	Ulcers	32.	Y	N	Nervous/Anxious
15.	Y	N	Epilepsy/Seizures	33.	Y	N	Psychiatric/Psychological Care
16.	Y	N	Implants/Artificial Joints ___Hip ___Knee ___Other				
17.	Y	N	Do you smoke? How much _____				
18.	Y	N	Are you allergic to: (circle) Aspirin Ibuprofen Penicillin Codeine Sulfa Drugs Latex				
			Details: _____				

WOMEN: Pregnant: Y N Nursing: Y N Taking birth control: Y N Reached menopause: Y N

Please list all medications your are currently taking: _____

_____

Patient Signature _____ **Date** _____

Updated: Date _____ Signed_____

Date _____ Signed_____

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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.

_____

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
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please specify)

_____

_____

_____

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 to 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 for 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 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 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 references to your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written consent.

Required by Law: We may use or disclose your health information if 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 offices health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement officials 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).

Sign-in Sheet: We utilize a sign-in sheet for our patients in the reception area. If you would prefer not to sign in, please notify our receptionist that you are here. The sheet may contain names of patients that have appointments that day.

Computer Screens: We have computer screens in our operatories within view of our patients. We use screen savers and prohibit any unauthorized use and/or viewing of our computers. We make every attempt to keep your computer information private.

E-mail: We may use e-mail to confirm appointments or to answer any dental related questions you may have. Additionally, we may contact our labs via e-mail. If you do not wish any e-mail communication about your dental care, please inform our front office.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may require 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 access 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.____ for each page, $____ 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 and 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.

Restrictions: You have the right to request that we place additional restrictions on our use and 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 Website 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 to have us communicate with you by alternative method 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.

Contact Officer: Bradley K. Greenway, DDS

Telephone: (770) 449-5901 Fax: (770) 449-7747

E-mail: _____

Address: 6175 Crooked Creek Rd, Peachtree Corners, GA 30092