LINCOLNTON
FAMILY DENTISTRY

PATIENT INFORMATION

Patient Name: _____ Today's Date: _____
LAST FIRST MI PREFERRED

DOB: ___/___/_____ SSN: _____-____-_____ Family Status: □S □M □W □D □SEP Gender: □M □F

Cell Phone: (___)_____ May We Text? □Yes □No Home Phone: (___)_____

Alternate Phone: (___)_____ Email: _____

Home Address: _____
STREET ADDRESS APT# STATE ZIP

Mailing Address (if different than above):_____
STREET ADDRESS APT# STATE ZIP

Who May We Thank for Referring You To Our Office? _____
PATIENT REFERRALS ARE WORTH $25 ON YOUR BILL **AND** THEIRS!!!

IF PATIENT IS UNDER AGE 21

Full-Time Student: □Y □N School Attending: _____ Grade: _____

Both Parents Names:_____ Marital Status of Parents: □S □M □W □D □SEP

SSN: _____-_____-_____ If Not Parent, Who Has Legal Custody? :_____

PRIMARY DENTAL INSURANCE

Type of Insurance: □Private Insurance □GA Medicaid (if less than 19yo) □None

Subscriber Name: _____
LAST FIRST MI PREFERRED

Subscriber DOB: ___/___/___ Subscriber ID# (or SSN): _____ Relation to Patient: _____

Insurance Co. Name: _____ Insurance Co. Phone #: (___)_____

Insurance Group #: _____ Insurance Group Name: _____

CONDITIONS OF TREATMENT & OFFICE FINANCIAL POLICIES

This page must be signed before any services are rendered.

- As a condition of your treatment by this office, financial arrangements must be made in advance. This practice depends on reimbursement from the patients for the cost incurred in their care, and financial responsibility on the part of each patient must be determined before treatment.

- All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed. If a minor patient is being brought by a non-parent/guardian, arrangements should be made in advance for the appropriate payment to be provided on the date of service.

- Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he/she is personally responsible for the ultimate payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collection to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

- I understand that the any fee/treatment plan estimate listed for dental care can only be extended for a period of six (6) months from the date of patient examination.

- In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services at the time services are rendered, or within five (5) business days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition shall not constitute a waiver of any further term or condition and I further agree to pay up to 50% collection fees and attorney fees and/or court costs if suit/collection procedure be instituted.

- I grant permission to you, or your assignee, to contact me at home or at work to discuss matters related to this form.

I acknowledge the Financial Policies of Lincolnton Family Dentistry as stated above:

Print Name: _____

Signature: _____ Date: _____

DENTAL HISTORY

So that we may provide you with the best possible dental care,
please complete both sides of this medical/dental history form.
All information is strictly confidential.

What is the reason for your visit today? _____

Approx. date of last dental visit? _____

What was done at your last visit? _____

Previous Dentist/Dental Practice Name: _____ City/State: _____

How often do you go to the dentist? □ Only when something hurts □ Yearly □ 2x a year □ 3+ times a year

How often do you brush your teeth? □ Rarely □ Most days □ Every single day □ 2x a day □ 3+ times a day

How often do you floss? □ Never □ Rarely □ When something is stuck in my teeth □ Most days □ Every single day

Are any of your teeth sensitive to:

Hot or cold? Y / N
Sweets? Y / N
Biting or Chewing? Y / N

Do your gums bleed or hurt? Y / N
Any loose teeth/changes in your bite? Y N
Does food get stuck in your teeth? Y N
If yes, where most often? _____

Do you:

Clench or grind your teeth while sleeping? Y N
Have tired jaws, especially in the morning? Y N
Bite your lips/cheeks regularly? Y N
Mouth-breathe while awake or asleep? Y N
Smoke or chew tobacco? Y N

Have you ever had:

Orthodontic treatment? Y N
Oral surgery? Y N
Periodontal treatment? Y N
Your teeth ground or bite adjusted? Y N
A bite plate or mouth guard? Y N
A serious injury to the mouth or head? Y N
If yes, please describe:_____
_____

Have you experienced:

Do you notice any mouth odors? Y N
Bad tastes? Y N
Cold sores, fever blisters, or lesions? Y N
Clicking or popping of the jaw? Y N
Pain (jaw, ear, side of face)? Y N
Difficulty opening/closing mouth? Y N
A serious injury to the mouth or head? Y N
If yes, please describe:_____
_____

How do you feel about your teeth's appearance? □ Not At All Satisfied □ Somewhat Satisfied □ Completely Satisfied

Would you like to keep your teeth all your life? □ No, I want dentures □ I don't know □ What kind of question is that!?

Do you feel nervous about coming to the dentist? Y N If so, why? _____

Have you ever had a bad experience at the dentist? Y N

If so, describe: _____

Is there anything else about having a dental treatment that you'd like us to know? _____

_____

MEDICAL HISTORY

Have you been under the care of a medical doctor during the past two years? . . . . . Y / N

If so, for what? _____

Physician/Practice Name: _____ City/State: _____

Have you taken any medications/drugs within the past two years? . . . . . Y / N

Are you taking any medications/drugs now? . . . . . Y / N

If yes, please list drug name and dosage: _____

_____

_____

_____

Are you aware of any allergic (or adverse) reaction to any medication or substance? . . . . . Y / N

If yes, please list: _____

_____

Please indicate which of the following you have had, or have at present. Circle "Y" or "N" for each item.

Heart Surgery/Disease/Attack . . Y / N	Diabetes . . . . . Y / N	AIDS . . . . . Y / N
Chest Pain . . . . . Y / N	Thyroid Problems . . . . . Y / N	HIV+ . . . . . Y / N
Congenital Heart Disease . . . . Y / N	Glaucoma . . . . . Y / N	Cold Sores/Fever Blisters . . . Y / N
Heart Murmur . . . . . Y / N	Contact Lenses . . . . . Y / N	Blood Transfusion . . . . . Y / N
High Blood Pressure . . . . . Y / N	Emphysema . . . . . Y / N	Hemophilia . . . . . Y / N
Mitral Valve Prolapse . . . . . Y / N	Chronic Cough . . . . . Y / N	Sickle Cell Disease . . . . . Y / N
Artificial Heart Valve . . . . . Y / N	Tuberculosis . . . . . Y / N	Bruise Easily . . . . . Y / N
Heart Pacemaker . . . . . Y / N	Asthma . . . . . Y / N	Liver Disease . . . . . Y / N
Rheumatic Fever . . . . . Y / N	Hay Fever . . . . . Y / N	Yellow Jaundice . . . . . Y / N
Arthritis/Rheumatism . . . . . Y / N	Latex Sensitivity . . . . . Y / N	Neurological Disorders . . . . . Y / N
Cortisone Medicine . . . . . Y / N	Allergies/Hives . . . . . Y / N	Epilepsy/Seizures . . . . . Y / N
Swollen Ankles . . . . . Y / N	Sinus Trouble . . . . . Y / N	Fainting/Dizziness . . . . . Y / N
Stroke . . . . . Y / N	Radiation Therapy . . . . . Y / N	Nervous/Anxious . . . . . Y / N
Special/Restricted Diet . . . . . Y / N	Chemotherapy . . . . . Y / N	Psychiatric/Psych Care . . . . . Y / N
Artificial Joints (hip/knee/etc) . . Y / N	Tumors . . . . . Y / N	
Kidney Trouble . . . . . Y / N	Hepatitis A or B . . . . . Y / N	
Ulcers . . . . . Y / N	Venereal Disease . . . . . Y / N	

Women: Are you: **Pregnant?** □ Y ___#Months □ N **Nursing?** □ Y □ N **Taking birth control?** □ Y □ N

I understand that the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature: _____ Date: _____

LINCOLNTON FAMILY DENTISTRY

Notice of Privacy Practices

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect July 9, 2018, 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protection under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party, For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations . For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the Requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Other Uses and Disclosures of PHI. Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law.) You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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 the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure, or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or services for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:
Prevent or control disease, injury, or disability;
Report child abuse or neglect;
Report reactions to medications or problems with products or devices;
Notify a person of a recall, repair, or replacement of products or devices;
Notify a person who may have been exposed to a disease or condition; or
Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

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 the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Website or by electronic mail (e-mail).

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 if 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 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.

Our Privacy Official: Matthew Cooper
Lincolnton Family Dentistry, LLC.
PO Box 505; 110 Pitts Lane
Lincolnton, GA 30817
Phone: (706)359-3129 Fax: (706)359-1329

Broken Appointment Policy

We understand that things happen, and schedules do change, if this happens we ask that provide us with **at least two (2) business days' notice** for any appointment changes. Please understand that we do value you as a patient **however** if you have multiple missed appointments (2 or more) we will no longer schedule you in advance. On the day that you know that you can keep your appointment give our office a call and we will do our best to work you in to the schedule for that day.

1- You must be on time for your appointment. If you arrive more than 10 minutes late without prior notice you **may** still be seen but you will have to wait.

2- We will attempt to call you the day before your appointment to confirm. If a message is left on your machine/voicemail and we do not receive a call back, we will assume that you know and understand your appointment time. **The reminder calls are only courtesy calls**. We do attempt to call everyone but ultimately the appointment made by you is your responsibility.

I have read and fully understand the above policy

_____ _____ Signature

Date

____Patient ____Parent ____Guardian

ACKNOWLEDGEMENT OF RECEIPT:
Notice of Privacy Practices

LINCOLNTON
FAMILY DENTISTRY

You May Refuse to Sign This Acknowledgment

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 acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- □ Individual refused to sign
- □ Communications barriers prohibited obtaining the acknowledgment
- □ An emergency situation prevented us from obtaining acknowledgment
- □ Other: _____

_____

_____