DOVE DENTAL
SPECIALISTS

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2883 North Decatur Road Decatur, Georgia 30033
404-299-7411

Dental History

Patient Name _____ Phone _____ Email _____

What would you like us to do today?_____ Are you in dental discomfort today? _____

Former Dentist _____ Address_____

Dentist's Email _____ Phone _____

Date of last dental care_____ Date of last x-rays _____

Check yes or no if you have had problems with any of the following:

Y	N		Y	N		Y	N		Y	N	
○	○	Bad breath	○	○	Food collection between teeth	○	○	Periodontal treatment	○	○	Sensitivity to sweets
○	○	Bleeding gums	○	○	Grinding or clenching teeth	○	○	Sensitivity to cold	○	○	Sensitivity when biting
○	○	Clicking or popping jaw	○	○	Loose teeth or broken fillings	○	○	Sensitivity to hot	○	○	Sores or growths in mouth

How often do you brush? _____ How do you feel about the appearance of your teeth?_____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ○Y ○N

Other information about your dental health or previous treatment:

_____

Medical History

Physician's name _____ Phone_____

Date of last visit _____ Have you had any serious illnesses or operations? ○Y ○N

If yes, describe:_____

Are you currently under physician care? ○ Y ○ N If yes, describe: _____

Have you ever had a blood transfusion? ○ Y ○ N If yes, give approximate dates:_____

Have you ever taken Fen-Phen/Redux? ○ Y ○ N

Have you ever used a biphosphonate medication? Brand names include: Fosamax, Actonel, Atelvia, Didronel, and Boniva. ○ Y ○ N

Women: Are you pregnant? ○ Y ○ N Nursing? ○ Y ○ N Taking birth control pills? ○ Y ○ N

Check yes or no whether you have had any of the following:

Y	N		Y	N		Y	N		Y	N	
○	○	Aids/Hiv Positive	○	○	Cough, persistent	○	○	High blood pressure	○	○	Shingles
○	○	Anaphylaxis	○	○	Cough up blood	○	○	Jaw pain	○	○	Shortness of breath
○	○	Anemia	○	○	Diabetes	○	○	kidney disease	○	○	Skin rash
○	○	Arthritis, Rheumatism	○	○	Epilepsy	○	○	Liver disease	○	○	Spina Bifida
○	○	Artificial heart valves	○	○	Fainting	○	○	Material allergies (Latex, wool, metal chemicals)	○	○	Stroke
○	○	Artificial joints	○	○	Food allergies				○	○	Surgical implant
○	○	Asthma	○	○	Glaucoma				○	○	Swelling of feet/ankles
○	○	Atopic (allergy prone)	○	○	Headaches	○	○	Mitral valve prolapse	○	○	Thyroid Disease or malfunction
○	○	Back problems	○	○	Heart murmur	○	○	Nervous problems	○	○	Tobacco habit
○	○	Blood disease	○	○	Heart problems	○	○	Pacemaker/Heart surgery	○	○	Tonsillitis
○	○	Cancer			Describe _____	○	○	Psychiatric care	○	○	Tuberculosis
○	○	Chemical dependency	○	○	Hemophilia/Abnormal bleeding	○	○	Rapid weight gain/loss	○	○	Ulcer/Colitis
○	○	Chemotherapy				○	○	Radiation treatment	○	○	Venereal disease
○	○	Circulatory problems	○	○	Herpes	○	○	Respiratory disease			
○	○	Cortisone treatment	○	○	Hepatitis	○	○	Rheumatic/Scarlet fever			

Is patient currently taking any medications? If yes, please list all:

_____

Does patient have drug allergies? If yes, please list all:

_____

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 VERY 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 will take effect 04/13/2003, 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 may 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 or 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 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 of 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 or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgement disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgement 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-RRELATED SERVICES** We will not use your health information for marketing communications without your written authorization

- **REQUIRED BY LAW** We ay 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.

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of this Dental Practice's HIPAA Notice of Privacy Practice

_____Patient Name (please print)

_____ Email Id _____Phone Number

_____Patient (Representative) Signature _____Date

Authority of Personal Representative to Sign for Patient (please circle):

◯ Parent ◯ Guardian ◯ Power of Attorney Other:_____

Insurance Policy

Patients using dental insurance are hereby advised that your insurance is filed as a courtesy, not a requirement. In the event your insurance company has not paid the claim within sixty days, any unpaid charges become the responsibility of the patient, as does following up with the insurance company.

_____ (Patient/Guardian Signature) _____ (Date)

Late Cancellation Policy

Dove Dental Specialists is always committed to providing exceptional care and service. Due to an increased demand for appointments, we must receive notice by 2:00 p.m. two business days prior to your scheduled appointment to inform us of any changes or cancellations. To cancel a Monday appointment, please call our office by 2:00 p.m. on Thursday.

If prior notification is not given, you will be assessed $50 for the missed appointment. It is the responsibility of the patient to keep track of their appointments, a reminder call is a courtesy. If you are not here at your specified appointment time, we will have to reschedule you.

Please prepare to arrive 10 minutes prior to your appointment to avoid rescheduling.

Appointment Confirmation Agreement

Please be aware if confirmation for your for your appointment has not been received by 2:00p.m. two business days prior, your appointment will be forfeited

_____ (Patient/Guardian Signature) _____ (Date)

Authorization for Release of Information to Family Members

_____Patient Name _____Phone Number

I authorize **Dove Dental Specialists** to release my medical and/or billing information to the following individual(s):

1. _____ Relation to Patient _____

2. _____ Relation to Patient _____

_____Patient Signature

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____