

# WELCOME TO OUR PRACTICE

Please take a few minutes to answer the following questions so we can better assist you with your dental care needs.

## PATIENT INFORMATION

Today's Date \_\_\_\_\_ Birth Date \_\_\_\_\_ Patient Social Security # \_\_\_\_\_  
Patient Name \_\_\_\_\_  
(Last Name) (First Name) (Initial)  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Occupation \_\_\_\_\_  Male  Female  Single  Married  Widowed  Divorced  Separated  
Patient Home Phone \_\_\_\_\_ Patient Work Phone \_\_\_\_\_  
Employer \_\_\_\_\_ Employer Phone \_\_\_\_\_  
Employer Address \_\_\_\_\_  
**In Case Of Emergency Contact:**  
Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Emergency Home Phone \_\_\_\_\_ Emergency Work Phone \_\_\_\_\_  
Whom may we thank for referring you to us? \_\_\_\_\_

## PRIMARY INSURANCE

Individual responsible for this account \_\_\_\_\_  
(Last Name) (First Name) (Initial)  
Relationship to Patient \_\_\_\_\_ Birth Date \_\_\_\_\_ Social Security # \_\_\_\_\_  
Street Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Responsible Party Employed By \_\_\_\_\_ Business Phone \_\_\_\_\_  
Business Address \_\_\_\_\_ Occupation \_\_\_\_\_  
Insurance Company \_\_\_\_\_  
Insurance Company Address \_\_\_\_\_  
Subscriber I.D. # \_\_\_\_\_ Group # \_\_\_\_\_

## ADDITIONAL INSURANCE

Insured Individual's Name \_\_\_\_\_  
(Last Name) (First Name) (Initial)  
Relationship to Patient \_\_\_\_\_ Birth Date \_\_\_\_\_ Social Security # \_\_\_\_\_  
Street Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Insured Party Employed By \_\_\_\_\_ Business Phone \_\_\_\_\_  
Insurance Company \_\_\_\_\_  
Insurance Company Address \_\_\_\_\_  
Subscriber I.D. # \_\_\_\_\_ Group # \_\_\_\_\_

## ASSIGNMENT AND RELEASE

I authorize my insurance company to pay to the dentist or dental group 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 \_\_\_\_\_

Payment is due in full at time of treatment unless prior arrangements have been approved.

## FAMILY HEALTH INFORMATION

Some health conditions are the result of hereditary spinal weaknesses. Information that you can furnish us pertaining to your immediate family members (brothers, sisters, parents and grandparents) will give us a better understanding of your total health needs.

RELATIONSHIP TO YOU	FAMILY MEMBER PRESENT AND PAST HEALTH PROBLEMS

## MEDICATIONS

List medications you are currently taking

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Pharmacy \_\_\_\_\_ Phone \_\_\_\_\_

- |   |  |
|---|--|
| <input type="checkbox"/> Aspirin          | <input type="checkbox"/> Penicillin          |
| <input type="checkbox"/> Barbiturates     | <input type="checkbox"/> Sulfa               |
| <input type="checkbox"/> Codeine          | <input type="checkbox"/> Other (please list) |
| <input type="checkbox"/> Iodine           | _____  |
| <input type="checkbox"/> Latex            | _____  |
| <input type="checkbox"/> Local Anesthetic | _____  |

## CHECK ANY SYMPTOM(S) OR CONDITION(S) BELOW THAT YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST YEAR:

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> AIDS                  | <input type="checkbox"/> Depression/Nervousness | <input type="checkbox"/> Hoarseness              | <input type="checkbox"/> Polio                     |
| <input type="checkbox"/> Appendicitis          | <input type="checkbox"/> Difficulty Swallowing  | <input type="checkbox"/> Indigestion             | <input type="checkbox"/> Poor Appetite             |
| <input type="checkbox"/> Arm Pain or Numbness  | <input type="checkbox"/> Dizziness/Fainting     | <input type="checkbox"/> Irregular Heartbeat     | <input type="checkbox"/> Poor Circulation          |
| <input type="checkbox"/> Arthritis             | <input type="checkbox"/> Double Vision          | <input type="checkbox"/> Itching                 | <input type="checkbox"/> Prostate Problem          |
| <input type="checkbox"/> Asthma                | <input type="checkbox"/> Excessive Thirst       | <input type="checkbox"/> Jaundice                | <input type="checkbox"/> Rapid Heartbeat           |
| <input type="checkbox"/> Back Pain or Numbness | <input type="checkbox"/> Emphysema              | <input type="checkbox"/> Kidney Disease          | <input type="checkbox"/> Rash                      |
| <input type="checkbox"/> Bleeding Disorders    | <input type="checkbox"/> Epilepsy               | <input type="checkbox"/> Lack of Bladder Control | <input type="checkbox"/> Rectal Bleeding           |
| <input type="checkbox"/> Bleeding Gums         | <input type="checkbox"/> Earache                | <input type="checkbox"/> Leg Pain or Numbness    | <input type="checkbox"/> Rheumatic Fever           |
| <input type="checkbox"/> Bloating              | <input type="checkbox"/> Ear Discharge          | <input type="checkbox"/> Liver Disease           | <input type="checkbox"/> Ringing in Ears           |
| <input type="checkbox"/> Blood in Urine        | <input type="checkbox"/> Feet Pain or Numbness  | <input type="checkbox"/> Loss of Hearing         | <input type="checkbox"/> Scarlet Fever             |
| <input type="checkbox"/> Blurred Vision        | <input type="checkbox"/> Fever                  | <input type="checkbox"/> Loss of Sleep           | <input type="checkbox"/> Scars                     |
| <input type="checkbox"/> Bowel Changes         | <input type="checkbox"/> Forgetfulness          | <input type="checkbox"/> Loss of Weight          | <input type="checkbox"/> Sciatica                  |
| <input type="checkbox"/> Breast Lump           | <input type="checkbox"/> Frequent Urination     | <input type="checkbox"/> Low Blood Pressure      | <input type="checkbox"/> Shoulder Pain or Numbness |
| <input type="checkbox"/> Brights Disease       | <input type="checkbox"/> Gas                    | <input type="checkbox"/> Lumbago                 | <input type="checkbox"/> Sinus Problems            |
| <input type="checkbox"/> Bruise Easily         | <input type="checkbox"/> Glaucoma               | <input type="checkbox"/> Measles                 | <input type="checkbox"/> Sore That Won't Heal      |
| <input type="checkbox"/> Bursitis              | <input type="checkbox"/> Hand Pain or Numbness  | <input type="checkbox"/> Migraine Headaches      | <input type="checkbox"/> Stomach Aches or Pains    |
| <input type="checkbox"/> Cancer                | <input type="checkbox"/> Hay Fever              | <input type="checkbox"/> Multiple Sclerosis      | <input type="checkbox"/> Stroke                    |
| <input type="checkbox"/> Cataracts             | <input type="checkbox"/> Headache               | <input type="checkbox"/> Mumps                   | <input type="checkbox"/> Sweats                    |
| <input type="checkbox"/> Change in Moles       | <input type="checkbox"/> Heart Disease          | <input type="checkbox"/> Nausea                  | <input type="checkbox"/> Swelling Ankles           |
| <input type="checkbox"/> Chemical Dependency   | <input type="checkbox"/> Hemorrhoids            | <input type="checkbox"/> Neck Pain or Numbness   | <input type="checkbox"/> Thyroid Problems          |
| <input type="checkbox"/> Chest Pain            | <input type="checkbox"/> Hepatitis              | <input type="checkbox"/> Neuralgia               | <input type="checkbox"/> Tuberculosis              |
| <input type="checkbox"/> Chicken Pox           | <input type="checkbox"/> Herpes                 | <input type="checkbox"/> Neuritis                | <input type="checkbox"/> Ulcers                    |
| <input type="checkbox"/> Chills                | <input type="checkbox"/> High Blood Pressure    | <input type="checkbox"/> Nose Bleeds             | <input type="checkbox"/> Varicose Veins            |
| <input type="checkbox"/> Constipation          | <input type="checkbox"/> High Cholesterol       | <input type="checkbox"/> Pacemaker               | <input type="checkbox"/> Venereal Disease          |
| <input type="checkbox"/> Crossed Eyes          | <input type="checkbox"/> Hip Pain or Numbness   | <input type="checkbox"/> Painful Urination       | <input type="checkbox"/> Vision Flashes            |
| <input type="checkbox"/> Diabetes              | <input type="checkbox"/> HIV Positive           | <input type="checkbox"/> Persistent Cough        | <input type="checkbox"/> Vomiting                  |
| <input type="checkbox"/> Diarrhea              | <input type="checkbox"/> Hives                  | <input type="checkbox"/> Pneumonia               | <input type="checkbox"/> Vomiting Blood            |

## CHECK DEGREE OF HABITS BELOW. ALL INFORMATION WILL BE KEPT STRICTLY CONFIDENTIAL.

	HEAVY	CASUAL	LIGHT	NONE		HEAVY	CASUAL	LIGHT	NONE		HEAVY	CASUAL	LIGHT	NONE
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Soft Drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sugar/Sugar Products	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Sweeteners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Salty Foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I certify that the above information is correct to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature \_\_\_\_\_ Date \_\_\_\_\_



**Dental Dreams, LLC**  
**MAKING DREAM SMILES A REALITY!**

**HIPAA NOTICE OF PRIVACY PRACTICES**

Effective date: April 14, 2003

We understand that health information about you and your health is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated by this office, whether made by Dental Dreams, LLC or others working in this office. This notice will tell you about the ways in which we may use and disclose health information we keep about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use of your health information.

**We are required by law to:**

- For treatment
- For payment
- For health care operations
- As required by Law
- To avert a serious threat to health and safety
- As required by the Military of Veterans and Workers Compensation
- Public Health risks
- Health Oversight activities
- Lawsuits and disputes
- Law enforcement
- Coroners, health examiners and funeral directors
- National Security and Intelligence activities
- Security Officials for Inmates

**Your rights regarding Health information about you:**

- Right to Inspect and copy
- Right to amend
- Right to an Accounting of Disclosures
- Right to Request Restrictions
- Right to Request Confidential Communications
- Right to a Paper copy of this Notice

**Changes to this Notice:**

We reserve the right to change this Notice. We will post a copy of the current notice in our facility with the current effective date on the first page.

**Complaints:**

If you believe that your privacy rights have been violated, you may file a complaint with us. All complaints must be in writing. Please contact our office manager.

**Acknowledgement of Receipt of this Notice:**

We will request that you sign a separate form acknowledging you have received a copy of this notice. This acknowledgement will become part of your records.

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**NOTICE OF PRIVACY PRACTICES-ACKNOWLEDGEMENT**

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting the office manager, Zerita Becker. Please call (404) 289-7311 and ask for the office manager.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

**By my signature below I acknowledge receipt of the Notice of Privacy Practices.**

\_\_\_\_\_  
Patient or legally authorized individual signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name if signed on behalf of the patient

\_\_\_\_\_  
Relationship  
(parent, legal  
guardian)

**This area for staff notes (if any):**

**This form will be retained in your dental record.**

**Last Update: April 14, 2003**

**Dental Dreams, LLC**  
**MAKING DREAM SMILES A REALITY!**

**Authorization and Broken Appointment Policy**

I understand that if I voluntarily suspend or terminate care at any time, my portion of all charges for professional services are due and payable to Dental Dreams, LLC. All services rendered by Dental Dreams, LLC are charged directly to you, and you, ultimately will be responsible for payment, regardless of your insurance coverage.

We must implement a fee assessment of \$25.00 per half hour per patient for broken scheduled appointments. This fee will need to be satisfied prior to your next scheduled visit unless arrangements have been made.

A Friday evening after hours appointment can be reserved between the hours of 5pm to 9pm. There is a \$75 reserved fee for this appointment that will apply toward treatment rendered for the specific scheduled appointment date. This \$75 fee is to be paid prior to the scheduled appointment. The \$75 fee is NON REFUNDABLE if the appointment is broken.

We respectfully ask our patients to give us at least a 48 hour advance notice if he/she is unable to keep their appointment for the patient and/or a family member.

We would like to thank you for choosing our dental team for your dental needs. We appreciate your business.

Thanks,

Dental Dreams, LLC

**Patient Signature** \_\_\_\_\_

**Date** \_\_\_\_\_