Edward C. Smith, DMD, MPH, LLC

5650 Whitesville Road, Suite 101
Columbus, GA 31904
(706) 494-5886

You must be 18 years or older to complete this form

Today's Date: ________________________________

Patient's Name _____________________________________ **Preferred Name** ________________________

Address ____ **City/St/Zip** ____________________________

Birth date __________________________ **Social Security #** ____

Home # _________________________ **Work #** _____________________ **Cell #** ________________________

E-Mail Address ____

Employer ____ **Occupation** _________________________________

Referred By: ____

Parent or Spouse Information – please circle one

Name ____ **Birth date** ________________________

Employer ____ **Occupation** _________________________

Social Security # ___________________________________ **Work #** _________________________________

Emergency Contact ____

Relationship _______________________________________ **Phone #** ________________________________

Closest relative <u>not</u> living with you ____

Relationship _______________________________________ **Phone #** ________________________________

Is another family member or relative a patient in our office (name(s) and relationship)?

____

Dental Insurance Information

Name of Insured Subscriber ____

Name of Insurance _______________________________________ **Phone #** ___________________________

Insurance company address: ____

____

Policy/Group # (on card) __________________________ **ID# (on card)** ______________________________

Dental History

(PLEASE FILL THIS FORM OUT COMPLETELY BOTH FRONT AND BACK, THANK YOU!)

Reason for today's visit ______________________________

Former Dentist ______________________________ **Date of Last X-rays** ______________

How often do you floss? ______________ **How often do you brush?** ______________

Please place a check beside any of the following that applies to you:

_____ Bad Breath
_____ Loose teeth
_____ Food collection between teeth
_____ Bleeding Gums
_____ Broken Fillings
_____ Grinding Teeth
_____ Clicking/popping jaw
_____ Periodontal treatment
_____ Sensitive to hot/cold
_____ Other, Please Explain: ______________________________

Medical History

Physician's Name ______________________________ **Phone number** ______________

Have you had any serious illnesses/operations/injuries? ______________ **If Yes, please describe:** ______________

____

Have you ever had a blood transfusion? ______________ **If yes, when?** ______________

<u>For women only:</u> Are you currently taking birth control pills? ______________ **Are you pregnant?** ______________

If Yes, how many weeks? ______________ **Are you currently nursing?** ______________

<u>PLEASE INDICATE YES OR NO BESIDE EACH MEDICAL CONDITION. ALL CONDITIONS MUST BE MARKEDWITH AN ANSWER:</u>

Y	**N**	Arthritis	**Y**	**N**	**Artificial Heart Valve**	**Y**	**N**	Anemia	**Y**	**N**	Liver Disease
Y	**N**	Cortisone/Steroid Treatments	**Y**	**N**	Pacemaker	**Y**	**N**	Fainting/Dizzy Spells	**Y**	**N**	Kidney Disease
Y	**N**	**Artificial joints/pins**	**Y**	**N**	Heart Attack	**Y**	**N**	Frequent Headaches	**Y**	**N**	Epilepsy
Y	**N**	Cancer	**Y**	**N**	Low Blood Pressure	**Y**	**N**	Glaucoma	**Y**	**N**	Taken Phen-Phen or Redux
Y	**N**	Radiation treatment	**Y**	**N**	Stroke	**Y**	**N**	Thyroid problems	**Y**	**N**	Head or Neck injury
Y	**N**	Chemotherapy	**Y**	**N**	High Blood Pressure	**Y**	**N**	Respiratory Disease	**Y**	**N**	Back Injury or Problems
Y	**N**	**Shunts**	**Y**	**N**	Heart Murmur	**Y**	**N**	Difficulty Breathing	**Y**	**N**	History of Substance Abuse
Y	**N**	**Stents in past 6 months**	**Y**	**N**	Blood Disease	**Y**	**N**	Asthma	**Y**	**N**	Hepatitis A, B, or C
Y	**N**	Heart Problems	**Y**	**N**	Circulatory Problems	**Y**	**N**	Frequent Cough	**Y**	**N**	Venereal Disease
Y	**N**	**History of endocarditis**	**Y**	**N**	Heavy Bleeding	**Y**	**N**	Diabetes	**Y**	**N**	HIV/AIDS

Y N Taken Osteoporosis or Osteopenia medication either as a pill, injection or intravenously. If so, please list the dates of treatment. ***This information is very important to the safety of your dental treatment.***______________________________

Please list any other condition not listed above that we should be aware of:

____

____

____

List ALL medications you are currently taking:

____

____

____

____

Are you ALLERGIC to any of the following? PLEASE MARK YES OR NO TO ALL ALLERGY INQUIRIES

Y	**N**	**Penicillin**	**Y**	**N**	**Amoxicillin**	**Y**	**N**	**Codeine**	**Y**	**N**	**Sulfa**
Y	**N**	**Metals**	**Y**	**N**	**Latex**	**Y**	**N**	**Ibuprofen**	**Y**	**N**	**Other**
Y	**N**	**Avocado**	**Y**	**N**	**Strawberries**	**Y**	**N**	**Tree Nuts**	**Y**	**N**	**Bananas**
Y	**N**	**Kiwi**	**Y**	**N**	**Peanuts**	**Y**	**N**	**Milk**	**Y**	**N**	**Rosin**

If other, please list: ____

____

AUTHORIZATION

I authorize my insurance company to pay 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 seek payment of benefits**. I understand there will be a $40 charge for any cancelled, missed, or rescheduled appointments with less than 24 business hours notice**. I understand that I am financially responsible for all charges not paid by my insurance company. I understand that payment is due at time of service on all dental procedures.

Signature ____ Date ________________________
(Patient's signature/Guardian's signature)

New Patient Assessment

Welcome to our practice. We would like to provide you with the highest standard of care concerning your dental needs. Please take a few minutes to complete our new patient assessment.

1. What is the primary reason for your visit? ________________________________

   ____

   ____

   ____

2. Do you have any problems with your mouth or teeth? ______________________

   ____

   ____

   ____

3. How important is it to you to keep your teeth?

   Not Very Important 1------2------3------4------5-----6 Extremely Important

4. How concerned are you about the appearance of your teeth?

   Not Bothered 1-----2-----3-----4-----5-----6 Conscious all the time

5. Do you prefer amalgam fillings (silver) or composite fillings (tooth color) for your posterior (back teeth). Amalgam fillings are less costly and composite fillings are more esthetic.

6. How did you hear about our practice? Insurance Company, Website, Friend, Family, Co-Worker, Telephone Book ___________________________________

7. Would you prefer for your appointments to be confirmed by phone or email, please list your best contact ____

Edward C. Smith, DMD, MPH, LLC
5650 Whitesville Road, Suite 101
Columbus, GA 31904
(706) 494-5886

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 THIS INFORMATION 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 this Notice about privacy practices, and 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 04/14/2003, 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 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 in 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 health 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

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 describe in the Patient Rights section of this Notice. We may disclose 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. Also, in the case of a minor child being treated in our facility, we will disclose the minor's health information to the person or persons who bring the child into our office for treatment. It is understood that the minor patient's legal guardian's authorization for someone other than themselves to bring the child into our office for treatment translates to authorization to discuss the minor patient's health information with this individual if medically necessary. If this is unacceptable, the minor patient must be accompanied by his or her legal guardian for all treatment performed in our office.

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 of disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosure. In the event of you 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 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 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 authorize federal officials 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 or protected health information of inmate or patient under certain circumstances.

APPOINTMENT REMINDERS
We may use or disclose your heath 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 in 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 in this Notice. If you request copies, we will charge you $0.75 cents for each page, $15.00 per hour for staff time to locate and copy your health information, and postage if you wan 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 in this Notice for a full explanation of our fee structure.

DISCLOSURE ACCOUNTING: You have the right to request that we place additional restrictions on our use of 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 COMMUNICATIONS: 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.

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 in response to a request you made to amend or restrict the use of disclosure of your health information or to have us communicated with you by alternative means or locations, you may complain to us using the contact information listed at the end of this Notice. You may also submit a written complaint to the Office for Civil Rights. We will provide you with the address to file your complaint with Office for Civil Rights 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 the Privacy officer or with the office for Civil Rights.

Privacy Officer: Jan Z. Jones
Telephone: (706) 494-5886 Fax: (706) 494-5887

Address: 5650 Whitesville Road, Suite 101
Columbus, GA 31904

U.S. Department of Health and Human Services
Atlanta Federal Center
61 Forsyth Street, SW, Suite 3B70
Atlanta, GA 30303-8909
Voice (404) 562-7886
Fax (404) 562-7881
TDD (404) 331-2867

Office for Civil Rights

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ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THE PRIVACY PRACTICES OF THIS OFFICE.

____
TODAY'S DATE

____
PATIENT NAME (PLEASE PRINT)

____
PATIENT SIGNATURE

____
PARENT/GUARDIAN SIGNATURE IF PATIENT IS UNDER 18 YEARS OF AGE

Edward C Smith DMD MPH LLC

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Written Financial Policy

Thank you for choosing Edward C Smith DMD MPH LLC. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Check, Visa or Mastercard
- NO INTEREST[1] Payment Plans[2] from CareCredit
    - Allow you to pay over time with NO INTEREST[1]
    - Convenient, low monthly payment plans[2] also available
    - No annual fees or pre-payment penalties

Please note:

Edward C Smith DMD MPH LLC requires payment prior to the beginning of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

For plans requiring multiple appointments, your co-pay for that appointment will be due prior to the beginning of your appointment.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.[3]

A fee of $40 is charged for patients who cancel, miss, or reschedule without 24-business hour notice.

Edward C Smith DMD MPH LLC charges $25 for returned checks. As of July 1, 2009 dishonored checks will be collected electronically along with any associated fees.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

____

Patient, Parent or Guardian Signature Date

____

Patient Name (Please Print)

[1]If paid within the promotional period. Otherwise, interest assessed from purchase date. Minimum monthly payment required.

[2]Subject to credit approval

[3]However, if we do not receive payment from your insurance carrier within 45 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.