ST. SIMONS ISLAND DENTAL ASSOCIATES, P.C.

2487 Demere Road, Suite 100, St. Simons Island, GA 31522 (912) 638-9921

FOR OFFICE USE:

ALERT: _____

PRE-MED: _____

LATEX ALLERGY: _____

ABOUT YOU

Patient's Name: _____
Last First MI

Address: _____ City: _____ State: _____ Zip: _____

Preferred Name: _____ Sex: ❑ M ❑ F

Birth Date: _____ SSN#: _____

Marital Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Minor

Occupation: _____

Employer/School: _____

Spouse's Name: _____
Last First MI

Spouse's Birthday: _____ SSN#: _____

Spouse's Employer: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Email: _____

IN CASE OF EMERGENCY:

Name: _____

Relation: _____

Phone: _____

Whom may we thank for referring you?

_____

ABOUT YOU

Who is responsible for this account? _____ Relation: _____

Do you have dental insurance? ❑ Yes ❑ No

Primary Insurance Co: _____ Group #: _____

Secondary Insurance Co: _____ Group #: _____

YOUR DENTAL HISTORY

Reason for today's visit: _____

Previous Dentist: _____ City: _____ State: _____

Date of last dental visit: _____ Date of last dental x-rays: _____

How would you describe your current oral health? ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Is there anything about your smile that you wish you could change? ❑ Yes ❑ No

If yes, please describe: _____

Are you currently being advised by a physician to take antibiotics prior to dental treatment? ❑ Yes ❑ No

Please check YES or NO to indicate if you have, have had or do any of the following:

Toothache	❑ Yes	❑ No	Burning sensation in tongue	❑ Yes	❑ No
Sensitive to cold	❑ Yes	❑ No	Loose teeth	❑ Yes	❑ No
Sensitive to hear	❑ Yes	❑ No	Smoke	❑ Yes	❑ No
Pain when chewing	❑ Yes	❑ No	If yes, how long? _____		
Sensitive to sweets	❑ Yes	❑ No	Chew tobacco	❑ Yes	❑ No
Swollen/Bleeding Gums	❑ Yes	❑ No	Nail biting	❑ Yes	❑ No
Jaw pain	❑ Yes	❑ No	Thumb sucking	❑ Yes	❑ No
Clicking/Popping Jaw	❑ Yes	❑ No	Food stuck between teeth	❑ Yes	❑ No
Ear pain	❑ Yes	❑ No	Cheek biting	❑ Yes	❑ No
Mouth or Lip Sores	❑ Yes	❑ No	Family history or oral cancer	❑ Yes	❑ No

How often do you brush? _____ How often do you floss? _____

Do you use any other cleaning aids? _____

YOUR MEDICAL HISTORY

GENERAL

Smoke	❑ Yes	❑ No
Alcohol or Drug Abuse	❑ Yes	❑ No
Cancer	❑ Yes	❑ No
Chemotherapy	❑ Yes	❑ No
Bacterial Endocarditis	❑ Yes	❑ No
Change in Weight	❑ Yes	❑ No
HIV/AIDS	❑ Yes	❑ No

MUSCULOSKELETAL

Arthritis	❑ Yes	❑ No
Osteoporosis	❑ Yes	❑ No
Artificial Joints	❑ Yes	❑ No

GENITOURINARY

Kidney Disease	❑ Yes	❑ No
Dialysis	❑ Yes	❑ No
Venereal Disease	❑ Yes	❑ No
HPV	❑ Yes	❑ No

EYES

Blurred/Double Vision	❑ Yes	❑ No
Glaucoma	❑ Yes	❑ No

SLEEP

Snoring	❑ Yes	❑ No
Sleep Apnea	❑ Yes	❑ No

EAR, NOSE, THROAT, MOUTH

Fever Blisters	❑ Yes	❑ No
Sinus Trouble	❑ Yes	❑ No
Frequent Nosebleeds	❑ Yes	❑ No
Sore Throat	❑ Yes	❑ No
Lump in Neck	❑ Yes	❑ No
Seasonal Allergies	❑ Yes	❑ No

NEUROLOGICAL

Migraines	❑ Yes	❑ No
Seizures	❑ Yes	❑ No
Dizziness/Fainting	❑ Yes	❑ No
Paralysis	❑ Yes	❑ No

RESPIRATORY

Asthma	❑ Yes	❑ No
Persistent Cough	❑ Yes	❑ No
Bloody Cough	❑ Yes	❑ No
Shortness of Breath	❑ Yes	❑ No
Emphysema	❑ Yes	❑ No
Tuberculosis	❑ Yes	❑ No

ENDOCRINE

Thyroid Problems	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No

CARDIOVASCULAR

Chest Pains	❑ Yes	❑ No
Heart Attack	❑ Yes	❑ No
High Blood Pressure	❑ Yes	❑ No
Heart Palpitations	❑ Yes	❑ No
Infective Endocarditis	❑ Yes	❑ No
Congenital Heart Defect	❑ Yes	❑ No
High Cholesterol	❑ Yes	❑ No
Mitral Valve Prolapse	❑ Yes	❑ No
Pacemaker	❑ Yes	❑ No
Irregular Heartbeat	❑ Yes	❑ No

GASTROINTESTINAL

Acid Reflux	❑ Yes	❑ No
Ulcer	❑ Yes	❑ No
Hepatitis (Type _____)	❑ Yes	❑ No

PSYCHIATRIC

Depression	❑ Yes	❑ No
Anxiety	❑ Yes	❑ No
Bi-Polar Disorder	❑ Yes	❑ No

WOMEN

Birth Control Pill	❑ Yes	❑ No
Nursing?	❑ Yes	❑ No
Pregnant?	❑ Yes	❑ No

MEDICATIONS

Are you currently taking any prescription or over-the-counter medications? ❑ Yes ❑ No
PLEASE LIST ALL MEDICATION BELOW:

Name	Dose	How often taken

Have you ever taken any bisphosphanate medications (Fosamax, Actonel, Boniva or Zometa) for osteoporosis or other bone disorders? ❑ Yes ❑ No

Have you taken any of the weight-loss drugs collectively referred to as "Fen-Phen? ❑ Yes ❑ No

Where do you fill prescriptions?

Pharmacy: _____

Phone:

ALLERGIES

Have you had hives, skin rash, breathing problems or other allergic reactions to medications? ❑ Yes ❑ No
PLEASE LIST ALL MEDICATION BELOW:

Name	Describe reaction:

Have you ever had an allergic reaction to latex?
❑ Yes ❑ No

Are there any medications, other than those you are allergic to, that you would prefer not to take due to unpleasant side effects? ❑ Yes ❑ No

If yes, please specify:

SURGERIES:		HOSPITALIZATIONS:	
Reason:	Year:	Reason:	Year:
Reason:	Year:	Reason:	Year:

Patient/Guardian Signature: _____ Date: _____

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FINANCIAL POLICY

St. Simons Island Dental Associates, P.C. is committed to providing you with optimal dental care and exemplary service. To accomplish this we ask for your cooperation in complying with our financial policies.

1. Payment for professional services is due at the time services are performed unless previous arrangements have been made with our staff. For your convenience we accept Visa, MasterCard, American Express, Discover, Cash, and Personal checks.

2. If you have dental insurance coverage we will be happy to file your claim for your reimbursement as a patient courtesy. By supplying us with your most recent information, we can expedite your reimbursement from the insurance company.

3. Since insurance coverage varies from plan to plan, should you have any questions regarding your covered benefits, we encourage you to contact your insurance carrier or your employer for details.

4. A prepayment courtesy of 5% will be subtracted from the total amount due (on services over $2000) if paid in full PRIOR to the first treatment date and if payment is made by cash or check.

5. We offer CareCredit℠, a no-interest alternative to pay for your dental care. CareCredit℠ offers several, no-interest, long-term payment options.

6. In the event payments are not received on agreed upon dates, a late charge of 1.5% (18%APR) may be added to your account. If required, a credit check may be performed.

7. Should you wish to inquire about our financial payment options, will be happy to help you.

I acknowledge that I have read and understand the financial policy of St. Simons Island Dental Associates, P.C.

_____ _____

Patient/Guardian Signature *Date*

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HIPAA PRIVACY POLICY

Our Legal Duty

St. Simons Island Dental Associates, P.C. ("we," "our," "us"), like all other medical and dental practices, is required by applicable federal and state laws 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 went into effect April 14, 2003 with the latest revision August 20, 2013, and will remain in effect until modified or replaced. 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 according to the means outlined 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/dentist, dental auxiliaries, students and other healthcare providers providing treatment to you.
Payment: We may use and 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. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performances, 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 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 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 prescriptions, dental supplies, X-rays, or other similar forms of health information.

Marketing Health-Related Services: We may use Patient Information internally to offer goods and services we believe may be of interest. We may use Patient Information to contact you to inquire or survey about the Patient experience at the location(s) visited and the prospect of future services or improvements needed to continue as your services provider. We may also create and use aggregate Patient Information that is not personally identifiable to understand more about the common traits and interests of our Patients.We may utilize one or more third-party service providers to send email or other communications to you on our behalf, including Patient satisfaction surveys. These service providers are prohibited from using your email address or other contact information for any purpose other than to send communications on our behalf. It is our intention to only send email communications that would be useful to you and that you want to receive. When you provide us with your email address as part of the registration or appointment setting process, we will place you on our list of patients to receive informational and promotional emails. In addition, patients and visitors to our website are given the opportunity to "opt-in" to receive electronic promotional communications by selecting the option to receive promotional emails from us on our website.Each time you receive a promotional email, you will be provided the choice to "opt-out" of future emails by following the instructions provided in the email, or you can "opt-out" at any time by following the instructions provided.

Cookies Our website utilizes "cookie" technology. "Cookies" are encrypted strings of text that a website stores on a user's computer. Our website uses cookies throughout the online process to keep together information entered on multiple pages. For example, cookies enable our website to "remember" information provided to us. In addition, cookies are used to:

1. Measure usage of various pages on our website to help us make our information more pertinent to your needs and easy for you to access; and
2. Provide functionality such, as online appointing, bill paying and other functionalities that we believe would be of interest and value to you.

The two types of cookies that we use are referred to as "session" cookies and "persistent" cookies. Session cookies are temporary and are automatically deleted once you leave our website. Persistent cookies remain on your computer hard drive until you delete them. We do not use cookies to gather any personally identifiable information about you apart from what you voluntarily provide us in your dealings with us. Our cookies do not corrupt or damage your computer, programs or computer files. You may set your browser to block cookies.

Fundraising: We will not use your health information for fundraising activities without your written consent.

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 authorized federal officials, health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to a correctional institution or law enforcement official having lawful custody of protected health information of an 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).

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. We may charge a fee for producing dental records and X-rays as allowed by law.
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.
Restriction: You have the right to request that we place additional restrictions on our use or 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). When you pay in full outside of your insurance plan for services you may request that we restrict this information and not disclose it to your healthcare plan or insurer.
Breach Notification: We will provide you with notification of a breach of unsecured PHI as required by law.
Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. This request must be 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.
Amendment: You have the right to request that we amend your health information. This 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 received this notice on our web site or by electronic mail (e-mail), you are also entitled to receive this notice in written form.

Questions and Concerns

If you would like additional information about our privacy practices or have questions, St. Simons Island Dental Associates, P.C.'s Compliance Officer may be reached at (912) 638-9921.

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 our handling of your 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 send your concerns to St. Simons Island Dental Associates, P.C., Attn: Courtney Guest/HIPAA Compliance Officer, 2487 Demere Road, Suite 100, St. Simons Island, Georgia 31522. You also may submit written concerns to the U.S. Department of Health and Human Services. We will provide you with the address to the U.S. Department of Health and Human Services upon request.

We support your right to maintain 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.

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HIPAA PRIVACY POLICY ACKNOWLEDGMENT

** under HIPAA, you may refuse to sign the acknowledgment*

I, _____, acknowledge that I have received a copy of the St. Simons Island Dental Associates' Privacy Policy.

_____ _____

Patient/Guardian Signature *Date*

FOR OFFICE USE ONLY

❑ Individual refused to sign

❑ Communication barrier prohibited obtaining the acknowledgment

❑ An emergency situation prevented us from obtaining the acknowledgment

❑ Other: _____

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CONSENT FOR TREATMENT

Patient Name: _____ DOB: _____ Date: _____

I give consent for myself/my child to receive dental treatment deemed necessary by the providers at the St. Simons Island Dental Associates, P.C.(hereby referred to as Doctor) These procedures include, but are not limited to: examinations, oral prophylaxes (cleanings), fluoride treatments, sealants, restorations (amalgam or composite fillings and crowns), periodontal (gum) treatments, endodontic (root canal) treatments, extractions, and the use of local anesthetics. I understand that the use of local anesthetics carries a small risk for swelling, bruising, allergic reaction, changes in pain perception, or prolonged anesthesia. This consent shall be considered in effect until rescinded or revoked.

I give consent to the Doctor's use and disclosure of any oral, written or electronic health records that are identifiable as mine for the purpose of carrying out treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health care information is available.

_____	_____	_____
Print Name	Relationship to Patient	Date
_____	_____	_____
Your Signature	Witness	Date

This section needs to be completed for children under the age of 18 by a parent or legal guardian ONLY.

I affirm that I am the parent or legal guardian for the above named minor child. If I am unable to accompany my child, I give permission for the individuals named below to escort my child for dental treatments:
Name:_____ Relationship:_____
Name:_____ Relationship:_____
Name:_____ Relationship:_____

If child is over 13, please check one:
____ Since my child is over the age of 13, I also give permission for him/her to present for treatment unaccompanied by an adult. I understand that no invasive treatment, such as extractions or the initiation of root canal therapies, will be performed unless I am notified by telephone. In the event of an emergency, when I cannot be reached, I give permission to perform whatever therapies are deemed necessary by the treating provider.
____ Although my child is over 13, I wish to be present for all treatments performed.

_____	_____
(signature of parent or legal guardian)	Date

This consent shall be considered in effect until rescinded or revoked.