PATIENT REGISTRATION AND MEDICAL HISTORY

First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name: _____

Street Address _____ City _____ State _____ Zip _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cell: _____

Sex: ☐ M ☐ F Age _____ ☐ Married ☐ Widowed ☐ Single ☐ Minor ☐ Separated ☐ Divorced

Birth Date: _____ ☐ College Student Name of School: _____

E-mail: _____ ☐ I would like to receive correspondences via e-mail.

In case of an emergency, who should we contact? Name: _____ Phone: _____

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ❍ Yes ❍ No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ❍ Yes ❍ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ❍ Yes ❍ No If yes, please explain: _____

Are you taking any medications pills or drugs? ❍ Yes ❍ No If yes, please explain: _____

Do you use tobacco? ❍ Yes ❍ No

Are you taking any type of blood thinners? ❍ Yes ❍ No

When was your last visit to a dentist? _____ Name of previous dentist? _____

Whom may we thank for referring you to this office? _____

Women: Are you

Pregnant/Trying to get pregnant? ❍ Yes ❍ No Taking Oral Contraceptives? ❍ Yes ❍ No Nursing? ❍ Yes ❍ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Sulfa ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other If yes, please explain: _____

HAVE YOU EVER BEEN TOLD TO PRE-MEDICATE? ❍ Yes ❍ No

Do you have, or have you had, any of the following? (Please check)

☐ AIDS/HIV Positive
☐ Alcohol Addiction
☐ Alzheimer's Disease
☐ Anaphylaxis
☐ Anemia
☐ Angina
☐ Arthritis/Gout
☐ Artificial Heart Valve
☐ Artificial Joint
☐ Asthma
☐ Blood Disease
☐ Blood Transfusion
☐ Breathing Problem
☐ Bruise Easily
☐ Cancer
☐ Chemotherapy
☐ Chest Pain
☐ Cold Sore/Fever Blisters
☐ Congenital Heart Disorder
☐ Convulsions
☐ Cortisone Medicine
☐ Diabetes
☐ Drug Addiction
☐ Easily Winded
☐ Emphysema
☐ Epilepsy or Seizures
☐ Excessive Bleeding
☐ Excessive Thirst
☐ Fainting Spells/Dizziness
☐ Frequent Cough
☐ Frequent Diarrhea
☐ Frequent Headaches
☐ Genital Herpes
☐ Glaucoma
☐ Hay Fever
☐ Heart Attack/Failure
☐ Heart Murmur
☐ Heart Pace Maker
☐ Heart Trouble/Disease
☐ Hemophilia
☐ Hepatitis A
☐ Hepatitis B
☐ Hepatitis C
☐ Herpes
☐ High Blood Pressure
☐ Hives or Rash
☐ Hypoglycemia
☐ Irregular Heartbeat
☐ Kidney Problems
☐ Leukemia
☐ Liver Disease
☐ Low Blood Pressure
☐ Lung Disease
☐ Mitral Valve Prolapse
☐ Pain in Jaw Joints
☐ Parathyroid Disease
☐ Psychiatric Care
☐ Radiation Treatments
☐ Recent Weight Loss
☐ Renal Dialysis
☐ Rheumatic Fever
☐ Rheumatism
☐ Scarlet Fever
☐ Shingles
☐ Sickle Cell Disease
☐ Sinus Trouble
☐ Spina Bifida
☐ Stomach/Intestinal Disease
☐ Stroke
☐ Swelling of Limbs
☐ Thyroid Disease
☐ Tonsillitis
☐ Tuberculosis
☐ Tumors or Growths
☐ Ulcers
☐ Venereal Disease
☐ Yellow Jaundice

Have you ever had any serious illness not listed above? ❍ Yes ❍ No If yes, please explain: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. it is my responsibility to inform the dental office of any changes in medical status.

Signature of patient, parent, or Guardian _____ Date _____

RESPONSIBLE PARTY INFORMATION

First Name: _____ Last Name: _____ Middle Initial: _____

Street Address _____ City _____ State _____ Zip _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cell: _____

☐ Responsible party is also a policy holder for patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

DENTAL INSURANCE INFORMATION

PRIMARY INSURANCE INFORMATION

Name of Insured _____ Relationship to Patient ❍ Self ❍ Spouse ❍ Child ❍ Other

Insured Soc. Sec. _____ Insured Birth Date _____

Employer _____ Insurance Company _____

Address _____ Address _____

Address 2 _____ Address 2 _____

City, State, Zip _____ City, State, Zip _____

Telephone (_____) _____

SECONDARY INSURANCE INFORMATION

Name of Insured _____ Relationship to Patient ❍ Self ❍ Spouse ❍ Child ❍ Other

Insured Soc. Sec. _____ Insured Birth Date _____

Employer _____ Insurance Company _____

Address _____ Address _____

Address 2 _____ Address 2 _____

City, State, Zip _____ City, State, Zip _____

Telephone (_____) _____

<u>Please Note</u>: Dr. Dellinger is not a contracted/participating provider with any insurance company. If you have an HMO/DMO plan or have to "pick from a list of dentists"; Dr. Dellinger will not be on that list. All charges you incur are your responsibility regardless of your insurance coverage.

William H. Dellinger, Jr., D.D.S., PC

If you are taking prescription medication, please complete this form.

Patient Name_____

Health Care Provider's Name_____

Health Care Provider's Phone #_____

I am currently taking the following medications:

Medication	When I take it	Dose	Other Instructions

PATIENT AGREEMENT

Dental Insurance:

We are not contracted with any insurance carrier and are not on any list of providers. We do accept insurance assignments as a courtesy to our patients and will file your claims for you. Insurance coverage benefits quoted are only estimates and your insurance company may pay less that the estimated amount. If this happens, you will be responsible for paying the difference. All charges you incur are your responsibility regardless of your insurance coverage

Some insurance companies will mail the insurance check to the subscriber. We ask that you endorse those checks over to our office as soon as you receive them.

Financial Options:

Payment for services rendered is due and payable at the time of treatment unless arrangements have been made in advance. We accept Cash, Personal Checks, Visa, MasterCard, Discover and CareCredit. The service charge on all returned checks will be $30.00. Accounts over 30 days are considered delinquent and are subject to 1½% monthly interest or a service charge of $3.00 whichever is greater.

Appointment Policy:

As a courtesy we will try to contact you to confirm your appointment. We ask that you give 24 hours notice if you are unable to keep your scheduled appointment. We may choose to charge a fee of $50.00 for every hour that you are scheduled with our office. Realizing that we all have unforeseen situations that occur, we will handle each circumstance on an individual basis.

Patient Consent:

I have been informed of Dr. Dellinger's financial and appointment policies. I agree to be responsible for all fees for services and materials incurred during the course of my treatment. To the extent permitted by law, I consent to the use of my protected health information to carry out payment activities in connection with my care. I give permission to the doctor or the appropriate staff to take radiographs, study models, photographs or any other diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. I also authorize the doctor or appropriate staff to administer treatment and perform such procedures as may be deemed necessary in the diagnostic and /or treatment of my dental condition. I also understand the use of anesthesia embodies certain risk.

I hereby certify that all of the preceding medical and financial information is correct to the best of my knowledge. I have read and fully understand the aforementioned medical questionnaire. If there are any changes to my medical condition and/or information, I will immediately inform the doctor or administrative staff.

Patient Name:_____ Date:_____

Patient or Responsible Party Signature:_____

NOTICE OF PRIVACY PRACTICES
WILLIAM H. DELLINGER, JR., DDS

THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION 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 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 the Notice while it is in effect. This Notice takes effect 04/14/03, 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 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 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 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 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 of 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 you 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 official having lawful custody of protected health information of 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. 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 at the end of 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 at the end of this Notice.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed you 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 his 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 of disclosure of you 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 Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (Your 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 COMPAINTS
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 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.

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 us or with the U.S. Department of Health and Human Services.

Contact Officer: Ann Raudonis
Telephone: (770) 954-1180 Fax: (770) 954-1640

Address: 50 Lawrenceville Street, Suite 201, McDonough, Ga 30253

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

Patient Name_____

I understand that, under the Health Insurance Portability & Accountability Act of 1996("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions.

Signature

_____Date_____
(Patient or Parent/Guardian)

PERMISSION TO DISCUSS DENTAL TREATMENT

In the event that you may want a family member or friend to discuss your dental treatment with our office, we must have in writing permission/consent from you to do so. Please list any person you give Dr. William Dellinger or member or staff consent to discuss your dental treatment. If you do not wish to give consent to any person, check the appropriate box and sign/date the bottom portion of this form.

If the patient is a minor, we will discuss dental treatment with either parent/guardian

Name:_____

Name:_____

- o I hereby give permission/consent to William H Dellinger Jr. DDS to discuss any and all dental treatment with the above named individuals.
- o I do not wish Dr. William H Dellinger Jr. to discuss any of my dental treatment with anyone other than me.