

3331 Hamilton Mill Rd Bldg 200 Suite 2200, Buford, GA 30519

Patient Information

First Name:	Last Nam	e:	Middle Initial:	
Preferred Name:	Date of Birth:			
Address:				
		k Phone:		
Cell Phone:	Email	;		
Preferred Contact Method:	TEXT O EMAIL	O CELL PHONE		
Social Security #:		Drivers License #:		
Employer:		Job Title:		
Sex: □ Female □ Male	Marital Status: □ N	Married □ Single □ Divorc	ed DWidow	
How did you hear about us:				
		Emergency Phone#:		
Responsible Party (if someons First Name:	-	В	Birth Date:	
		~~		
		Vork Phone:		
Primary Insurance Informa	ation			
Name of Subscriber:		Subscriber Date of	Birth	
		Insurance phone #		
		_Subscriber Social Security#		
		Group#		
. ,				
Signature of Responsible Par	ty:]	Date:	



PATIENT ME	DICAI	HIST	ORY Patie	nt Nar	ne:				DOB:		_
	-								th problems that you may have		
Are you under a phy Have your ever been			? nad a major operation		es O No						
Have you been advis					es O No				ion:		
Do you use controlle					es O No						-
Do you use tobacco				ОΥ	es O No						
Do you have or have	you eve	r taken a	any of the following m	nedicatio	ns?						
Blood Thinner	(Cortison	e Medicine	High/Lo	ow Blood	Pressure	Pł	nen-fen or l	Redux		
CURRENT MEDIO	CATION	IS, REA	SON and DOSAGE:								
Are you allergic to a	ny of the	followi	ng?								
17.31	7		Codeine	Late	Y	Sulfa Drugs		Local	Anesthetics		
			Codemc					_ Local	Allesticues		
Women: Are you	Pregna	ant/Tryii	ng to get pregnant O	Yes	Taki	ng oral contracep	tives	O Yes			
Do you have or l	nave yo	u had	any of the following	ing?							
Aids/HIV Positive	O Yes	O No	Hemophilia	O Yes	O No	Alzheimer's	O Ye	es O No	Diabetes	O Yes	O No
Anaphylaxis	O Yes	O No	Hepatitis A, B, or C	O Yes	O No	Renal Dialysis	O Ye	es O No	Anemia	O Yes	O No
Herpes	O Yes	O No	Rheumatic Fever	O Yes	O No	Angina	O Ye	es O No	Emphysema	O Yes	O No
High Blood Pressure	O Yes	O No	Rheumatism	O Yes	O No	Arthritis/Gout	O Ye	es O No	Epilepsy/Seizures	O Yes	O No
High Cholesterol	O Yes	O No	Scarlett Fever	O Yes	O No	Artifical Valve	O Ye	es O No	Hives/Rash	O Yes	O No
Shingles	O Yes	O No	Artificial Joint	O Yes	O No	Hypoglycemia	O Ye	es O No	Sickle Cell Disease	O Yes	O No
Asthma	O Yes	O No	Fainting/Dizziness	O Yes	O No	Blood Disease	O Ye	es O No	Kidney Problems	O Yes	O No
Spina Bifida	O Yes	O No	Blood Transfusion	O Yes	O No	Leukemia	O Ye	es O No	Stomach/Intestinal Disease	O Yes	O No
Frequent Headaches	O Yes	O No	Liver Disease	O Yes	O No	Stroke	O Ye	es O No	Bruise Easily	O Yes	O No
Low Blood Pressure	O Yes	O No	Swelling of Limbs	O Yes	O No	Cancer	O Ye	es O No	Lung Disease	O Yes	O No
Thyroid Disease	O Yes	O No	Allergies/Hay Fever	O Yes	O No	Osteoporosis	O Ye	es O No	Tuberculosis	O Yes	O No
Cold Sore/Fever Bliste	rs O Yes	O No	Pain in Jaw Joints	O Yes	O No	Tumors/Growths	O Y	es O No	Congenital Heart Disorder	O Yes	O No
Pacemaker	O Yes	O No	Ulcers	O Yes	O No	Heart Trouble	O Ye	es O No	Psychiatric Care	O Yes	O No
Venereal Disease	O Yes	O No	ADD/ADHD	O Yes	O No	Autism	O Ye	es O No			
Do you have any medic	cal conditi	ion not lis	sted above?	O Yes	O No	If yes, please list	belov	v in commer	ats.		
			estions on this form ha								

Date:

Signature of Patient, Parent or Guardian:



Welcome to our practice!
We appreciate the trust you have placed in us.

OFFICE POLICIES

Payment is due at the time service is rendered. We accept cash, check and all major credit cards. If you present a check for insufficient funds or stop payment on an issued check, you will be charged a \$30.00 processing fee.

In the event that your account is turned over to our collection agency, a 40% charge will be added on to the entire family balance. If an account is turned over to collections, all family members will be automatically dismissed.

If you break an appointment with our office, we ask for a 24-hour notice of cancellation. If we do not receive a 24-hour notice, you will be charged a \$30.00 fee for the scheduled appointment. If you repeatedly miss scheduled appointments, you may be asked to pursue treatment elsewhere.

INSURANCE

Professional services are rendered and charged to you, not your insurance company. Please understand that the contract is between you and the insurance company and payment for services is your responsibility. We will accept assignment of claims for primary insurance. All deductibles and coinsurances are due at the time of treatment.

Our office will not enter into a dispute with your insurance company over your claim. This is your responsibility and obligation. If at the end of 60 days your insurance company has not paid, you are responsible for the entire balance. Upon request, we will supply you with a copy of the claim so that you can resubmit if necessary.

In order to honor any insurance benefits, you must provide insurance identification (i.e., insurance cards, phone numbers, & picture I.D.) and we must be able to verify the current benefits available. It is your responsibility to provide new policy information to our office if your insurance changes.

Be advised that you may be billed for services that your insurance company will not cover due to exclusions or plan limitations. In most cases, a pre-treatment estimate can be sent to your insurance company, therefore giving us an estimated portion due by you at time of service.

Please be advised that we do not do amalgams (silver fillings) in our office. At times, insurance may pay the composite (white) restorations at a reduced rate, making you responsible for the balance owed.

I have read and understand the statements outlined above.

Patient/ Responsible Party:	
Signature:	Date:



Authorization Form for Use or Disclosure of Patient Information

Patien	t Name:Patient Date of Birth:
HIPAA	laws and regulations prevent disclosure of your medical information to anyone other
than y	ourself, insurance company, or specialist you are referred to. This form allows us to sha
inform	nation with other person(s) with your permission.
	orize Magnolia Ridge Dental to speak to the following person(s) listed below on my
behalf	
Please	print names of persons or write "none".
Type o	f information authorized to be disclosed (check all that apply):
	Dental treatment
	Appointments
	Patient finances and fiscal responsibilities
Patie	nt Signature: Date:



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

	YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT				
I,_ co	I,, have received a copy of this office's Notice of Privacy Practices.				
Ple	ease Print Name				
Sig	gnature				
Da	ite				
	For Office Use Only				
	attempted to obtain written acknowledgement of receipt of our Notice of Privacy actices, but acknowledgement could not be obtained because:				
(Individual refused to sign				
(Communications barriers prohibited obtaining the acknowledgement				
(An emergency situation prevented us from obtaining acknowledgement				
(Other (please specify)				

MAGNOLIA RIDGE DENTAL ASSOCIATES

NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

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 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 takes effect 12/12/06, 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 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. 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 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 you healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of you 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 communication 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 authorized 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. If you request copies, we will charge you \$.25 for each page, \$__ per hour for staff time to locate and you're your health information, and postage if you want 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 at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclose 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 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 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 Communication: 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.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (email), you are entitled to receive this Notice in written form.

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 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 of the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint to 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 Telephone: (678) 541-0770 Fax: (678) 541-0721

Address: 3331 Hamilton Mill Road BLDG 200 STE 2200, Buford, GA. 30519