

**PATIENT INFORMATION**

**CONFIDENTIAL**

PATIENT# \_\_\_\_\_

DATE \_\_\_\_\_

(PLEASE PRINT)

NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ HOME PHONE \_\_\_\_\_  
FIRST MI LAST

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

E-MAIL \_\_\_\_\_ CELL PHONE \_\_\_\_\_

CHECK APPROPRIATE BOX:  MINOR  SINGLE  MARRIED  DIVORCED  WIDOWED  SEPARATED

PATIENT'S OR PARENT/GUARDIAN'S EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_

BUSINESS ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

SPOUSE OR PARENT/GUARDIAN'S NAME \_\_\_\_\_ EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_

IF PATIENT IS A STUDENT, NAME OF SCHOOL/COLLEGE \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_

WHOM MAY WE THANK FOR REFERRING YOU? \_\_\_\_\_

PERSON TO CONTACT IN CASE OF AN EMERGENCY \_\_\_\_\_ PHONE \_\_\_\_\_

**RESPONSIBLE PARTY**

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

ADDRESS \_\_\_\_\_ HOME PHONE \_\_\_\_\_

E-MAIL \_\_\_\_\_ CELL PHONE \_\_\_\_\_

DRIVER'S LICENSE# \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ FINANCIAL INSTITUTION \_\_\_\_\_

EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE?  YES  NO

**INSURANCE INFORMATION**

NAME OF INSURED \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

BIRTHDATE \_\_\_\_\_ SS#/SIN \_\_\_\_\_ DATE EMPLOYED \_\_\_\_\_

NAME OF EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_

ADDRESS OF EMPLOYER \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

INSURANCE COMPANY \_\_\_\_\_ GROUP# \_\_\_\_\_ UNION OR LOCAL# \_\_\_\_\_

INS. CO. ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOW MUCH IS YOUR DEDUCTIBLE? \_\_\_\_\_ HOW MUCH HAVE YOU USED? \_\_\_\_\_ MAX. ANNUAL BENEFIT? \_\_\_\_\_

DO YOU HAVE ANY ADDITIONAL INSURANCE?  YES  NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

BIRTHDATE \_\_\_\_\_ SS#/SIN \_\_\_\_\_ DATE EMPLOYED \_\_\_\_\_

NAME OF EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_

ADDRESS OF EMPLOYER \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

INSURANCE COMPANY \_\_\_\_\_ GROUP# \_\_\_\_\_ UNION OR LOCAL# \_\_\_\_\_

INS. CO. ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOW MUCH IS YOUR DEDUCTIBLE? \_\_\_\_\_ HOW MUCH HAVE YOU USED? \_\_\_\_\_ MAX. ANNUAL BENEFIT? \_\_\_\_\_

X \_\_\_\_\_  
SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR

**SIGNATURE**

Greg Ware D.M.D.

MEDICAL HISTORY

PATIENT NAME \_\_\_\_\_ Birth Date \_\_\_\_\_

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?
Have you ever been hospitalized or had a major operation?
Have you ever had a serious head or neck injury?
Are you taking any medications, pills, or drugs?
Do you take, or have you taken, Phen-Fen or Redux?
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?

- Are you on a special diet?
Do you use tobacco?
Do you use controlled substances?
Women: Are you Pregnant/Trying to get pregnant?
Taking oral contraceptives?
Nursing?

Are you allergic to any of the following?

- Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa drugs
Other If yes, please explain:

Do you have, or have you had, any of the following?

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

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

Comments:

Four horizontal lines for writing comments.

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 \_\_\_\_\_



## Protecting Your Confidential Health Information is Important to Us

### Notice of Privacy Practices

This information describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

### Our Promise!

### To Conduct Health Care Operations

Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.

### In Patient Reminders

Because we believe regular care is very important to your oral and general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family. These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best preventive and restorative care modern dentistry can provide. They may include postcards, folding postcards, letters, telephone reminders or electronic reminders such as email (unless you tell us that you do not want to receive these reminders).

### To Business Associates

We have contracted with one or more third parties (referred to as a business associate) to use and disclose your health information to perform services for us, such as billing services. We will obtain each business associate's written agreement to safeguard your health information.

## NOTICE OF PRIVACY PRACTICES

Federal law generally permits us to make certain uses or disclosures of health information without your permission. Federal law also requires us to list in the Notice each of these categories of uses or disclosures. The listing is below.

### As Required by Law

We may use or disclose your health information as required by any statute, regulation, court order or other mandate enforceable in a court of law.

### Abuse or Neglect

We may disclose your health information to the responsible government agency if (a) the Privacy Official reasonably believes that you are a victim of abuse, neglect, or domestic violence, and (b) we are required or permitted by law to make the disclosure. We will promptly inform you that such a disclosure has been made unless the Privacy Official determines that informing you would not be in your best interests.

### Public Health and National Security

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

### For Law Enforcement

As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

### Family, Friends and Caregivers

We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want, we will use our best judgment when sharing your health information only when it will be important to those participating in your care.

### Dear Patient:

This notice is not meant to alarm you. Quite the opposite! It is our desire to communicate to you that we are taking seriously Federal law (HIPAA-Health Insurance Portability And Accountability Act) enacted to protect the confidentiality of your health information. We do not ever want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside our office.

### Why do you have a privacy policy? Very good question!

The Federal government legally enforces the importance of the privacy of health information largely in response to the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the Internet, phone, faxes, copy machines and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we follow to protect your health information when we use it.

We want you to know about these policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures and your rights as our valuable patient.

We will use and communicate your HEALTH INFORMATION only for the purposes of providing your treatment, obtaining payment, conducting health care operations, and as otherwise described in this notice.

### How your HEALTH INFORMATION may be used To Provide Treatment

We will use your HEALTH INFORMATION within our office to provide you with dental care. This may include administrative and clinical office procedures, designed to optimize scheduling and coordination of care between hygienist, dental assistant, dentist, and business office staff. In addition, we may share your health information with physicians, referring dentists, clinical and dental laboratories, pharmacies or other health care personnel providing your treatment.

### To Obtain Payment

We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

Greg Ware, D.M.D.  
1031 Village Drive • Watkinsville, GA 30677 • (706) 769-1245  
www.gregwaremd.com

## Worker's Compensation Purposes

We may disclose your health information as required or permitted by State or Federal workers' compensation laws.

## Judicial and Administrative Proceedings

We may disclose your health information in an administrative proceeding in response to a subpoena or a request to produce documents. We will disclose your health information in these circumstances only if the requesting party first provides written documentation that the privacy of your health information will be protected.

## Incidental Uses and Disclosures

We may use or disclose your health information in a manner which is incidental to the uses and disclosures described in this Notice.

## Health Oversight Activities

We may disclose your health information to a government agency responsible for overseeing the health care system or health-related government benefit program.

## To Avert a Serious Threat to Health or Safety

We may use or disclose your health information to reduce a risk of serious and imminent harm to another person or to the public.

## To the U.S. Department of Health and Human Services (HHS)

We may disclose your health information to HHS, the government agency responsible for overseeing compliance with federal privacy law and regulations regulating the privacy and security of health information.

## For Research

We may use or disclose your health information for research, subject to conditions. "Research" means systemic investigation designed to contribute to generalized knowledge.

## In Connection With Your Death Or Organ Donation

We may disclose your health information to a coroner for identification purposes, to a funeral director for funeral purposes, or to an organ procurement organization to facilitate transplantation of one of your organs.

If applicable State law does not permit the disclosure described above, we will comply with the stricter State law.

## Authorization to Use or Disclose Health Information

Other than is stated above or where Federal, State or Local Law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

## Patient Acknowledgement

Patient Name(s): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not, we would appreciate very much your acknowledging your receipt of our policy by signing and returning this form. We look forward to seeing you again soon!

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

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

For additional information about the matters discussed in this notice, please contact our Privacy Officer.

Effective Date: \_\_\_\_\_

## PATIENT RIGHTS

You have the following rights related to your health information:

### Restrictions

You have the right to request restrictions on the use or disclosure of your health information for treatment, payment, or health care operations in addition to the restrictions imposed by federal law. Our office is not required to agree to your request, but we will endeavor to honor those reasonable requests. We generally are not required to agree to a requested restriction. Our office will honor your request that we not disclose your health information to a health plan for payment or healthcare operation purposes if the health information relates solely to a health care item or service for which you have paid us out-of-pocket in full.

### Confidential Communications

You have the right to request that we communicate with you by alternative means or at an alternative location. You may, for example, request that we communicate your health information only privately with no other family members present or through mailed communications that are sealed. We will honor your reasonable requests for confidential communications.

### Inspect and Copy Your Health Information

You have the right to read, review, and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable, cost-based fee to duplicate and assemble your copy. If there will be a charge, we will first contact you to determine whether you wish to modify or withdraw your request.

### Amend Your Health Information

You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe the information to be changed and your reason for the change.

Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete. If we deny your request, we will provide you with a written explanation of the denial.

### Accounting of Disclosures of Your Health Information

You have the right to ask us for a description of how and where your information was disclosed. Our documentation procedures will enable us to provide information on health information disclosures that we are required to disclose to you. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We may charge a reasonable, cost-based fee for each additional accounting during the same 12-month period. If there will be a charge, the Privacy Official will first contact you to determine whether you wish to modify or withdraw your request.

### Request a Paper Copy of this Notice

You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you.

We are required by law to maintain the privacy of your health information and to provide to you or your personal representative with this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all of our patients receive a copy of the revised Notice. You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. We will not retaliate against you for submitting a complaint. Please let us know of your concerns or complaints in writing by submitting your complaint to our Privacy Officer.

**Personal Health Information Release Form  
(HIPAA Release Form)**

**Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Release of Information**

**I authorize the release of any and all information including the diagnosis, financial and dental records, examination rendered to me and claims information. This information may be released to:**

Spouse \_\_\_\_\_

Child(ren) \_\_\_\_\_

Other \_\_\_\_\_

Information is NOT to be released to anyone.

**This Release of Information will remain in effect until terminated by me in writing.**

**We are now using eReminders (electronic/automated system) to notify patients of their appointments. Please indicate which method(s) you would allow and provide current information.**

**HOME:** \_\_\_\_\_ **WORK:** \_\_\_\_\_

**CELL:** \_\_\_\_\_ **RECEIVE TEXT ( Y / N )**

**EMAIL:** \_\_\_\_\_

**Has your address, employer or insurance changed since your last visit? If so please provide current information:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**I understand that this office will try to accommodate my wishes about my contact information, but may have to contact me at the other numbers if unable to contact me at my requested number/location.**

**Signed:** \_\_\_\_\_ **Date** \_\_\_\_/\_\_\_\_/\_\_\_\_