CLAYTON DENTAL

(770)932-0290

4320 Suwanee Dam Road Suite 1800B
Suwanee, GA 30024

Patient Information (Confidential)	Dental Insurance Information Only
Name _____ M F First MI Last Sex Address _____ City_____State_____Zip_____ SS#_____Birthdate_____Age___ Phone #'s Cell:_____Work:_____ Email Address: _____ Check One: ___Minor ___Single ___Married ___Divorced ___Widowed ___Separated If college student; ___Fulltime ___Part time Patient or parent's employer_____ Business Address _____ City_____State_____Zip_____ Spouse or Parent's Name_____ Employer_____ Wk Phone_____ Emergency Contact_____ Phone_____	Name of Insured_____ Relationship to Patient_____ Birthdate_____SS#_____ Employer Name_____ Work Phone_____ Cell_____ Insurance Company_____ Phone_____ Group # _____ Claims Address_____ City_____ State____ Zip_____ Max. Annual Benefit_____Deductible___ How much have you used this year? _____ Have you met your deductible? _____ Do you have additional insurance? _____

RESPONSIBLE PARTY

Name of person responsible for this account _____Relationship_____

Address_____ Home Phone _____ Cell_____

Is this person currently a patient in our office? _____Yes _____ No

X _____ _____
Signature of patient or parent if a minor Date

Patient Medical History / Name _____ Age ___ Date _____

	Yes	No
Are you in good health?	___	___
Have there been any changes in your general health within the past year?	___	___
Date of last physical exam _____		
Physician's Name and Phone Number _____		
Are you under care of physician?	___	___
Have you ever been hospitalized?	___	__
If yes, explain _____		
Are taking any medications?	___	___
If yes, please list _____		
Do you use tobacco?	____	____
Are you allergic to medications or anything else?	____	____
list: _____		
Do you have or have you had any of the following:		
Rheumatic fever	____	____
Heart defect, murmur, MVP	____	____
High / low blood pressure	____	____
Asthma	____	____
Cancer	____	____
Diabetes	____	____
Epilepsy / seizures	____	____
HIV	____	____
Joint replacement	____	____
Kidney / liver disease	____	____
Mental disorders	____	____
Pacemaker	____	____
Pregnancy	____	____
Due Date _____		

	Yes	No
Radiation therapy	____	____
Respiratory problems	____	____
Sinus problems	____	____
Stomach problems	____	____
Stroke	____	____
Tuberculosis	____	____
Tumors	____	____
Thyroid problems	____	____
Ulcers	____	____
Codeine allergy	____	____
Penicillin allergy	____	____

Are you:

Presently being treated for any illness? Y N

Aware of a change in your general health? Y N

Subject to frequent headaches? Y N

Considered a touchy person? Y N

Often unhappy or depressed? Y N

Easily upset or irritated? Y N

Whom may we thank for referring you to our practice? ____ _____

If not referred by another patient, how did you hear about us? ____ Sign ____Dental office ____ Yellow pages ____ Newspaper ____ Brochure ____ Other

DENTAL HISTORY

Please answer yes or no to the following:

* unhappy with the appearance of your teeth Y N
* unfavorable dental experiences Y N
* dental fears Y N
* problems with effectiveness or bad reactions to dental anesthetic Y N
* orthodontic treatment (braces) Y N
  If yes, when:_____
* periodontal (gum) treatment Y N
  If yes, when:_____
* bleeding gums Y N
* avoid brushing any part of your mouth Y N
* part of your mouth is sensitive to temperature Y N
* sore teeth Y N
* burning sensation in your mouth Y N
* difficulty swallowing Y N
* an unpleasant taste or odor in your mouth Y N
* dry mouth, throat, or eyes Y N
* jaw problems (temporomandibular joint) Y N
* difficulty opening your mouth widely Y N
* stiff neck muscles Y N
* awaken with awareness of your teeth or jaws Y N
* tension headaches Y N
* clench or grind your teeth Y N
* jaw clicking or popping Y N
* lost any teeth Y N
* do you sweat or tremble during exams Y N
* do strange people or places make you afraid Y N

Date of last dental visit:_____
Dentist's name:_____
Reason for this visit:_____

Have you ever considered whitening your smile? Y N
Would you like to improve your smile? Y N
If yes, what would you improve? Y N
Do you ever wake up with sore jaws, a sore neck, or a headache? Y N
Are you experiencing any dental discomfort? Y N
If yes, explain _____

Consent for Services

**So that you do not have to sign forms and to assist you in filing your insurance, we will keep a "signature on file" form on file and an authorization to release information. This authorizes any provider, insurer or other organization to release any information regarding dental history, treatment, or benefits payable for this claim to the plan administrator or its authorized agents to determine benefits payable. Do we have permission to keep your signature on file as explained? _____ Yes _____ No

**We take photographs of patients before and after extensive treatment. These pictures allow others to visualize the dramatic effects of dentistry. We will not release any photos without your consent. Do we have your permission to release photos? ____Yes ____No

**Every appointment made is reserved exclusively for each patient. We reserve the right to charge a minimum of $50.00 for any appointments cancelled or broken without 48 hours advance notice. Please acknowledge you understand. _____ I understand the policy.

To the best of my knowledge, all of the information provided is true and correct. If I ever have any change in my health, I will inform doctors at the next appointment without fail. I have read the above conditions of treatment and payment and agree to their consent.

Signature of patient, parent, or guardian _____

Date_____Relationship to patient: _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this to acknowledge receipt of this Notice. You may refuse to sign this acknowledgement if you wish.

I acknowledge that I have received a copy of the office's Notice of Privacy Practices.

Printed name:_____ Date:_____

Signature:_____

FOR OFFICE USE ONLY

We made every effort to obtain written acknowledgement of receipt of out Notice of Privacy from this patient but it could not be obtained because:

A. The patient refused to sign
B. Due to emergency situation it was not possible to obtain an acknowledgement
C. We were not able to communicate with the patient
D. Other. Please provide specific details.

Authorization for Release/Use of Protected Health Information In the Form of Photos, Radiographs, and Electronic Images

Name of office:

_____

Your photos and x-rays are part of your diagnostic and clinical record and are considered to be protected health information under federal HIPAA Privacy Laws.

We make use of radiographs (x-rays), photographs, and digital images. These images may be used for diagnosis, documentation, reference, teaching, and research publication. Some cases that present exceptional results, particularly remarkable smiles, or interesting situations may be utilized for demonstration, education or advertising to potential and existing patients in our office either in print media, social media, television, on digital media and on our webpage. In some instances, you may be recognizable in some of these images.

By initialing and signing this form, you are authorizing us and releasing us from any liability resulting
from the use/release of such images. Your authorization and release to use images will in no way affect the quality
of your results in our office. We do our best to provide exceptional dentistry to all patients.

___ I authorize the use of my images where my face is identifiable
___ I authorize the use of my images where only my teeth are identifiable
___ I authorize the use of my radiographs

The purpose of this request to release and/or disclose the PHI described above is for personal reasons. I understand that I have the right to revoke this Authorization, in writing, at any time by notifying the office above. Such revocation will not affect actions taken by the requesting person prior to the date he or she received the written revocation. I also understand information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and will no longer be protected by this rule.

I understand that my health care provider cannot condition treatment on whether I sign this Authorization. This Authorization will expire at such time that:

___ I determine that I no longer wish for my images to be used and I revoke this authorization in writing; or
___ The following date: _____ (*within one year of current date*).

Signature of Patient _____ Date_____

Medical Information Release and Authorization Form

Name: _____ Date of Birth: _____/____/_____

Authorization for Release of Information

[ ] I authorize the release of information including the entire contents of dental record, including diagnosis, treatment details and financial information.
This information may be released to:

[ ] Spouse_____
[ ] Child(ren)_____
[ ] Other_____
[ ] Information is not to be released to anyone.

I understand that I have the right to revoke this Authorization, in writing, at any time by notifying this office. Such revocation will not affect actions taken by the requesting person prior to the date he or she received the written revocation. I also understand information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and will no longer be protected by this rule. I understand that my health care provider cannot condition treatment on whether I sign this Authorization.
This Authorization will remain in effect until terminated by me in writing or until the following date (within one year of today's date): _____.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:_____
If unable to reach me:
[ ] you may leave a detailed message
[ ] please leave a message asking me to return your call
[ ] _____
The best time to reach me is (day)_____ between (time)_____

Signed: _____ Date: ____/____/_____

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I authorize the use or disclosure of the protected health information ("PHI") as described below. By authorizing the use or disclosure of the PHI described below, I authorize the custodian of the PHI:

(1) to open the PHI for review or inspection by the person(s) identified below, and

(2) to furnish the person(s) identified below with a copy of the PHI if he or she so requests.

Patient Name: _____ DOB: _____

Description of PHI requested: entire contents of dental record, including diagnosis, treatment details and financial information.

I authorize _____ (ofc name) to release and/or disclose the PHI described above to the following person/people:

_____

The purpose of this request to release and/or disclose the PHI described above is for personal reasons.

I understand that I have the right to revoke this Authorization, in writing, at any time by so notifying the requesting person. Such revocation will not affect actions taken by the requesting person prior to the date he or she received the written revocation. I also understand information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and will no longer be protected by this rule.

I understand that my health care provider cannot condition treatment on whether I sign this Authorization. However, if I refuse to sign this Authorization, I understand that I will be financially responsible for any dental work provided by this office.

This Authorization will expire at such time that: ___ I become financially responsible for all dental work performed by this office; or ___ the following date: _____ (within one year of current date).

_____ _____
Signature of patient Date