# PATIENT INFORMATION QUESTIONNAIRE

TODAYS DATE:_____

Who referred you to this office? _____ Social Security # _____

Patient's Name _____ Birthdate _____

Address _____ City _____ ST_____ ZIP _____

Home Phone _____ Work Phone _____ Ext _____

Cell Phone _____ Pager _____ E-Mail _____

Employer _____ City _____ Occupation _____

Name of Spouse / Parent / Guardian (circle one) _____

Birthdate _____ Social Security # _____

Address if different _____ City _____ ST _____ ZIP _____

Home Phone _____ Work Phone _____ Ext _____

Employer _____City _____ Occupation _____

In case of emergency, whom shall we notify other than spouse?

Name _____ Relationship _____ Phone _____

**DENTAL INSURANCE INFORMATION**

EMPLOYEE NAME _____

INS CO NAME_____

GROUP / POLICY # _____

EMPLOYEE ID or SS # _____

INS CO ADDRESS _____

INS CO CITY, ST, ZIP _____

INSURANCE PHONE _____

BIRTHDATE _____

**ASSIGNMENT and RELEASE**: I hereby authorize my insurance benefits to be paid directly to the dentist. I am financially responsible for any balances due. I also authorize the dentist to release any information required for this claim. I authorize that the dentist may use my records if he so determines. If I am receiving dental hygiene services only, I understand that if any dental or medical problems are discovered during the course of my dental hygiene treatment, I will be referred to the appropriate dental or medical expert for any needed evaluation.

In consideration of the service rendered to me by this dental office, I am obligated to pay said office in accordance with its credit terms and policy.

I consent to the taking of photographs and x-rays before, during, and after treatment, and to the use of same by the doctor in scientific papers or demonstrations.

I certify that I have read or had read to me, the contents of this form.

This office complies with Notice of Privacy Practices. You may request a copy of our Notice at any time.

I have read the above:
Signature _____ Date _____
Parent or Guardian if a minor

# *Medical History Questionnaire*

| | | | | | |
|---|---|---|---|---|---|
| Patient Name | | | | | |
| Have you been under the care of a medical doctor during the past two years? | | | | Yes | No |
| If yes, for what? | | | | | |
| Physician's Name | | Phone | | | |
| Address | | City, State Zip | | | |
| Have you taken any medications or drugs in the past two years? | | | | Yes | No |
| Are you taking any medication drugs or pills now? | | | | Yes | No |
| If yes, please list name and dosage | | | | | |
| Are you aware of having an allergic (**or adverse reaction**) to any medication or substance? | | | | Yes | No |
| If yes, please list: | | | | | |

Indicate which of the following you have had, or have at present. Circle "yes" or "no."

| | | | | | | |
|---|---|---|---|---|---|---|
| Heart (Surgery, Disease, Attack) | Yes | No | | Ulcers | Yes | No |
| Chest Pain | Yes | No | | Diabetes | Yes | No |
| Congenital Heart Disease | Yes | No | | Thyroid Problems / Disease | Yes | No |
| Heart Murmur | Yes | No | | Glaucoma | Yes | No |
| High Blood Pressure | Yes | No | | Stroke | Yes | No |
| Mitral Valve Prolapse | Yes | No | | Emphysema | Yes | No |
| Artificial Heart Valve | Yes | No | | Chronic Cough | Yes | No |
| Heart Pacemaker | Yes | No | | Tuberculosis | Yes | No |
| Rheumatic Fever | Yes | No | | Asthma | Yes | No |
| Latex Sensitivity | Yes | No | | Hives | Yes | No |
| Diet (Restricted/Special) | Yes | No | | Radiation Therapy | Yes | No |
| Artificial Joints | Yes | No | | Chemotherapy | Yes | No |
| Kidney Trouble / Disease | Yes | No | | Tumors | Yes | No |
| Hepatitis A or B | Yes | No | | Venereal Disease | Yes | No |
| A.I.D.S. | Yes | No | | HIV Positive | Yes | No |
| Cold Sores Fever Blister | Yes | No | | Blood Transfusion | Yes | No |
| Hemophilia | Yes | No | | Sickle Cell | Yes | No |
| Bruise Easily | Yes | No | | Liver Disease | Yes | No |
| Yellow Jaundice | Yes | No | | Neurological Disorder | Yes | No |
| Epilepsy or Seizures | Yes | No | | Fainting Spells | Yes | No |
| Nervous/Anxious | Yes | No | | Psychiatric Care | Yes | No |

Do you have or have you had any disease, condition, or problem not listed?...Yes No

If yes, please list:_____

**Women:** Pregnant? Yes,_____Months No **Nursing?** Yes No **Taking birth control pills?** Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.

Patient/Guardian Signature_____Date_____

# South Georgia Cosmetic and General Dentistry

## RESTORATIVE COOPERATION AGREEMENT

1. I understand that the treatment I am receiving today is restorative dentistry.

2. I understand that I must Cooperate with the recommendation of my dentist in my prescribed care regarding prevent health appointments with their hygienist in order to prevent any further disease once my teeth have been restored by any and all restorative procedures including implants and periodontal care.

3. I acknowledge I have been told to maintain my health by coming in for my hygiene care a minimum of twice a year including; x-rays and periodontal charting to keep my tissue and bone in a state of good health.

4. I accept responsibility for my mouth and realize with full understanding that if additional care is needed for further restorative care, due to active disease it is an additional charge and not inclusive of my initial diagnoses from my dentist, and that my insurance may not approve additional benefits for the same tooth and that I will be fully responsible for the fee at the time of service.

5. I commit to cooperate with my providers care by keeping my appointments, homecare and any other maintenance that is prescribed to me in order to sustain and maintain of my oral and overall health.

**I have read and understand the above restorative care policies**

Patient's Name _____

Email _____

Cell Phone _____ Text: (Y) (N)

_____ _____

Patient Signature (or Signature of responsible party) Date

WF South Georgia DENTISTRY
IMPLANT • COSMETIC • GENERAL
DR. STEVE WILKERSON & DR. CHAD FUSSELL
WWW.SOUTHGEORGIADENTISTRY.COM

# Our Office Financial Policy

Thank you for choosing us as your dental health care provider. We believe that all patients deserve the very best dental care we can provide. We also believe that everyone benefits when specific financial arrangements are agreed upon. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require that you read and sign prior to any treatment. All patients must complete our information and insurance forms before seeing the doctor.

FULL PAYMENT IS DUE AT TIME OF SERVICE.
WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, DISCOVER AND
AMERICAN EXPRESS CREDIT CARDS, AND DEBIT CARDS.
WE ALSO ACCEPT **CARE CREDIT** WHICH IS AN EXTENDED PAYMENT
PLAN WITH PRIOR CREDIT APPROVAL.

**Regarding Insurance**
As a courtesy, we will be happy to file your claim for you if you present your dental plan card and all required employer information. We request any co-payments, deductibles, and any services not covered by your insurance plan to be paid at the time the service is provided. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance unless you bring in all insurance information at your initial visit. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid your account in full within 45 day, the balance will be automatically transferred to your account. Please be aware some and possibly all of the services provided may be non-covered services and not considered reasonable, usual, and customary under the terms of your dental policy.

**Usual and Customary Rates**
Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. We will do our best to give you a rough estimate of your investment in your dental health for each upcoming visit, based on your individual treatment plan.

**Adult Patients**
Adult patients are responsible for full payment at the time of service.

**Minor Patients**
The adult accompanying a minor and/or the parents (or guardians) are responsible for full payment at the time of service. For unaccompanied minors, full payment is required at time of service.

**Payment Plans**
South Georgia Dentistry has partnered with Care Credit, a patient financing company, to offer our patients options for 0% interest financing for 3, 6, 12, 36, or 48 months with approval.

**Refunds**
Refunds for overpayment will be sent after all treatment is completed and insurance has been collected.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns. We look forward to providing the highest quality dental care in a relaxing and caring atmosphere.

I have read the above and understand and agree to these terms.

_____
Patient/Responsible Party

# AUTHORIZATION FOR USE OR DISCLOSEUR OF PROTECTED HEALTH INFORMATION



**1. Client's name:** _____
First Name Middle Name Last Name

**2. Date of Birth:** ____/____/_____ **3. SSN:** ____/ ___/ _____ **4. Date Authorization Initiated:** ____/____/_____

**5. Authorization initiated by:** _____
Name (client or provider) (if provider, please specify relationship to client)

**6. Information to be Used or Disclosed:**

- ☐ My dental information relating to the following treatment of condition: _____
- ☐ My Most recent _____ years of record
- ☐ My dental records for the following date(s): _____
- ☐ Entire dental record
  - ☐ Include ☐ Exclude: My health information related to drug and/or alcohol abuse
  - ☐ Include ☐ Exclude: My health information related to HIV/AIDS

Other information to be used or disclose (describe information in detail): _____

_____

_____

**7. Purpose of Use or Disclosure:**

- ☐ Treatment, Payment or Health Care Operations
- ☐ Disclosure to Life Insurer for Coverage Purposes
- ☐ Disclosure to Employer of results of pre-employment physical or lab tests
- ☐ Marketing Purposes
- ☐ To the Following Family Members: _____
- ☐ Other (describe each purpose of the requested use and disclosure in detail): _____

_____

_____

**8. Person(s) Authorized to Make the Disclosure:** _____

**9. Person(s) Authorized to Receive the Disclosure:** _____

**10. This Authorization will: ☐ not expire, ☐ expire on ___/___/_____ or ☐ upon the happening of the following event:**

_____

**Authorization and Signature:** I authorize the release of my confidential protected dental information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be redisclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected dental information.

**Signature of the Client:** _____

**Signature of Personal Representative:** _____

**Relationship to Client if Personal Representative:** _____

**Date of signature:** ____/ ____/ _____

SOUTH GEORGIA DENTISTRY, LLC

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You May Refuse to Sign This Acknowledgement*

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of our receipt of our Notice of Privacy Practices, 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)

_____

_____

_____

# SOUTH GEORGIA DENTISTRY, LLC

# NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MA BE USED AND DISCLOSED AND HOW 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 April 14, 2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practices at the term of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in out privacy practice 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 ne Notice available upon request.

For more information about our privacy practices, or to request a copy of our Notice, please contact us using the information listed on this website.

**USES AND DISCLOUSURES 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, evaluation practitioner and provider performance, conduction 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 of disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of you incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgement disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgement 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, 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. We may charge you a reasonable cost-based fee for expenses such as copies and staff time. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format.

**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purpose, other than treatment, payment, healthcare operations, and certain other activities, but not before April 14, 2003. If you request this accounting more than once in a 12month 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 disclosures 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 website or by electronic mail (e-mail), 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 at the address or phone number provided on this website.

If you are concerned that we may have violated your privacy rights, 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 om this website. 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.



**This form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002; April30, 2009)**

**Contact Office:** Cindy Nugent/ Office Manager
**Telephone:** (912) 384-4432 **Fax:** (912) 383-6452
**E-mail:** cindy.wfdmd@gmail.com
**Address:** 1108 N Madison Avenue, Douglas, Ga 31533

**CLIENT RIGHTS AND HIPAA AUTHORIZATIONS**
**(Page 2 of 2)**

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time (**"*HIPAA*")**.

1. Tell your provider if you do not understand this authorization, and the provider will explain it to you.
2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to provider at the following address (insert address of provider):
   _____
3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, payment, Enrollment or your eligibility for benefits. However, you may be required to complete this authorization form before receiving treatment if you have authorized your provider to disclose information about you to a third party. If you refuse to sign this authorization, and you have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a patient in their practice.
4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA. If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations
5. You may inspect or copy the protected dental information to be used or disclosed under this authorization. You do not have the rights of access to the following protected dental information: psychotherapy notes, information complied for legal proceedings, laboratory results to which the Clinical Laboratory Improvement Act ("CLIA") prohibits access, or information held by certain research laboratories. In addition, our provider may deny access if the provider reasonably believes access could cause harm to you or another individual. If access is denied, you may request to have a licensed health care professional for a second opinion at your expense.
6. If this office initiated this authorization, you must receive a copy of the signed authorization.
7. ***Special Instructions for completing this authorization for the use and disclosure of Psychotherapy Notes.*** HIPAA provides special protections to certain medical records known as "Psychotherapy Notes." All Psychotherapy Notes recorded on any medium by a mental health professional (such as psychologist or psychiatrist) must be kept by the author and filed separate from the rest of the client's medical records to maintain a higher standard of protection. "Psychotherapy Notes" are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separate from the rest of the individual's medical records. Excluded from the "Psychotherapy Notes" definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. Except for limited circumstances set forth in HIPAA, in order for a medical provider to release "Psychotherapy Notes" to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization form to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other dental records.
8. You have a right to an accounting of the disclosures of your protected dental information by provider or its business associates. The maximum disclosure accounting period is the six years immediately preceding the accounting request. The provider is not required to provide an accounting for disclosures: (a) for treatment, payment, or dental care operations; (b) to you or your personal representative; (c) for notification of or to persons involved in an individual's dental care or payment for dental care, for disaster relief, for facility directories; (d) pursuant to an authorization: (e) of a limited data set; (f) for national security or intelligence purposes; (g) to correctional institutions or law enforcement officials for certain purposes regarding inmates or individuals in lawful custody; or (h) incident to otherwise permitted or required uses or disclosures. Accounting for disclosures to dental oversight agencies and law enforcement officials must be temporarily suspended on their written representation that an accounting would likely impede their activities.