Gwinnett Dental Images

Barry E. Malkiel, D.D.S., P.C.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Social Security #: _____

SECTION B: TO THE PATIENT — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:
Contact Person: Barry E. Malkiel, D.D.S., P.C.
Telephone: 770-995-9255 Fax: 770-995-9686 E-mail: office@drmalkiel.com
Address: 916 Lawrenceville Highway South, Suite 201 Lawrenceville, GA 30046

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and tat we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE
I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:
Personal Representative's Name: _____
Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____Date: _____

We are complimented that you have selected us to provide dental care for you and your family.

(Please complete ALL information to the best of your knowledge. Thank You.)

Patient Information

Date_____ Patient Name_____ Birthdate_____ Sex_____

(If patient is a full time student fill in school name)_____

Address_____
Street City State Zip

Home Phone_____ Work #_____ Social Security #_____

Cell Phone:_____ Pager:_____ E-Mail:_____

If patient is a minor, give parent's or guardian's name_____

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

Name of nearest relative not living with you_____

Complete Address_____ Phone_____

Person to contact in case of emergency_____ Phone_____

Responsible Party Information

Name_____
Last First Middle Marital Status

Residence_____
Street City State Zip

Mailing Address_____
Street City State Zip

How long at this address_____ Home Phone_____ Work Phone_____

Previous Address (if less than 3 years)_____
Street City State Zip

Social Security #_____ Birthdate_____ Relationship to Patient_____

Employer_____ Occupation_____ No. years employed_____

Employer Address_____

Insurance Information

Insured's Name_____ Birthdate_____ SS#_____

Insurance Company_____ Group No._____

Insurance Co. Address_____ Phone_____

Insured's Employer_____ Phone_____

Do you have dual coverage? Yes_____ No_____ If yes: Please complete the following secondary Insurance Information.

Insured's Name_____ Birthdate_____ SS#_____

Insurance Company_____ Group No._____

Insurance Co. Address_____ Phone_____

Insured's Employer_____ Phone_____

Dental Information

Do your gums bleed when you brush? Yes_____ No_____

Are your teeth sensitive? Yes_____ No_____ Sensitivity to:

Do you grind or clench your teeth? Yes_____ No_____ Pressure? Yes____ No____ Sweets? Yes____ No____

Do you have any fear of dental work? Yes_____ No_____ Hot? Yes____ No____ Cold? Yes____ No____

Date of last dental examination_____ What was done at that time?_____

_____

Main Dental Concerns:_____

How do you feel about the appearance / color of your teeth?_____

Do you have any chipped or broken teeth?_____

For Children 12 or Younger

Is this your first dental visit? Yes_____ No_____

Have there been unpleasant medical or dental visits? Yes_____ No_____

Is there a finger sucking habit? Yes_____ No_____

Have there been fluoride treatments? Yes_____ No_____

Check if involved with following programs: ____ Speech therapy ____Special education ____Physically handicapped

Medical Information

1. Are you having pain or discomfort at this time? ..... YES NO
2. Have you been a patient in the hospital during the past two years? ..... YES NO
3. Have you been under the care of a medical doctor during the past two years? ..... YES NO

   Physician's Name _____ Phone No. _____

   Address _____
4. Have you taken any medication or drugs during the past two years? ..... YES NO
5. Are you now taking any medication or drugs? ..... YES NO

   If yes, please list: _____
6. Are you sensitive or allergic to any medication or anesthetics? ..... YES NO

   If yes, please list: _____
7. Indicate which of the following you have had or have at present. Circle "yes or "no" to each item.

Heart Failure	YES	NO	Artificial Joints (hip, knee, etc.)	YES	NO	Allergy to Latex	YES	NO
Heart Disease or Attack	YES	NO	Kidney Trouble	YES	NO	Hepatitis B (serum)	YES	NO
Angina Pectoris	YES	NO	Ulcers	YES	NO	Venereal Disease	YES	NO
Congenital Heart Disease	YES	NO	Diabetes	YES	NO	A.I.D.S.	YES	NO
Heart Murmur	YES	NO	Thyroid Problems	YES	NO	H.I.V. Positive	YES	NO
High Blood Pressure	YES	NO	Glaucoma	YES	NO	Cold Sores/Fever Blisters	YES	NO
Arteriosclerosis	YES	NO	Cancer	YES	NO	Blood Transfusion	YES	NO
Mitral Valve Prolapse	YES	NO	Emphysema	YES	NO	Hemophilia	YES	NO
Artificial Heart Valve	YES	NO	Chronic Cough	YES	NO	Anemia	YES	NO
Heart Pacemaker	YES	NO	Tuberculosis	YES	NO	Sickle Cell Disease	YES	NO
Heart Surgery	YES	NO	Asthma	YES	NO	Bruise Easily	YES	NO
Rheumatic Fever	YES	NO	Hay Fever/Sinus	YES	NO	Liver Disease	YES	NO
Arthritis or Rheumatism	YES	NO	Allergies or Hives	YES	NO	Yellow Jaundice	YES	NO
Stomach or Intestinal Disease	YES	NO	Radiation Therapy	YES	NO	Epilepsy or Seizures	YES	NO
Cortisone Medicine	YES	NO	Chemotherapy	YES	NO	Fainting or Dizzy Spells	YES	NO
Drug Addiction	YES	NO	Hepatitis A (infectious)	YES	NO	Tumors	YES	NO
Stroke	YES	NO	Mental Disorder	YES	NO	Developmentally Disabled	YES	NO

8. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? ..... YES NO
9. Do your ankles swell during the day? ..... YES NO
10. Do you use more than two pillows to sleep? ..... YES NO
11. Have you lost or gained more than 10 pounds in the past year? YES NO Loss or Gain_____
12. Do you ever wake up from sleep and feel short of breath? ..... YES NO
13. Are you on a special diet? YES NO Reason for special diet _____
14. Do you have or have you had any disease, condition, or problem not listed? ..... YES NO

    If yes, please list: _____

FOR WOMEN ONLY:

Are you pregnant? ☐ Yes, what month? _____ ☐ No Are you nursing? ☐ Yes ☐ No Are you taking birth control pills? ☐ Yes ☐ No

CONSENT:

1. The undersigned hereby authorizes doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient) _____. I understand that using anesthetic agents embodies a certain risk. Futhermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1 - 1/2% finance charge (18% APR) may be added to my account, in addition to any collection charges.
4. I understand that where appropriate, credit bureau reports may be obtained.
5. I understand that it is my responsibility to advise your office of any changes in the information contained on this form.
6. I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature_____ Date_____

Parent or Responsible Party_____ Relationship to Patient_____

FOR OFFICE USE: Reviewed by Dr. _____ Date_____

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Barry E. Malkiel, D.D.S., P.C.

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 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)

Gwinnett Dental Images
916 Lawrenceville Hwy., S., Suite 201
Lawrenceville, GA 30046
770-995-9255

FINANCIAL POLICY

We are committed to providing you with the best possible dental care. Our fees reflect our professional commitment to excellence. In order to achieve these goals we need your assistance and understanding of our payment policy.

We Offer The Following Methods Of Payment Of Fees:

- Payment in full is due at time of service for those without insurance. A courtesy allowance of 5% is offered on fees over $500.00.
- For patients with insurance, we will accept payment directly from the insurance company, **however, we required that the deductible and non-covered fees be paid at each visit.**
- We partner with CareCredit for a financing option. To apply go to www.carecredit.com. If approved, print off approval with your account number and bring to your appointment.
-

Important Information Regarding Your Insurance:

- Your dental benefit program is a contract between you, your employer, and the insurance company. We are not a party to that contract. This office files your insurance as a courtesy for you.
- Not all dental services are covered benefit in all contracts. **It is your responsibility to know your benefits.**
- You (not your insurance company) are responsible to us for all of our fees for services rendered to you.
- An *Estimate* will be given of the benefits that the insurance company is expected to pay. Remember that this is only an estimate and that the actual cost may vary.
- If your insurance company does not pay within 90 days of your date of service then you will become responsible to pay at that time.

We Request 24 Hours Notice For Changing Appointments:

We do not overbook patients, therefore, time has been set aside exclusively for your appointment. We request the 24 hour notice to fill times with patients who are waiting for sooner times. If we do not receive 24 hours notice, we will charge a $50 broken appointment fee.

Collection Fees:

In the event payments are not received by the agreed upon dates, a 1-1/2% finance charge per month (18% APR) will be added to your account. If the account is sent to our collections attorney, *all collection fees and court costs will be your responsibility*. This will be reported on your credit report.

Patient Signature _____ Date _____

Parent or Responsible Party _____Relationship to Patient_____