WELCOME TO ANNISTON DENTAL GROUP

Thank You for Selecting Our Dental Team

To help us meet all your healthcare needs, please fill out this form completely in ink.

If you have any questions or need assistance, please ask us and we will be happy to help.

Patient Information (Confidential)

Name_____Date_____

SS#_____ Birthdate _____ Home Phone_____ CellPhone _____

Address_____City_____State/Prov._____Zip Code_____

Check Appropriate Box: ❑ Minor ❑Single ❑Married ❑Separated ❑Divorced ❑Widowed

Person Responsible for Account _____Phone _____Drivers License#_____

Is this Person Currently a Patient in our Office? ❑Yes ❑No

Patient's Place of Employment _____Work Phone_____

If Minor, Parent/Guardian's Place of Employment _____Work Phone_____

Spouse_____Employer_____Work Phone_____

Person to Contact in Case of Emergency_____Phone_____
(Person that does not live with you)

Whom May We Thank for Referring You? _____

Payment in full is due at each appointment.
For your convenience, we offer the following methods of payment, please check the option you prefer:
❑Cash ❑ Visa ❑ MasterCard

Insurance Information Relationship
Primary Insurance_____ Policy Holder_____ to Patient_____

Name of
Employer_____Birthdate_____SS#_____

Insurance Company _____Group #_____Policy ID#_____

Ins. Co. Address_____ City _____ State _____Zip Code _____

Do You Have Any Additional Insurance? **❑ Yes** **❑No** **If Yes, Complete The Following**
Relationship
Secondary Insurance _____Policy Holder_____ to Patient_____

Name of Employer_____Birthdate_____SS#_____

Insurance Company_____ Group # _____ Policy ID# _____

Ins. Co. Address_____City_____State_____ Zip Code_____

I understand and agree that any insurance quote given is an estimate only. X_____
Signature of Patient (or parent/guardian)

Back→

Dr. Karen Connell D.M.D. Anniston Dental Group, LLC 1613 Leighton Avenue Anniston, AL 36207

Effective Date of this Notice: August 14, 2002

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 (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In treating you, we will create medical records about you, and will comply with all laws regarding confidentiality of those records. Every member of our staff is trained and informed confidentiality and will follow this notice, including physicians, nursing staff, and office personnel. We will take all precautions to restrict access to confidential records by unauthorized persons.

Ways we may use your IIHI:

Treatment. Information is needed to properly evaluate, diagnose and treat you. It is required in order to prescribe medication, order laboratory tests, reschedule you for further treatments, evaluations, and discuss findings with you, your other physicians & caretakers etc., and family, if you desire. We will remind you of appointments.

Payment. If we file insurance for your, we will provide information to your insurer(s), or to other 3rd parties who may be paying on your behalf, so that we may obtain payment for our services. Statements of any possible outstanding bills will be sent to you, and may contain medical information.

Health Care Operations. Our practice may use and disclose your IIHI to operated our business, such as to evaluate quality of care given to you.

Other Reasons: Include disclosures required by federal, state or local law; certain special circumstances such as public health risks, health oversight activities, lawsuits, etc. This can include disclosures to medical examiners or coroners, military authorities, police investigations, and the like.

YOUR RIGHTS REGARDING YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI)

Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.

Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or health care operations and, to only certain individuals. **We are not required to agree to your request.** Your request must be in a clear & concise manner to our privacy officer given below.

Inspection and Copies. You have the right to inspect & obtain copies of your IIHI that may be used to make decisions about you by submitting your request in writing to the privacy officer. We may charge fees for the costs involved and in certain limited circumstances deny requests. You may request a review of our denial.

Amendment. You may request, in writing, an amendment of your health information if you believe it is incorrect or incomplete, for as long as information is kept by or for our practice. A request MUST provide a reason that supports your request. We will not amend something that, in our opinion, is accurate and complete.

Accounting of Disclosures. You have the right to request an "accounting of disclosures", a list of certain *non-routine* disclosures our practice might have made of your IIHI for non-treatment or operation purposes. These requests must be in writing & must state a time period, which may not be longer than years from the date of disclosure and may not include dates before April 14, 2003. Multiple requests within a 12-month period will be charged a fee.

Right to a Paper Copy of This Notice. You may ask us to give you a copy of this notice at any time.

Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of Department of Health and Human Services. To file a complaint with our office, contact the Privacy Officer. You will not be penalized for filing a complaint.

Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in authorization. Please note we are required to retain records of your care.

CHANGES TO THIS NOTICE: We reserve the right to make any changes to this notice, but a current copy will always be posted and available. Any complaints or requests are to be directed to our PRIVACY OFFICERS:

Stephanie Nunn or Denise Walling - - 1613 Leighton Avenue Anniston, AL 36207 **(256)236-6021**

I acknowledge, by signing below, that I have read and agree to the *Notice of Privacy Practices and Individual Rights*

_____ **Date:**_____

Patient or Patient's Guardian/ Representative

PAYMENT & TREATMENT CONSENT

Treatment: I hereby give my consent to Anniston Dental Group, L.L.C. for dental treatment, and I acknowledge that no guarantees or assurances have been made to me concerning the results intended from the procedure(s). I understand that during the course of the procedure(s), unforeseen conditions may arise which necessitate procedures different from those contemplated. I, therefore, consent to the performance of additional procedure(s) which the above named Dentist or his/her associates may consider necessary.

Insurance: Our professional services are rendered to you, not the insurance company. You should be aware that most insurance pays for only a portion of the cost of dental services. We are happy to help you file the necessary forms so that you receive the benefits to which you are entitled; however, we make no guarantee of any estimated coverage. We cannot be responsible for any changes in coverage. If payment from insurance carrier is not paid within 90 days of treatment day, the patient is responsible for the full amount. In case of default of payment, I promise to pay the balance due, together with any collection costs and attorney's fees incurred to affect collection of the account. I understand and agree to be fully responsible for the total payment for procedures in the office, and agree to these arrangements.

Payment: I agree to pay the difference between the allowed Blue Cross Blue Shield (or any other Dental Insurance Company) for a silver (amalgam) and the allowed fee for a white filling (composite or resin).For example: A provider submits a charge of $100.00 for a composite or resin filling (white filling). The PDP fee schedule for this service may be $90.00. Assuming 100% coverage, this service would be reimbursed as an amalgam (silver) filling at $68.00. Due to this we are allowed to bill the patient for the difference between an amalgam (silver) filling and a composite or resin (white) filling. So, if it is $100.00 and your Insurance allows $90.00, then we would accept the $68.00 for the amalgam fee and write off $10.00 (if BCBS-AL) and you would be billed for remaining. (This is just an example, not exact fees).

I understand that any insurance quote given is an estimate only and not a guarantee of payment.

_____

Signature of Patient or Guarantor

Date_____

_____

Signature of Office Representative

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? _____ _____ _____ _____	☐	☐
3. Are you allergic to or have you had any reaction to the following:		
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or any other Antibiotic	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other_____	☐	☐
4. Have you ever taken Fen-Phen/Redux?	☐	☐
5. Do you use tobacco?	☐	☐
6. Do you use controlled substances?	☐	☐
7. Are you wearing contact lenses?	☐	☐
8. Please list any medication(s) including non-prescription medicine you are currently taking. _____ _____ _____ _____ _____		
9. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?		
10. Women only:		
Are you pregnant or think you may be pregnant?	☐	☐
Are you nursing?	☐	☐
Are you taking oral contraceptives?	☐	☐

11. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
AIDS or HIV Infection	☐	☐	Frequently Tired	☐	☐	Low Blood Pressure	☐	☐
Anemia	☐	☐	Glaucoma	☐	☐	Mitral Valve Prolapse	☐	☐
Angina	☐	☐	Hay Fever/Allergies	☐	☐	Radiation Therapy	☐	☐
Arthritis	☐	☐	Heart Disease	☐	☐	Recent Weight Loss	☐	☐
Asthma	☐	☐	Heart Murmur	☐	☐	Respiratory Problems	☐	☐
Cancer	☐	☐	Hepatitis/Jaundice	☐	☐	Rheumatic Fever	☐	☐
Cardiac Pacemaker	☐	☐	High Blood Pressure	☐	☐	Sexually Transmitted Disease	☐	☐
Chest Pains	☐	☐	High Cholesterol	☐	☐	Stomach Troubles/Ulcers	☐	☐
Diabetes	☐	☐	Joint Replacement/Implant	☐	☐	Stroke	☐	☐
Easily Winded	☐	☐	Kidney Diseases	☐	☐	Thyroid Problem	☐	☐
Emphysema	☐	☐	Leukemia	☐	☐	Tuberculosis	☐	☐
Epilepsy	☐	☐	Liver Disease	☐	☐	Other_____	☐	☐

Patient Dental History

Name of Previous Dentist _____ Date of Last Cleaning/Exam _____

Previous Dentist's Location _____ Did you have the same insurance with previous dentist? _____

	Yes	No
1. Do your gums bleed while brushing/flossing?	☐	☐
2. Do you feel pain or sensitivity to any teeth?	☐	☐
3. Do you have any sores or lumps in your mouth?	☐	☐
4. Have you had any head, neck, or jaw injuries?	☐	☐
5. Have you experienced any problems in your jaw; (clicking, pain, difficulty in chewing or opening)	☐	☐
6. Do you have frequent headaches?	☐	☐
7. Do you clench or grind your teeth?	☐	☐
8. Do you bite your lips or cheeks?	☐	☐
9. Have you had any difficult extractions before?	☐	☐
10. Any prolonged bleeding following extractions?	☐	☐
11. Have you had any orthodontic treatments?	☐	☐
12. Do you wear dentures or partials?	☐	☐
If yes, date of placement? _____		
13. Do you like your smile?	☐	☐

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including diagnosis and records of treatment to third party payer and/or health practitioners. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

X_____

Signature of patient(or parent/guardian, if minor)

ANNISTON DENTAL GROUP

NO SHOW/CANCELLATION POLICY

Due to the increased number of patients that do not show up for their scheduled appointments, or cancel/reschedule less than 24 hours in advance, other patients are waiting longer for scheduled appointments.

We want to be sure that all our patients can be evaluated and treated as soon as possible, so we ask that you please call our office at 256-236-6021 as soon as possible if you must cancel or reschedule an appointment. You may leave a message on the answering machine if it is after hours.

There will be a $25.00 charge for all patients who miss an appointment without giving a 24 hour (one business day) notice. The $25.00 non-cancellation fee must be paid by each individual prior to or on the next appointment date. No exceptions with be made.

If you no show for your appointment 3 consecutive times or if you cancel less than 24 hours in advance 5 consecutive times, you will not be allowed to schedule anymore appointments at our office.

If you have any questions regarding this policy, please contact Denise (Financial Coordinator) or Stephanie (Scheduling Coordinator) at 256-236-6021.

I have read the No Show/Cancellation policy above and understand that if I do not follow this policy I will be charged $25.00 to be paid before my next appointment.