HEALTH HISTORY & REGISTRATION

WELCOME TO OUR OFFICE! We will do our best to make your appointment as convenient and pleasant as possible. It is important to know your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone without your consent.

PATIENT INFORMATION

Patient's Name _____ Sex: M F Birthdate _____ Age_____ Today's Date _____

Home Address _____ City _____ State _____ Zip _____

Phone (Home) _____ (Work) _____ (Cell)_____

Please indicate one: Single _____Married _____Divorced _____Widowed_____, Soc. Sec # _____

Email Address: _____

SPOUSE/PARENT INFORMATION

Name of Spouse _____ Spouse's Birthdate _____ Work Phone _____

Name of Parent (If Minor) _____ Work Phone _____ May we contact you at work? Yes No

Address (If Different)_____ City _____ State _____ Zip _____

Are you a full time student? No Yes If Patient is a minor we need: Mother's DOB _____Father's DOB _____

ACCOUNT INFORMATION

Person responsible for account _____ Relationship _____

Phone (Home) _____ (Work) _____ Soc. Sec. # _____

Home Address _____ City _____ State _____ Zip _____

EMPLOYER INFORMATION

Employer Name _____

Occupation _____How long employed _____

EMERGENCY INFORMATION

Name_____ Phone _____

Address _____ City _____ State _____ Zip _____

Reason for this visit _____ Referred to us by _____

DENTAL INSURANCE INFORMATION (Primary Carrier)	SECONDARY COVERAGE
Insured's Name _____	Insured's Name _____
Insured's Employer_____	Insured's Employer_____
Insured's Soc. Sec # _____	Insured's Soc. Sec # _____
Insurance Company_____	Insurance Company _____

CONSENT:

The undersigned hereby authorizes the Doctor to take X-rays, study model, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents and injections embody a certain risk.

RESPONSIBILITY OF ACCOUNT:

I understand that responsibility for payment for Dental Services provided in this office for my self or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made.

PATIENT Signature (Parent if Minor) _____Date_____

Sign here to authorize insurance payment, _____

Signature on File

MEDICAL HEALTH FORM NO YES

Have you been instructed by a physician or dentist to take antibiotics before dental treatment? _____ _____

Are you under any medical treatment now? ……. _____ _____

If so, for what? _____

Have you been hospitalized within the last 5 years? ..... _____ _____

If so, for what? _____

Have you had any major operations? ..... _____ _____

If so, for what? _____

Are you taking any medications? (including over-the-counter & herbal)_____ _____ _____

Provide name of drug/ its purpose: _____

Physician's Name _____ Phone # _____

Date of Last Physical Exam _____ Last Blood Pressure Reading _____/_____

Are you allergic to any medications? Yes [ ] No [ ]

If "Yes", please circle or list: Penicillin Codeine Latex Local Anesthetics _____

Do you have, or have you ever had:

No	Yes		No	Yes		No	Yes	
___	___	Artificial heart valve/Prosthesis	____	____	Cortisone Medicine	____	____	Multiple Myeloma, Metastatic Cancer, Paget's Disease or Osteoporosis
____	____	Heart ailment / Murmur/ Defect	____	____	Diabetes	____	____	Pregnant or Nursing (**Now)**
____	____	High Blood Pressure	____	____	Drug Addiction	____	____	Psychiatric Treatment
____	____	Heart Attack/Heart Disease	____	____	Emphysema	____	____	Oral Bisphoshonates (Fosamax, Actonel, Boniva, Skelit,Didrorel)IV: (Aredia, Zometa)
____	____	Rheumatic Fever/ Rheumatic Heart disease	____	____	Epilepsy / Seizures	____	____	Seasonal Allergies/Hayfever
____	____	AIDS / HIV Positive	____	____	Fainting / Dizzy Spells	____	____	Stroke
____	____	Anemia/ Sickle Cell	____	____	Glaucoma	____	____	Tuberculosis (TB)
____	____	Arthritis / Rheumatism	____	____	Heart Pacemaker	____	____	Ulcers
____	____	Artificial Joints (i.e. hip)	____	____	Hepatitis A (infectious) or Hepatitis B (serum)	____	____	Venereal Disease / STD Type:_____
____	____	Asthma	____	____	Hemophilia / Excessive Bleeding	____	____	Hearing Impaired
____	____	Blood Transfusion	____	____	Kidney Trouble	____	____	Conditions NOT LISTED
____	____	Cancer/ Radiation Treatment	____	____	Liver Disease			
____	____	Chemotherapy (cancer)						

Name of previous Dentist? _____ Your last visit to the dentist? _____

Have you had any unusual difficulties with any previous dental treatment? YES NO

Are you apprehensive (nervous) about your dental treatment? ……. YES NO

If yes, have you had: Nitrous Oxide (Laughing gas), prior to treatment? YES NO

Are you satisfied with your past dentistry? ..... YES NO

Are your teeth sensitive to: ____hot, ___cold, ___ sweets, ___pressure? YES NO

Are you unhappy with the appearance of your teeth? ……. YES NO

Are you aware of grinding or clenching your teeth? ……. YES NO

Have you had periodontal (gum) treatments or seen a PERIODONTIST? YES NO

Do your gums bleed when you brush and floss your teeth? ……. YES NO

Have you ever had pain or noises in your jaw joint / TMJ? …….. YES NO

Do you, or have you ever smoked or used tobacco? ……. YES NO If so, type: _____ How long_____

Have you worn braces on your teeth: ORTHODONTICS? ……. YES NO If so, when: _____

Do you have skin reactions to jewelry? ……. YES NO

Do you currently wear a retainer, nightguard or partial? ……. YES NO

Is there anything that you prefer to talk to the Doctor in private about? YES NO

Date: _____ _____ _____

Patient Signature (Parent of Child) Dentist Signature

Shauna H. Mitchell, D.D.S. , P.C.
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU 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 4/14/03, and will remain in effect until we replace it.

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

USES AND DISCLOSURES 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 for you.

Healthcare Operation: 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, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of 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, or your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment 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: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or 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. 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 will charge you a $10.00 fee for expenses such as copies, xray's, and postage if you want the copies mailed to you.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost based fee for responding to these additional requests.

Questions or Concerns: If you have any questions or concerns about our privacy practices please let us know. Any concerns may also be submitted to the U.S. Dept. of Health & Human Services.

Restriction: you have the right to request that we place additional restrictions on our use or disclosure 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 payment 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.

Signature: _____ Date: _____

Signature for Dependents: _____ /Names: _____ _____
(If requested, we will provide a copy of this form)

SHAUNA H. MITCHELL, D.D.S., P.C.
3642 FLAKES MILL ROAD, SUITE B
DECATUR, GA 30034

Office Policies

We would like to thank you in advance for choosing our office for your dental needs. Our staff will estimate your co-payment and deductible. The amount the insurance company will pay varies. At the time of your visit, you will be financially responsible for the percentage or portion that is not covered by your dental insurance. Changes in benefits and exclusions, which may be unique to your policy, may result in a refund, or additional balance due after your insurance has paid.

If we have over estimated your benefits, a refund will be sent after your claim has been processed (4-6 weeks). If we have under estimated your benefits, you will be billed for the difference after your claim has been processed. *Missed and broken appointments without 24 hours notice will result in an $85.00 charge.*

We must emphasize that as dental care providers our relationship is with you and not your insurance company. As a courtesy to our patients we will bill your insurance company for you. **If your insurance company has failed to pay within 60 days, we will expect you to pay the balance of your bill in full.** If it is necessary for us to pursue collection efforts against you, you will be held responsible for applicable collection fees. It is your responsibility to provide updated insurance information.

White tooth colored fillings for back teeth are more difficult and time consuming than silver fillings. Therefore, they are a higher fee. Most insurance companies limit their benefits to the lesser fee. The patient will be responsible for the difference.

Consent to Dental Photography

In connection with dental services, I may be receiving from SHAUNA H. MITCHELL D.D.S., P.C. I agree and consent to allow photographs taken.

A full face photo will be taken for identification purposes. This photo will be uploaded into our computer program. Photographs may also be taken of before, during, and after completion of my dental treatments, to be used for dental records, research, education, public relations, patient counseling or other professional purposes. I further agree and consent that the photographs relating to my dental care may be published and re-published either separately or in connection with each other in dental photo albums, professional journals or dental books. My entire face will not be shown unless I give separate written consent. All photographs are the property of SHAUNA H. MITCHELL D.D.S., P.C.

If you have any questions, please feel free to ask us.

Signature_____ Date_____