PATIENT REGISTRATION

Patient Information:

First Name:_____ Last Name:_____ Middle Initial:_____

Address:_____

City, State, Zip:_____

Home Phone:_____ Work Phone: _____ Cell Phone:_____

Sex: ○ Female ○ Male Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth date:_____ Social Security #:_____

E-mail: _____ ☐ I would like to receive email correspondences

Patient is : ○ Responsible Party ○ Policy Holder

Responsible Party: (if someone other than the patient)

First Name:_____ Last Name:_____ Middle Initial:____

Address:_____

City, State, Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Birth date:_____ Social Security #:_____

○ Responsible Party is Policy Holder for Patient ○ Primary Policy Holder ○ Secondary Policy Holder

Smile Creations Dental

3245 Peachtree Pkwy, Suite H

Suwanee, GA 30024

I consent to be a patient at the above named office and agree to a radiographic and clinical examination. I also understand and consent to the following:

1. During the course of treatment, I may undergo procedures in all phases of dentistry including periodontics (gum treatment and surgery), oral surgery, endodontics (root canals), fixed and removable prosthodontics (crowns, bridges, and dentures), implant dentistry, restorative dentistry, temporomandibular disorder treatment, sleep apnea, treatment, oral pathology, pediatric dentistry, and radiography.

2. I will provide a thorough and complete medical history, supply a full list of my medications with dosages, and consent to my dentist communicating with my other medical practitioners to inquire about any aspect of my health history.

3. No guarantees can be made about treatment outcomes, restoration longevity, or prognoses. I understand that any branch of medicine, including dentistry, can involve unanticipated results.

4. I will pay in full any cost of treatment or insurance copayments according to the office's financial policy. **I understand that even if an insurance pre estimate is given or a procedure has been preapproved, I am responsible for any costs that my insurance does not cover.**

5. My treatment plan may change at any time and I will do my best to approach my dental care with optimism and open communication with my dentist, hygienist, and dental office staff.

6. I am welcome to ask questions about any aspects of my dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspects of my treatment that I am unsure about.

Patient Name:_____

Patient/Guardian Signature:_____

Date:_____

Time 2:23 PM

Smile Creations Dental

Medical History(Copy)

Date 9/13/2016

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication

Are you under a physician's care now?	◯Yes◯No	If yes
Have you ever been hospitalized or had a major operation?	◯Yes◯No	If yes
Have you ever had a serious head or neck injury?	◯Yes◯No	If yes
Are you taking any medications, pills, or drugs?	◯Yes◯No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯Yes◯No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯Yes◯No	If yes
Are you on a special diet?	◯Yes◯No	
Do you use tobacco? If yes, how much per day?	◯Yes◯No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Other?	☐	If yes
Do you use controlled substances?	◯Yes◯No	If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯Yes◯No	Cortisone Medicine ◯Yes◯No	Hemophilia ◯Yes◯No	Radiation Treatments ◯Yes◯No
Alzheimer's Disease ◯Yes◯No	Diabetes ◯Yes◯No	Hepatitis A ◯Yes◯No	Anaphylaxis ◯Yes◯No
Drug Addiction ◯Yes◯No	Hepatitis B or C ◯Yes◯No	Renal Dialysis ◯Yes◯No	Anemia ◯Yes◯No
Easily Winded ◯Yes◯No	Herpes ◯Yes◯No	Rheumatic Fever ◯Yes◯No	Angina ◯Yes◯No
Emphysema ◯Yes◯No	High Blood Pressure ◯Yes◯No	Rheumatism ◯Yes◯No	Arthritis/Gout ◯Yes◯No
Epilepsy or Seizures ◯Yes◯No	High Cholesterol ◯Yes◯No	Scarlet Fever ◯Yes◯No	Artificial Heart Valve ◯Yes◯No
Excessive Bleeding ◯Yes◯No	Hives or Rash ◯Yes◯No	Shingles ◯Yes◯No	Artificial Joint ◯Yes◯No
Excessive Thirst ◯Yes◯No	Hypoglycemia ◯Yes◯No	Sickle Cell Disease ◯Yes◯No	Asthma ◯Yes◯No
Fainting Spells/Dizziness ◯Yes◯No	Irregular Heartbeat ◯Yes◯No	Sinus Trouble ◯Yes◯No	Blood Disease ◯Yes◯No
Frequent Cough ◯Yes◯No	Kidney Problems ◯Yes◯No	Spina Bifida ◯Yes◯No	Blood Transfusion ◯Yes◯No
Frequent Diarrhea ◯Yes◯No	Leukemia ◯Yes◯No	Stomach/Intestinal Disease ◯Yes◯No	Breathing Problems ◯Yes◯No
Frequent Headaches ◯Yes◯No	Liver Disease ◯Yes◯No	Stroke ◯Yes◯No	Bruise Easily ◯Yes◯No
Genital Herpes ◯Yes◯No	Low Blood Pressure ◯Yes◯No	Cancer ◯Yes◯No	Glaucoma ◯Yes◯No
Lung Disease ◯Yes◯No	Thyroid Disease ◯Yes◯No	Chemotherapy ◯Yes◯No	Hay Fever ◯Yes◯No
Mitral Valve Prolapse ◯Yes◯No	Tonsilitis ◯Yes◯No	Chest Pains ◯Yes◯No	Heart Attack/Failure ◯Yes◯No
Osteoporosis ◯Yes◯No	Tuberculosis ◯Yes◯No	Cold Sores/Fever Blisters ◯Yes◯No	Heart Murmur ◯Yes◯No
Pain in Jaw Joints ◯Yes◯No	Tumors or Growths ◯Yes◯No	Congenital Heart Disorder ◯Yes◯No	Heart Pacemaker ◯Yes◯No
Parathyroid Disease ◯Yes◯No	Ulcers ◯Yes◯No	Convulsions ◯Yes◯No	Heart Trouble/Disease ◯Yes◯No
Psychiatric Care ◯Yes◯No	Venereal Disease ◯Yes◯No	Yellow Jaundice ◯Yes◯No	Recent Weight Loss ◯Yes◯No

Have you ever had any serious illness not listed ◯Yes◯No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date:_____

Smile Creations Dental

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Dental Practice Covered by this Notice

This Notice describes the privacy practices of Smile Creations Dental ("Dental Practice"). "We" and "our" means the Dental Practice. "You" and "your" means our patient.

II. How to Contact Us/Our Privacy Official

If you have any questions or would like further information about this Notice, you can contact Smile Creations Dental's Privacy Official at:

Natasha Lisin-Queen, DMD
3245 Peachtree Pkwy, Suite H
Suwanee, GA 30075
(470) 239-8110
(678) 807-5428
office@smilecreationsdental.org

III. Our Promise to You and Our Legal Obligations

The privacy of your health information is important to us. We understand that your health information is personal and we are committed to protecting it. This Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected health information is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required by law to:

- Maintain the privacy of your protected health information;
- Give you this Notice of our legal duties and privacy practices with respect to that information; and
- Abide by the terms of our Notice that is currently in effect.

IV. Last Revision Date

This Notice was last revised on MARCH 1ST, 2018.

V. How We May Use or Disclose Your Health Information

The following examples describe different ways we may use or disclose your health information. These examples are not meant to be exhaustive. We are permitted by law to use and disclose your health information for the following purposes:

A. Common Uses and Disclosures

1. Treatment. We may use your health information to provide you with dental treatment or services, such as cleaning or examining your teeth or performing dental procedures. We may disclose health information about you to dental specialists, physicians, or other health care professionals involved in your care.

2. Payment. We may use and disclose your health information to obtain payment from health plans and insurers for the care that we provide to you.

3. Health Care Operations. We may use and disclose health information about you in connection with health care operations necessary to run our practice, including review of our treatment and services, training, evaluating the performance of our staff and health care professionals, quality assurance, financial or billing audits, legal matters, and business planning and development.

4. Appointment Reminders. We may use or disclose your health information when contacting you to remind you of a dental appointment. We may contact you by using a postcard, letter, phone call, voice message, text or email.

5. Treatment Alternatives and Health-Related Benefits and Services. We may use and disclose your health information to tell you about treatment options or alternatives or health-related benefits and services that may be of interest to you.

6. Disclosure to Individuals Involved in Your Care or Payment for Your care. We may disclose your health information to a family member or friend who is involved with your care or payment for your care if you do not object or, if you are not present, we believe it is in your best interest to do so. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to you health information.

7. Disclosure to Business Associates. We may disclose your protected health information to our third-party service providers (called, "business associates") that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use a business associate to assist us in maintaining our practice management software. All of our business associates are obligated, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

B. Less Common Uses and Disclosures

1. Disclosures Required by Law. We may use or disclose patient health information to the extent we are required by law to do so. For example, we are required to disclose patient health information to the U.S. Department of Health and Human Services so that it can investigate complaints or determine our compliance with HIPAA.

2. Public Health Activities. We may disclose patient health information for public health activities and purposes, which include: preventing or controlling disease, injury or disability; reporting births or deaths; reporting child abuse or neglect; reporting adverse reactions to medications or foods; reporting product defects; enabling product recalls; and notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

3. Victims of Abuse, Neglect or Domestic Violence. We may disclose health information to the appropriate government authority about a patient whom we believe is a victim of abuse, neglect or domestic violence.

4. Health Oversight Activities. We may disclose patient health information to a health oversight agency for activities necessary for the government to provide appropriate oversight of the health care system, certain government benefit programs, and compliance with certain civil rights laws.

5. Lawsuits and Legal Actions. We may disclose patient health information in response to (i) a court or administrative order or (ii) a subpoena, discovery request, or other lawful process that is not ordered by a court if efforts have been made to notify the patient or to obtain an order protecting the information requested.

6. Law Enforcement Purposes. We may disclose your health information to a law enforcement official for a law enforcement purposes, such as to identify or locate a suspect, material witness or missing person or to alert law enforcement of a crime.

7. Coroners, Medical Examiners and Funeral Directors. We may disclose your health information to a coroner, medical examiner or funeral director to allow them to carry out their duties.

8. Organ, Eye and Tissue Donation. We may use or disclose your health information to organ procurement organizations or others that obtain, bank or transplant cadaveric organs, eyes or tissue for donation and transplant.

9. Research Purposes. We may use or disclose your information for research purposes pursuant to patient authorization waiver approval by an Institutional Review Board or Privacy Board.

10. Serious Threat to Health or Safety. We may use or disclose your health information if we believe it is necessary to do so to prevent or lessen a serious threat to anyone's health or safety.

11. Specialized Government Functions. We may disclose your health information to the military (domestic or foreign) about its members or veterans, for national security and protective services for the President or other heads of state, to the government for security clearance reviews, and to a jail or prison about its inmates.

12. Workers' Compensation. We may disclose your health information to comply with workers' compensation laws or similar programs that provide benefits for work-related injuries or illness.

VI. Your Written Authorization for Any Other Use or Disclosure of Your Health Information

Uses and disclosures of your protected health information that involve the release of psychotherapy notes (if any), marketing, sale of your protected health information, or other uses or disclosures not described in this notice will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke this authorization at any time, in writing, except to the extent that this office has taken an action in reliance on the use of disclosure indicated in the authorization. If a use or disclosure of protected health information described above in this notice is prohibited or materially limited by other laws that apply to use, we intend to meet the requirements of the more stringent law.

VII. Your Rights with Respect to Your Health Information

You have the following rights with respect to certain health information that we have about you (information in a Designated Record Set as defined by HIPAA). To exercise any of these rights, you must submit a written request to our Privacy Official listed on the first page of this Notice.

A. Right to Access and Review

You may request to access and review a copy of your health information. We may deny your request under certain circumstances. You will receive written notice of a denial and can appeal it. We will provide a copy of your health information in a format you request if it is readily producible. If not readily producible, we will provide it in a hard copy format or other format that is mutually agreeable. If your health information is included in an Electronic Health Record, you have the right to obtain a copy of it in an electronic format and to direct us to send it to the person or entity you designate in an electronic format. We may charge a reasonable fee to cover our cost to provide you with copies of your health information.

B. Right to Amend

If you believe that your health information is incorrect or incomplete, you may request that we amend it. We may deny your request under certain circumstances. You will receive written notice of a denial and can file a statement of disagreement that will be included with your health information that you believe is incorrect or incomplete.

C. Right to Restrict Use and Disclosure

You may request that we restrict uses of your health information to carry out treatment, payment, or health care operations or to your family member or friend involved in your care or the payment for your care. We may not (and are not required to) agree to your requested restrictions, with one exception: If you pay out of your pocket in full for a service you receive from us and you request that we not submit the claim for this service to your health insurer or health plan for reimbursement, we must honor that request.

D. Right to Confidential Communications, Alternative Means and Locations

You may request to receive communications of health information by alternative means or at an alternative location. We will accommodate a request if it is reasonable and you indicate that communication by regular means could endanger you. When you submit a written request to the Privacy Official listed on the first page of this Notice, you need to

provide an alternative method of contact or alternative address and indicate how payment for services will be handled.

E. Right to an Accounting of Disclosures

You have a right to receive an accounting of disclosures of your health information for the six (6) years prior to the date that the accounting is requested except for disclosures to carry out treatment, payment, health care operations (and certain other exceptions as provided by HIPAA). The first accounting we provide in any 12-month period will be without charge to you. We may charge a reasonable fee to cover the cost for each subsequent request for an accounting within the same 12-month period. We will notify you in advance of this fee and you may choose to modify or withdraw your request at that time.

F. Right to a Paper Copy of this Notice

You have the right to a paper copy of this Notice. You may ask us to give you a paper copy of the Notice at any time (even if you have agreed to receive the Notice electronically). To obtain a paper copy, ask the Privacy Official.

G. Right to Receive Notification of a Security Breach

We are required by law to notify you if the privacy or security of your health information has been breached. The notification will occur by first class mail within sixty (60) days of the event. A breach occurs when there has been an unauthorized use or disclosure under HIPAA that compromises the privacy or security of your health information.

The breach notification will contain the following information: (1) a brief description of what happened, including the date of the breach and the date of the discovery of the breach; (2) the steps you should take to protect yourself from potential harm resulting from the breach; and (3) a brief description of what we are doing to investigate the breach, mitigate losses, and to protect against further breaches.

VIII. Special Protections for HIV, Alcohol and Substance Abuse, Mental Health and Genetic Information

Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including HIV-related information, alcohol and substance abuse information, mental health information, and genetic information. For example, a health plan is not permitted to use or disclose genetic information for underwriting purposes. Some parts of this HIPAA Notice of Privacy Practices may not apply to these types of information. If your treatment involves this information, you may contact our office for more information about these protections.

IX. Our Right to Change Our Privacy Practices and This Notice

We reserve the right to change the terms of this Notice at any time. Any change will apply to the health information we have about you or create or receive in the future. We will promptly revise the Notice when there is a material change to the uses or disclosures, individual's rights, our legal duties, or other privacy practices discussed in this Notice. We will post the revised Notice on our website (if applicable) and in our office and will provide a copy of it to you on request. The effective date of this Notice is March 1, 2016.

X. How to Make Privacy Complaints

If you have any complaints about your privacy rights or how your health information has been used or disclosed, you may file a complaint with us by contacting our Privacy Official listed on the first page of this Notice.

You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you in any way if you choose to file a complaint.

Patient Consent for Electronic Communication

You have requested that our practice communicate with you either electronically OR text via cell phone. By utilizing our practice's electronic services, you agree that Smile Creations Dental may send to you any of the following that you identify as communication that can be sent through the Internet to an email address or a text via cell phone that you designate in previous patient records.

Consent and Acknowledgement
I, in the presence of my dentist or the dental practice's privacy official, agree that the practice may electronically communicate with me at the email address provided in patient records or text via cell phone.

Items that may be sent via email or text include:
Information about an invoice or accounts payable.
Information about any dental visit.
Email confirmation or text via cell phone of appointments/reminders.
Records request to or from Smile Creations Dental with other professional Dental/Medical offices

(I understand this will be the only confirmation of appointments and agree to provide 24 hour notice should I need to cancel/reschedule)

Please note:
All electronic communications from our practice will be encrypted.
I am responsible for providing the dental practice any updates to my email address or cell phone number.
I am able to receive information electronically & via text message and store it securely away from any public computer or cell phone.
I can withdraw my consent to electronic communications at any time by calling (470) 239-8110.

Please inform the front desk if you have any questions or objections to electronic communication so that we can ensure we take proper steps in communicating with you.

If you have a request for confidential communication (communication other than primary phone number and address), please speak with the front desk

_____ _____

Patient Signature Date

Appointments and Cancellations

When we make your appointment, we are reserving a room for your particular needs. We ask that if you must change an appointment, please give us at least 24 hours notice. This courtesy makes it possible to give your reserved room to another patient who would like it.

There is a $50 charge for not showing up for scheduled appointments*. Repeated cancellations or missed appointments will result in loss of future appointment privileges.*

We feel that our patient's time is valuable. When your appointment is made, a room is reserved, your records are prepared, and special instruments are readied for your visit. We take all measures to respect your time and appreciate your efforts in doing the same for us.

_____ _____

Patient Signature Date

Insurance Disclaimer

(Please read carefully)

Please note we do not accept nor participate with any DMO/HMO insurance plans, prepay plans, Medicaid or discount plans.

Our goal is to help you maximize your dental insurance benefits. As a courtesy, we are happy to bill your dental plan for services. When we call on your insurance and verify benefits it is not a guarantee of payment by the insurance company and may vary according to your individual plan when the actual claim is submitted.

Any treatment plan that our office proposes to you is an **estimate** of what your insurance coverage will be, it is not a guarantee. If you need **exact** payment of benefits, then a pretreatment is required. If you would like this done, you must specify to the office manager **before** any work is initiated. **(This takes 6-8 weeks).**

Please remember that the contract itemizing your dental benefits is between you, your employer, and your insurance company. Regardless of coverage, your estimated co-payment is due in full the day of treatment. If your insurance plan does not pay within **120 days** of treatment, you must pay any outstanding balance and seek reimbursement from your dental plan. If your dental plan pays more than expected, you will receive a refund check. Also remember dental insurance plans are not designed to cover all of your dental needs.

I have chosen to allow Smile Creations Dental to file my insurance and I accept full responsibility for this account and for all dentistry performed upon my family in this dental office. I understand it is my responsibility to be aware of what type of dental plan I have. I also understand this office cannot guarantee my insurance company will cover all services rendered and it is only an estimate of benefits. I also understand that if my insurance company does not pay within **120 days** of my date of service then I will become responsible to pay at that time.

Acknowledgement of Receipt of Notice of Privacy Practices

NATASHA A LISIN DMD PC

SMILE CREATIONS DENTAL

You May Refuse to Sign This Acknowledgement

I have reviewed a copy of this office's Notice of Privacy Practices

Print Name: _____

Signature: _____

Date: _____

For Office Use Only

Submit

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practice, but acknowledgement could not be obtained because:

___ Individual refused to sign

___ Communication barriers prohibited obtaining the acknowledgement

___An emergency situation prevented us from obtaining acknowledgement

___Other (Please specify)

_____
_____
_____