Marvin R. Winter, DDS 160 Clairemont Avenue | Suite 140 | Decatur, GA 30030 | 404.373.2667

1 Patient Information

Today's Date: _____ /_____ /_____

Mr Mrs Ms Dr Rev

Patient Name: _____
Last First MI

I Prefer to be Called: _____

SSN: _____

Date of Birth: _____ /_____ /_____ Male Female

Status: Single Married Widowed
Minor Life Partnership

Spouse/Partner Name: _____

Mailing Address: _____

_____
City State Zip

Home Phone # (_____)_____

Work Phone # (_____)_____ Ext: _____

Cell Phone # (_____)_____

Email Address: _____

Employer: _____

Occupation: _____

If Student, School Name: _____

How were you referred to us? _____

Other family members seen by us: _____

2 Account Information

Person responsible for payment of account:

Same as Patient Information

Name: _____

Relation to Patient: _____

Billing Address: _____

_____

SSN: _____ Date of Birth: _____ /_____ /_____

Home Phone # (_____)_____

Work Phone # (_____)_____ Ext: _____

Cell Phone # (_____)_____

3 Dental Insurance Information

Primary Dental Insurance

Ins Co Name: _____

Address: _____

_____

_____

Phone # (_____)_____

Employee's ID/SSN: _____

Employee's Date of Birth: _____ /_____ /_____

Relation to Patient: _____

Insured's Employer: _____

Group # (Plan, local, or policy #) _____

Secondary Dental Insurance

Ins Co Name: _____

Address: _____

_____

_____

Phone # (_____)_____

Employee's ID/SSN: _____

Employee's Date of Birth: _____ /_____ /_____

Relation to Patient: _____

Insured's Employer: _____

Group # (plan, local, or policy #) _____

_____
Initials

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.

4 In Event of Emergency

Emergency contact: _____

Relation: _____

Home Phone # (_____)_____

Work Phone # (_____)_____ Ext: _____

Cell Phone # (_____)_____

Name of Medical Doctor: _____

Phone # (_____)_____

5 Dental History

Previous Dentist: _____ Phone # (_____)_____

Date of most recent dental exam: _____ /_____ /_____ Date of most recent x-rays: _____ /_____ /_____

I see my dentist every: ◯ 3 mon ◯ 4 mon ◯ 6 mon ◯ 12 mon ◯ Not routinely

What is the reason for your visit today? _____

Do you or have you experienced any of the following?

YES	NO		YES	NO	
◯	◯	Currently experiencing dental pain or discomfort?	◯	◯	Difficulty swallowing any food?
◯	◯	Wish to change anything about the appearance of your teeth?	◯	◯	Unfavorable dental experience?
◯	◯	Complications from past dental treatment?	◯	◯	Does the amount of saliva in your mouth seem too little?
◯	◯	Pain or popping with your jaw joint?	◯	◯	Any cavities within the past 3 years?
◯	◯	Sensitivity to hot, cold, biting, sweets?	◯	◯	Previously seen or currently seeing a periodontist?
◯	◯	Gums bleed when brushing or flossing?	◯	◯	Any prior treatment for gum disease?
◯	◯	Unpleasant taste or odor in your mouth?	◯	◯	History of periodontal disease in your family?
◯	◯	Are you pregnant? # of weeks _____	◯	◯	Previous orthodontics or bite adjusted?
◯	◯	Currently taking birth control pills or hormone replacements?	◯	◯	Use tobacco?
◯	◯	Are you nursing?	◯	◯	Use controlled substances?

6 Medical History

Are you allergic to or have you had a reaction to:

YES	NO		YES	NO		YES	NO		YES	NO	
◯	◯	Aspirin	◯	◯	Dental anesthetics	◯	◯	Metals/Jewelry	◯	◯	Seasonal allergies
◯	◯	Codeine or other narcotics	◯	◯	Latex	◯	◯	Penicillin or other antibiotics	◯	◯	Sedatives

Other allergies not listed above: _____

Are you taking any of the following?

YES	NO		YES	NO		YES	NO		YES	NO	
◯	◯	Antiobiotics	◯	◯	Bisphosphonates	◯	◯	Digitalis/Heart medication	◯	◯	Steroids/Cortisone
◯	◯	Antihistamines	◯	◯	Blood pressure medication	◯	◯	Insulin/Diabetes medication	◯	◯	Thyroid medication
◯	◯	Aspirin	◯	◯	Blood thinners	◯	◯	Nitroglycerin	◯	◯	Tranquilizers

Other prescription or over-the-counter drugs not listed above: _____

Have you ever experienced the following?

YES	NO		YES	NO		YES	NO		YES	NO	
◯	◯	Abnormal bleeding	◯	◯	Congestive heart failure	◯	◯	Hepatitis	◯	◯	Rheumatic fever
◯	◯	Anemia	◯	◯	Damaged heart valves	◯	◯	High blood pressure	◯	◯	Rheumatic heart disease
◯	◯	Arthritis	◯	◯	Diabetes	◯	◯	HIV	◯	◯	Rheumatoid arthritis
◯	◯	Artifical heart valves	◯	◯	Eating disorder	◯	◯	Kidney problems	◯	◯	Seizures
◯	◯	Asthma	◯	◯	Emphysema	◯	◯	Low blood pressure	◯	◯	Sinus trouble
◯	◯	Autoimmune disease	◯	◯	Epilepsy	◯	◯	Lupus	◯	◯	Sleep disorder
◯	◯	Cancer	◯	◯	Gastrointestinal disease	◯	◯	Mental health disorders	◯	◯	Stroke
◯	◯	Cardiovascular disease	◯	◯	GE reflux/heartburn	◯	◯	Mitral valve prolapse	◯	◯	Swollen glands in neck
◯	◯	Chemotherapy/Radiation	◯	◯	Heart attack	◯	◯	Neurological disorders	◯	◯	Thryroid problems
◯	◯	Chronic pain	◯	◯	Heart murmur	◯	◯	Osteoporosis	◯	◯	Tuberculosis
◯	◯	Congenital heart defects	◯	◯	Hemophilia	◯	◯	Pacemaker	◯	◯	Ulcers

◯ ◯ Have you had an orthopedic total joint replacement? Date: _____

◯ ◯ Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?

Name of Physician making recommendation: _____ Phone # (_____)_____

Other medical conditions not listed above: _____

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that Dr. Winter and his staff wil rely on this information for treating me. I understand that it is my responsibility to inform this office of any changes in my medical status. I will not hold Dr. Winter, or any other member of his staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form. I authorize the dental staff to perform the necessary dental services I may need.

Signature of Patient/Legal Guardian:	_____	Date:	_____
Signature of Doctor:	_____	Date:	_____

Marvin R. Winter, D.D.S.

Financial Policy

Thank you for choosing our office for your dental needs. Obtaining dental treatment is very important for your overall health. We are committed to providing you with the best possible care. Please understand that payment of your bill is considered as part of your treatment. The following is a statement of our Financial Policy which we ask you to read and sign prior to any treatment.

PAYMENT

Payment is due on the day of treatment. If we accept assignment of insurance payment, the amount not covered by your insurance is due the day of treatment (your portion will be estimated). Total payment is due for first visits. You may find it more convenient to pay in full at the time of treatment, and we will direct your insurance company to pay you. Cash, Check, Visa, MasterCard, American Express or Discover are acceptable methods of payment.

INSURANCE

Your complete insurance information must be presented at the time services are provided.

As a courtesy, we are happy to help you by submitting insurance claims. However, our office does not guarantee payment or coverage by your insurance company. Your dental benefit plan is a contract between your employer, or plan sponsor, and the insurance company. We are not a party to that contract. Some plans require you to choose your dental care from a list of providers. Our office is not a participating provider for any insurance company. This means that we will be considered "Out of Network". Dental insurance usually pays only a portion of your charges and we urge you to be fully aware of the provisions of your dental plan. Please be advised that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and customary under the terms of your insurance policy. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Dental insurance does not always provide coverage with your dental health in mind. We will diagnose with the best interest of ***your dental health***, not your insurance, as our primary concern.

A late charge will be added to your account on any unpaid balances including outstanding amounts to be paid by your insurance company. We will not accept responsibility for your insurance company's delay of payment.

CANCELLATIONS

If you must cancel an appointment, we request 24 hours notice. If we do not receive 24 hours notice, we reserve the right to charge for the cancelled time. The cancellation fee must be paid prior to being given another appointment.

Print Name Signature Date

Marvin R. Winter, D.D.S.

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. The Notice takes effect 04/14/03, 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.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USED 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 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, 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 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 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 or Neglect: We may disclose your health information to appropriate authorities if we reasonable 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. 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. You may obtain a form to request access by used the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0._____ for each page, $_____ per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

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.

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 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. (You request my be in writing, and it my explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this notice on our Web site 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 or privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or your 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 use using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with 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 chose to file a complaint with us or with the U.S. Department of Health and Human Services.

Privacy Officer: Kari Taunton
160 Clairemont Avenue
Suite 140
Decatur, GA 30030
Telephone: 404-373-2667
Fax: 404-373-7022

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue S.W.
Room 509F, HHH Building
Washington, D.C. 20201

Marvin R. Winter, D.D.S.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

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. A copy of our *Notice* accompanies 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.* 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.

I have received a copy of this office's *Notice of Privacy Practices*. I have had full opportunity to read and consider the contents of this consent form and the *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 healthcare operations.

_____

Print Name **Signature** **Date**

If a personal representative on behalf of the patient signs this consent, complete the following:

_____

Representative Name **Relationship to Patient**

Right to Revoke: You have the right to revoke this consent at any time by giving us written notice of your revocation. 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 that we may decline to treat you or to continue treating you if you revoke this consent.