

Patient Health Record/Update

Name _____ Date _____
 Age _____ Date of Birth _____ SS# _____
 Home Address _____ City/Zip _____
 Home Phone _____ Mobile Phone _____ Work Phone _____
 May we leave a voice message? Yes No
 Emergency Contact Name _____ Phone Number _____
 Insurance Co _____ Name of Insured _____ Employer _____
 ID# _____ Gp# _____ DOB of Insured _____
 How did you find us? Billboard Website Church Bulletin Pinecrest Academy Patient Other _____
 Date of Last Physical Exam _____ Name of Physician _____
 Pharmacy Name/Number _____
 Have you been hospitalized or under a Physician's Care in the past 2 years? Yes No If yes, for _____
 Any major surgeries? Yes No If yes, please describe. _____
 Knee or Hip Replacement? Yes No Date _____ Do you take antibiotics prior to dental work? Yes No
 Pregnant or Nursing? Yes No Do you take birth control pills? Yes No
 Do you take osteoporosis meds, Fosamax, Boniva or other bisphosphonates? Yes No
 Allergic to: Latex Local Anesthetics Penicillin Aspirin NSAIDS Codeine Foods
 Please list **ALL** medications **and** supplements:

Have you had, or do you now have:

High Cholesterol	<input type="checkbox"/>	Emphysema/COPD	<input type="checkbox"/>	Respiratory Issues	<input type="checkbox"/>
High blood Pressure	<input type="checkbox"/>	Epilepsy/Seizures	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>
Atrial Fibrillation	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	STD	<input type="checkbox"/>
ADD/ADHD	<input type="checkbox"/>	Gastric Reflux	<input type="checkbox"/>	Severe Gag Reflex	<input type="checkbox"/>
AIDS/HIV Positive	<input type="checkbox"/>	Heart Attack Date _____	<input type="checkbox"/>	Sickle Cell Anemia	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	Sleep Apnea	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	Herpes/Fever Blisters	<input type="checkbox"/>	Smoke/Dip	<input type="checkbox"/>
Angina/Chest Pain	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	Stroke Date _____	<input type="checkbox"/>
Artificial Heart Valves	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>
Artificial Joints	<input type="checkbox"/>	Organ Transplant	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	Stomach Ulcers	<input type="checkbox"/>
Cancer/Type _____	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	Anything Not Listed _____	
Chemotherapy	<input type="checkbox"/>	Prolonged Bleeding	<input type="checkbox"/>		
Compromised Immunity	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/> I understand that withholding	
Congenital Heart Defect	<input type="checkbox"/>	Prolonged Cough	<input type="checkbox"/>	information could seriously	
Diabetes	<input type="checkbox"/>	Psychiatric Care	<input type="checkbox"/>	jeopardize my safety and I have	
Diarrhea	<input type="checkbox"/>	Recreational Drug Use	<input type="checkbox"/>	answered truthfully to the best of	
Drug Dependency	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	my knowledge.	

I consent to a dental exam including x-rays, photographs, study models or other diagnostic aids deemed appropriate by the doctor to make a complete diagnosis of my current dental condition.

Signature _____

Date _____

Adult Dental History

Name: _____ Date: _____
Cell number: _____ Email: _____

Please answer the following questions so that we have a better understanding of your dental concerns and expectations. *Thank you again for choosing us as your dental home.*

1. The following best describes my attitude toward my dental health:
 - I want to be completely informed of my oral health condition and want the best treatment possible to keep my teeth for life.
 - I want to be completely informed of my current dental condition and only want options to improve it for a time.
 - At this time I'm only interested in my immediate problem.

2. If you do need dental treatment, your wishes would best be described as:
 - Wanting the best restoration possible that will last the longest.
 - Wanting the least expensive restoration that will get me by for now.

3. Have you had poor dental experiences? Yes No If yes, please describe

4. Does dental treatment make you nervous? **Yes, I need laughing gas for treatment.**
 Not at all
 A Little

5. Why did you leave your previous dentist?

6. When do you recall having your last dental cleaning/xrays taken? _____

7. Are you concerned with the mercury silver metal fillings in your mouth? Yes No

8. If there was anything you could change about your smile or current dental condition what would it be? _____

9. Are you in any dental pain right now? No Yes,
If yes, describe _____

10. Do you have any present concerns or expectations I should know about?

11. Have you maintained professional dental care at least every 6 months? Yes No
If not, what is the main reason you've delayed it? _____

12. Some patients have flexible or rigid schedules. Are you better suited to be on
 last minute appointment opening call list OR
 committed to a set pre booked appointment time?

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 9/23/13 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.

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 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/Fundraising Health-Related Services: We will not use or sell your health information for marketing or fundraising communications without your written authorization. Furthermore, we will inform you if there are any financial conflicts of interest with the dentist(s) and any products or services utilized within the practice as part of treatment.

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 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. 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 using 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 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.

Breach of Information: You will be notified of any breach of your personal information within a timely manner.

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 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. (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 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 our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you 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 us 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 the 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 choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Stephanie O'Rourke, DMD

Telephone: 770-888-6285

Fax: 770-844-9119

E-mail: Info@MyCummingDentist.com

Address: 757 Peachtree Parkway Cumming GA 30041

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This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002; April 30, 2009).

O'Rourke Family and Cosmetic Dentistry

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient #: _____ 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: Stephanie O'Rourke, DMD

Telephone: 770-888-6285 Fax: 770-844-9119

Email: Info@MyCummingDentist.com

Address: 757 Peachtree Parkway Cumming GA 30041

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 that 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.

REVOCAION 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: _____

Financial Responsibility

Thank you for choosing O'Rourke Family & Cosmetic Dentistry. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of this mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options

Cash, Check, Visa, Mastercard, American Express and Discover

To qualify for our 5% discount, you must PrePay for your treatment in FULL with Cash or Check prior to your scheduled treatment appointment.

Monthly Financing Options Available:

* NO INTEREST Payment Plans from CareCredit
Allow you to pay over time, 6-12 months, with NO interest (subject to credit approval). No annual fees or pre-payment penalties



For Patients with Dental Insurance:

For patients with dental insurance: we are happy to work with your primary dental insurance carrier to maximize your benefit and directly bill them for reimbursement for your treatment. You are responsible for your estimated payment at time of service.

We are Non Participating providers for all insurance. Some insurances companies pay the patient directly, not us. This is a function of each specific plan your employer has chosen for you. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract.

Please remember you are fully responsible for all charges by this office regardless of your insurance coverage. We will file ONE appeal on your behalf. If your insurance carrier has not paid the claim within 60 days, your are responsible for the entire balance and finance charges of 18% APR will incur. A \$25 late fee may be assessed on your account if amount due is not paid by due date.

O'Rourke Family & Cosmetic Dentistry charges \$35 for returned checks.

\$50 will be charged to your account for missed dental appointments without 24 hour notice.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want and need.

Patient, Parent or Guardian Signature: _____ Date: _____

Patient Name (Please Print) _____

O'Rourke Family & Cosmetic Dentistry

757 Peachtree Pkwy #1 | CUMMING GA, 30041 | (770) 888-6285

FACTS YOU SHOULD KNOW ABOUT INSURANCE

Thank you for choosing O'Rourke Family & Cosmetic Dentistry. We strongly feel our patients deserve the best possible care and we would like to share some facts about dental insurance with you.

Fact 1: Dental insurance is NOT meant to be a PAY-ALL, it's only meant to aid.

Fact 2: Many plans tell their insured they will be covered "up to 80%-100%." Despite what you are told, we have found that most plans cover 40% to 70% of an average fee. The amount that your plan pays is determined by THEIR fee schedule and those benefits are largely based on how much your employer paid for the plan. Remember, you get back only what the employer puts in, less the profits of the insurance company. Most insurance plans have a maximum benefit and a deductible each year that has not changed since the 1970's.

Fact 3: It has been the experience of many dentists that some insurances tell their customers the "fees are above the usual and customary fee" when a much more accurate statement would be, "Any difference in the fee charged, and the benefits paid, is due to limitations in the plan contract."

Fact 4: Some dental services are not covered by insurance carriers. Please do not hesitate to ask us any questions about our policies. We want you to be comfortable in dealing with these matters, and we urge you to consult with us if you have any questions regarding our services and/or fees. We will gladly file with your insurance company and will make every effort to maximize your insurance benefits.

However, please remember that ultimately, you are financially responsible for your account with our office, not your insurance company.

I authorize payment of dental treatment directly to O'Rourke Family and Cosmetic Dentistry for all dental services:

I authorize release of any dental information necessary to process insurance claims:

Signature

Date