

# PATIENT REGISTRATION

TODAY'S DATE \_\_\_\_\_ Home Phone # \_\_\_\_\_

Patient \_\_\_\_\_  
Last name First name Initial circle or add: (Mr., Ms., Mrs., Dr., Hon.)

I prefer to be called \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Birthdate \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Age \_\_\_\_\_

Full Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

E-mail Address \_\_\_\_\_ Cell Phone # \_\_\_\_\_

Married \_\_\_\_\_ Single \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_ Separated \_\_\_\_\_

Employer Name & Address \_\_\_\_\_ Office Phone # \_\_\_\_\_

Position \_\_\_\_\_ Office Fax # \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

General Dentist Name \_\_\_\_\_ Phone # \_\_\_\_\_

Other family members seen by us \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Employer \_\_\_\_\_

Spouse's Daytime # \_\_\_\_\_ Occupation \_\_\_\_\_

Person Responsible for Account: (only if patient is a minor or disabled)

Name \_\_\_\_\_ Daytime # \_\_\_\_\_

Street/City/State/Zip \_\_\_\_\_

Employer/Address \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Birthdate \_\_\_\_\_ Relationship to patient \_\_\_\_\_

I agree to be financially responsible for the above patient \_\_\_\_\_

Payment for services are due at the time of treatment. We do not offer financing. American Express, Visa, Mastercard, Discover, cash, checks, and CareCredit® are accepted.

If unable to keep a reserved appointment we request notice of 2 business days and reserve the right to charge a broken appointment fee up to \$500.00 for repeated late cancellations or no show.

## Regarding Dental Insurance: ***WE ARE OUT OF NETWORK WITH ALL CARRIERS***

We offer insurance billing assistance for treatment fees of \$500.00 or more. You must provide current information and a signed consent/authorization form to be kept on file. If you choose to reserve an appointment before your carrier's pretreatment estimate has processed, we require fees to be paid at the time of service. You as the patient assume financial responsibility for your care.

For services under \$500.00 we provide an attending dentist statement for you to submit to your insurance carrier. If your insurance carrier has any requests for radiographs or records, we will need your signed consent on file in your chart.

Primary Carrier Name and Address: \_\_\_\_\_

Patient relationship to employee: \_\_\_\_\_ Subscriber birthdate: \_\_\_\_\_ Subscriber sex: M F

Subscriber name and address: \_\_\_\_\_

Subscriber ID # \_\_\_\_\_ Policy # \_\_\_\_\_

Subscriber's Employer: \_\_\_\_\_

Are you covered by a Secondary Plan? Yes or No If so:

Secondary Carrier Name and Address: \_\_\_\_\_

Patient relationship to employee: \_\_\_\_\_ Subscriber birthdate: \_\_\_\_\_ Subscriber sex: M F

Subscriber name and address: \_\_\_\_\_

Subscriber ID # \_\_\_\_\_ Policy # \_\_\_\_\_

Subscriber's Employer: \_\_\_\_\_

I have been informed of the treatment plan and fees. I agree to be responsible for all fees for services and materials not paid by my dental benefit plan. To the extent permitted by law I consent to your use of my protected health information to carry out payment activities in connection with this:

\_\_\_\_\_ Date \_\_\_\_\_

I hereby authorize payment of the benefits otherwise payable to me directly to Dental Specialists of Buckhead.

\_\_\_\_\_ Date \_\_\_\_\_

## HEALTH HISTORY

**NAME** \_\_\_\_\_

Do you have a personal physician? ☐ Yes ☐ No

Physicians name \_\_\_\_\_

Phone # \_\_\_\_\_ Last visit \_\_\_\_\_

In the event of an emergency, who do we call:

Name \_\_\_\_\_

Relation \_\_\_\_\_

Home# \_\_\_\_\_

Office# \_\_\_\_\_

Are you currently under the care of a physician? ☐ Yes ☐ No

Which condition/s? \_\_\_\_\_

Have you had any RECENT SURGERY? ☐ Yes ☐ No

### MEDICATIONS

Are you currently taking prescription or over-the-counter drugs or herbal supplements? ☐ Yes ☐ No

Please list here: \_\_\_\_\_

Are you on aspirin therapy? ☐ Yes ☐ No

Do you take Ginger, Ginseng, Ginko Biloba, and/or Garlic? ☐ Yes ☐ No

Which? \_\_\_\_\_

*Attach separate list if necessary*

Pharmacy name and phone #: \_\_\_\_\_

### ALLERGIES: Please check if you have

☐ Aspirin ☐ Local Anesthetic

☐ Codeine ☐ Penicillin

☐ Latex ☐ Sulfa

☐ Erythromycin

☐ Others \_\_\_\_\_

**Do you require premedication with antibiotics before dental treatment?**

☐ Yes or ☐ No

For what condition \_\_\_\_\_

Do you or have you ever used:

☐ Tobacco? Frequency \_\_\_\_\_

☐ Alcohol? Frequency \_\_\_\_\_

☐ Controlled substances? Frequency \_\_\_\_\_

### WOMEN ONLY

Are you pregnant? ☐ Yes ☐ No Week \_\_\_\_\_

Are you taking birth control pills? ☐ Yes ☐ No

Are you nursing? ☐ Yes ☐ No

Hormone replacement therapy ☐ Yes ☐ No

Have you had a Pap Smear? ☐ Yes ☐ No

**Check illnesses or symptoms you currently have or had the the past**

- ☐ ACID REFLUX
- ☐ AIDS/HIV
- ☐ ANEMIA
- ☐ ARTHRITIS OR RHEUMATISM
- ☐ ARTIFICIAL HEART VALVES
- ☐ ARTIFICIAL JOINTS
- ☐ ASTHMA
- ☐ AUTO-IMMUNE DISORDERS
- ☐ BACK PROBLEMS
- ☐ BENIGN ESSENTIAL TREMOR
- ☐ BLEEDING ABNORMALLY
- ☐ BLOOD DISEASE
- ☐ CANCER
- ☐ CHEMICAL DEPENDENCY
- ☐ CHEMOTHERAPY
- ☐ CIRCULATORY PROBLEMS
- ☐ CONGENITAL HEART LESIONS
- ☐ CORTISONE TREATMENTS
- ☐ COUGH, PERSISTANT OR BLOODY
- ☐ COVID 19
- ☐ CROHN'S DISEASE/INFLAMMATORY BOWEL DISEASE
- ☐ DIABETES
- ☐ EMPHYSEMA
- ☐ EPILEPSY
- ☐ FAINTING OR DIZZINESS
- ☐ GLAUCOMA
- ☐ GOUT
- ☐ HEADACHES
- ☐ HEART MURMUR
- ☐ HEART PROBLEMS
- ☐ HEPATITIS, TYPE \_\_\_\_\_
- ☐ HERPES
- ☐ HIGH BLOOD PRESSURE
- ☐ HIGH CHOLESTEROL
- ☐ ORAL CANCER
- ☐ HPV HUMAN PAPILLOMA VIRUS
- ☐ IRRITABLE BOWEL DISORDER
- ☐ JAUNDICE
- ☐ JAW PAIN
- ☐ KIDNEY DISEASE
- ☐ LIVER DISEASE
- ☐ LOW BLOOD PRESSURE
- ☐ MITRAL VALVE PROLAPSE
- ☐ MULTIPLE SCLEROSIS
- ☐ NERVOUS PROBLEMS
- ☐ OSTEOPOROSIS/MEDICATIONS
- ☐ PACEMAKER
- ☐ PARKINSON'S
- ☐ PROSTATE PROBLEMS
- ☐ PSYCHIATRIC CARE
- ☐ RADIATION TREATMENT
- ☐ RESPIRATORY DISEASE
- ☐ RHEUMATIC FEVER
- ☐ SCARLET FEVER
- ☐ SHORTNESS OF BREATH
- ☐ SINUS TROUBLE
- ☐ SKIN RASH
- ☐ SPECIAL DIET
- ☐ STROKE
- ☐ SWOLLEN FEET OR ANKLES
- ☐ SWOLLEN NECK GLANDS
- ☐ THYROID PROBLEMS
- ☐ TMJ PROBLEMS (JAW JOINT)
- ☐ TONSILLITIS
- ☐ TUBERCULOSIS
- ☐ TUMOR OR GROWTH ON HEAD OR NECK
- ☐ ULCER
- ☐ VENEREAL DISEASE
- ☐ WEIGHT LOSS, UNEXPLAINED

The information on this two-page registration/health history is accurate and complete to the best of my knowledge and is only for use in my treatment, billing, and or processing of insurance benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature \_\_\_\_\_ Date \_\_\_\_\_



## DENTAL SPECIALISTS OF BUCKHEAD

3280 HOWELL MILL ROAD, N.W., SUITE 331

WEST WING

ATLANTA, GEORGIA 30327

(404) 261-9593 – FAX (404) 261-9409

Website: [www.dentalspecialistsbuckhead.com](http://www.dentalspecialistsbuckhead.com)

Secure Email: [info@securedsbuckhead.com](mailto:info@securedsbuckhead.com)

LAURA D. BRASWELL, D.D.S.

COLIN S. RICHMAN, D.M.D.

MARK A. BARR, D.D.S.

## CONTACT AND CANCELLATION

(PLEASE READ BOTH SECTIONS AND INITIAL AT THE BOTTOM)

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

### **Text Messaging and Emailing Patient Information**

We offer helpful administrative information by text messaging and email, like appointment reminders, medical records requests from patients, completed medical forms, etc. Any information that includes confidential patient information would be sent by encrypted email. There is some level of risk that information in a regular text message or email could be read by someone besides you.

### **Please circle either YES or NO for your communication preferences:**

- 1) Yes - I authorize communication with me by encrypted email. I understand it is my responsibility to make Dental Specialists of Buckhead aware if my email listed on my registration form changes.

No - Please do not communicate with me by email. This would make U.S.P.S. the mail carrier.

- 2) Yes - Please communicate with me by text message. I understand it is my responsibility to make Dental Specialists of Buckhead aware if my cell phone number listed on my registration form changes.

No - Please do not communicate with me via text messaging.

### **24-Hour Cancellation and "No Show" Administrative Fee Policy**

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving dental care. Therefore, effective February 16, 2024, Dental Specialists of Buckhead reserves the right to charge a fee for missed appointments not canceled with a 24-hour advance notice.

### **The following fees will be assessed for no-shows and late cancellations:**

**Prophylaxis (cleaning) with Dental Hygienist                      \$75.00**

**Evaluations with Dentist    \$100.00**

**Surgeries within 48 hours' notice                                      \$500.00**

**"No Show" and late cancellation fees will be billed to the patient. This fee is not covered by insurance and must be paid prior to your next appointment. Multiple "no shows" and late cancellations in any 12-month period may result in termination from our practice.**

INITIAL \_\_\_\_\_

## **DENTAL SPECIALISTS OF BUCKHEAD**

**3280 Howell Mill Rd. NW, Suite 331  
Atlanta, GA, 30327  
(404)261-9593 FAX (404)261-9409  
www.dentalspecialistsbuckhead.com**

### **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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect September 9, 2013, 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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.

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### **HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU**

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.



**Treatment.** We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

**Payment.** We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

**Healthcare Operations.** We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

**Individuals Involved in Your Care or Payment for Your Care.** We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. 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 your health information.

**Disaster Relief.** We may use or disclose your health information to assist in disaster relief efforts.

**Required by Law.** We may use or disclose your health information when we are required to do so by law.

**Public Health Activities.** We may disclose your health information for public health activities, including disclosures to:

- o Prevent or control disease, injury or disability;
- o Report child abuse or neglect;
- o Report reactions to medications or problems with products or devices;
- o Notify a person of a recall, repair, or replacement of products or devices;
- o Notify a person who may have been exposed to a disease or condition; or
- o Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

**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 the protected health information of an inmate or patient.

**Secretary of HHS.** We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

**Worker's Compensation.** We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

**Law Enforcement.** We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

**Health Oversight Activities.** We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

**Judicial and Administrative Proceedings.** If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

**Research.** We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

**Coroners, Medical Examiners, and Funeral Directors.** We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

**Fundraising.** We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

#### **Other Uses and Disclosures of PHI**

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

## **Your Health Information Rights**

**Access.** You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

**Disclosure Accounting.** With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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 the additional requests.

**Right to Request a Restriction.** You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

**Alternative Communication.** You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

**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. If we agree to your request, we will amend



your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

**Right to Notification of a Breach.** You will receive notifications of breaches of your unsecured protected health information as required by law.

**Electronic Notice.** You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

## **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 if 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.

Our Privacy Official: Michelle Webber, Office Manager

Telephone: 404-261-9593

Fax: 404-261-9409

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# DENTAL SPECIALISTS OF BUCKHEAD

3280 HOWELL MILL ROAD, N.W., SUITE 331

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Website: [www.dentalspecialistsbuckhead.com](http://www.dentalspecialistsbuckhead.com)

Secure Email: [info@securedsbuckhead.com](mailto:info@securedsbuckhead.com)

## Acknowledgement of Receipt of Notice of Privacy Practices

**\* You May Refuse to Sign This Acknowledgment\***

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

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

### For Office Use Only

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

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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