Athena Dental Associates Medical History

Patient Name: _____ Date: _____
Mailing Address: _____ City: _____
State: _____ Zip Code: _____ E-mail: _____
Birthdate: _____ Age: _____ o Single o Married o Divorced o Widowed
Home Phone: _____ Cell Phone: _____ Work Phone: _____
o Employed o Student o Homemaker o Retired Social Security #: _____
Employer: _____ Dental Insurance: _____
Male or Female: _____

Spouse, Partner, or other person responsible for payment:
Name: _____ Address: _____
City: _____ State: _____ Zip Code: _____ Phone #: _____
Date of Birth: _____ Employer: _____
Insurance Company: _____

Nearest relative not living with you:
Name: _____ Phone #: _____
Referred by: o Another patient, friend o Another patient, relative o Dental office doctor or staff
Other: _____
Name of person who referred you: _____

DENTAL HISTORY
Have you been having any specific problems? o Yes o No
Describe: _____

_____

Last dental visit: _____ Purpose: _____ Last exam: _____
Has fear of discomfort kept you from regular visits? o Yes o No
How would you describe your health? o Good o Fair o Poor
Do you think you have active dental disease: decay? o Yes o No
Homecare: Brush? o Yes o No Floss? o Yes o No Gum Disease? o Yes o No
Do your gums ever bleed? o Yes o No How often? _____
Are you troubled with bad breath? o Yes o No
How do you feel about ever losing your teeth? _____
Have you had any unusual effects from previous dental treatment? o Yes o No
Would you describe yourself as "hard to numb" for dental procedures? o Yes o No
Describe: _____

_____

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AUTHORIZATION: I here authorize the doctor(s) and/or staff of this dental office to administer such medications and to perform such diagnostic and therapeutic procedures as may be necessary for proper dental treatment. I state that my medical history is correct to the best of my knowledge. I understand that payment is due when services are rendered. Interest is charged on any unpaid balance over 30 days. You are responsible for your total fees whether you have dental insurance or not. Please note that our office requires a 24 hour notice for changing an appointment or there will be a $50 broken appointment fee.

Patient Signature: _____ Date: _____

Athena Dental Associates Medical History

Patient Name: _____ **SSN:** _____ **DOB:** _____ **Date:** _____

Phone #:_____**Address:** _____ **City:** _____ **State:** ____ **Zip Code:** _____

Email: _____ 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 that you may be taking, could have an important interrelationship with the dentistry that you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ○ Yes ○ No If yes: _____

Have you ever been hospitalized or had major surgery? ○ Yes ○ No If yes: _____

Have you had serious head or neck trauma? ○ Yes ○ No If yes: _____

Are you taking any medication? ○ 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 medication containing bisphosphonates? ○ Yes ○ No If yes: _____

Are you on a special diet? ○ Yes ○ No If yes: _____

Do you use tobacco? ○ Yes ○ No If yes: _____

Women: **are you pregnant?** ○ Yes ○ No **Nursing?** ○ Yes ○ No **Taking oral Contraceptives?** ○ Yes ○ No

Are you allergic to any of the following?

○ Aspirin ○ Penicillin ○ Codeine ○ Acrylic Other: _____

○ Metal ○ Latex ○ Sulfa drugs ○ Local Anesthetics _____

Do you use controlled substances? ○ Yes ○ No If yes: _____

Have you had, or have any of the following?	Y	N		Y	N		Y	N		Y	N
AIDS/HIV positive			Cortisone Medication			Hemophilia			Radiation Treatments		
Alzheimer Disease			Diabetes			Hepatitis A			Recent Weight Loss		
Anaphylaxis			Drug Addictions			Hepatitis B or C			Renal Dialysis		
Anemia			Easily Winded			Herpes			Rheumatic Fever		
Angina			Emphysema			High Blood Pressure			Rheumatism		
Arthritis/Gout			Epilepsy or Seizures			High Cholesterol			Scarlet Fever		
Artificial Joints			Excessive Bleeding			Hives or rash			Shingles		
Artificial Heart Valve			Excessive Thirst			Hypoglycemia			Sickle Cell Disease		
Asthma			Fainting Spells/ Dizziness			Irregular Heart Beat			Sinus Trouble		
Blood disease			Frequent cough			Kidney Problems			Spina Bifida		
Blood Transfusion			Frequent Diarrhea			Leukemia			Stomach/Intestinal Disease		
Breathing Problems			Frequent Headaches			Liver Disease			Stroke		
Bruise Easily			Genital Herpes			Low Blood Pressure			Swelling of Limbs		
Cancer			Glaucoma			Lung Disease			Thyroid Disease		
Chemotherapy			Hay Fever			Mitral Valve Prolapse			Tonsillitis		
Chest Pains			Heart Attack/Failure			Osteoporosis			Tuberculosis		
Cold Sores/Fever Blisters			Heart Murmur			Pain in Jaw Joint			Tumors or growths		
Congenital Heart Disorder			Heart Pacemaker			Parathyroid Disease			Ulcers		
Convulsions			Heart Trouble/ Disease			Psychiatric Care			Venereal Disease		
									Yellow Jaundice		

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 change in medical status.

Signature: _____ Date: _____

Doctor Signature: _____ Date: _____

Email

athenadent@bellsouth.net

Athena Dental Associates

1020 Hawthorne Avenue.
Athens, GA. 30606
OFFICE: (706) 546-7390
FAX: (706) 546-0806

Website

athenadental.com

Financial Options

We are pleased that we can help you with your dental needs. Financially, you are expected to pay for dental services as they are rendered. When a child visits our office for dental care, the party responsible for the fee incurred by that child is the adult that brings the child in for their visit(s). (Regardless of whom is truly responsible in their individual family situation). We cannot bill another parent or guardian. We will be happy to provide you with a receipt of your service and payment at your visit. We do not send out monthly statement from this office. We offer several payment options for your convenience:

1. When you have dental treatment totaling $300 or more and pay in full by cash or check at the time of service, we are able to extend to you a 5% bookkeeper's allowance for patients without insurance. This nice benefit is available to all patients.
2. You may use your VISA, MASTERCARD, AMERICAN EXPRESS or DISCOVER card.
3. If you would prefer an extended payment plan, you may use our Care Credit plan. It is especially designed for our patients. There is no down payment and no interest for 6 months.
4. IF YOU HAVE DENTAL INSURANCE, we will be more than happy, as a service to you, to file your insurance and accept payment from your dental insurance company. At the time of your treatment you will be expected to pay any deductible that you may have and the percentage that your insurance is not expected to pay. IF FOR ANY REASON YOUR DENTAL INSURANCE HAS NOT PAID IN 90 DAYS, YOU ARE RESPONSIBLE FOR YOUR PAYMENT ON YOUR SERVICES. If for any reason you have a balance after your insurance has paid you will be responsible for the remaining balance. For any major work, when you have dental insurance, we will do a pre-treatment estimate for you. When we receive the pre-treatment estimate back from your insurance company we will be able to begin your work. YOU ARE RESPONSIBLE FOR YOUR TOTAL FEE WHETHER YOU HAVE DENTAL INSURANCE OR NOT.
5. If you are changing dentists and you would like to have your records and x-rays sent to new dentist we would be glad to make copies and send. There will be a charge of $32.00 for duplication fee.
6. Please note that our office requires a 24-hour notice for changing an appointment or there will be a $50 broken appointment fee.

Please direct your financial questions to us during our normal business hours Monday-Thursday 8:00 a.m. to 5:00 p.m. and Friday 8:00 a.m. to 12:00 p.m.

Sincerely,

Mark H. Blankenship, D.M.D.

_____

Patient Signature **Date**

ATHENA DENTAL ASSOCIATES

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 April 14, 2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practice 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 or 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 an authorization you may revoke it in writing at any time. Your revocation will not affect any use or disclosed permitted by your authorization while it was in effect. Unless you give 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 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 person responsible for your care, of your location, your general condition or death. If you are present then prior to use or disclose of your health information, we will provide you with an opportunity to object to such uses or discloses. In the event of your incapacity or emergency circumstances, we will disclose heath 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.

ATHENA DENTAL ASSOCIATES

Patient Name: _____

Address: _____ City: _____ Zip: _____

I have agreed to let certain individuals participate in discussions and decisions related to my medical/dental care. Therefore, I hereby give permission for Athena Dental Associates and staff to disclose my personal dental/medical information to the following individual(s):

Name: _____ Relationship to Pt: _____

Name: _____ Relationship to Pt: _____

Name: _____ Relationship to Pt: _____

Conditions for Disclosure. Check the item(s) that apply:

○ The practice may disclose my personal health information to the individual(s) above **only** in my presence.

○ The practice may disclose my personal health information to the individual(s) above when I am not physically present, including disclosures by telephone, answering machine, facsimile, e-mail or regular mail.

○ Other Conditions of Disclosure:

_____

_____

I understand that this consent maybe revoked by me at any time by written notice to the practice.

Patient Signature:

_____

Date of Signature: _____

Witnessed by: _____ Title/Position: _____

Print Name of Witness: _____

Date: _____