

To help provide you with the best possible care, please verify the information you have previously provided us and fill out this form completely and legibly. If you have any questions, please ask us and we will be happy to help.

Patient
Name \_\_\_\_\_ What name do you like to be called? \_\_\_\_\_
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
Date of birth \_\_\_\_\_ SS# \_\_\_\_\_ Driver's license # \_\_\_\_\_ State \_\_\_\_\_
E-mail \_\_\_\_\_ Home phone \_\_\_\_\_ Cell \_\_\_\_\_
Employer \_\_\_\_\_ Work phone \_\_\_\_\_
If patient is a child, name of parent/guardian \_\_\_\_\_

Spouse
Marital status \_\_\_\_\_ Name of spouse \_\_\_\_\_ Spouse's SS# \_\_\_\_\_
Date of birth \_\_\_\_\_ Employer \_\_\_\_\_

Insurance
Insurance Company Name \_\_\_\_\_ Phone \_\_\_\_\_
Insurance Co. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
Name of insured \_\_\_\_\_ Subscriber ID# \_\_\_\_\_ Group# \_\_\_\_\_

In case of emergency, contact \_\_\_\_\_ Phone# \_\_\_\_\_
Name & address of nearest relative not living with you \_\_\_\_\_
\_\_\_\_\_ Phone# \_\_\_\_\_

How did you hear about our practice? \_\_\_\_\_
Last dental visit? \_\_\_\_\_ Reason for today's visit \_\_\_\_\_
Are x-rays available? \_\_\_\_\_ Approximate date taken \_\_\_\_\_
Do you currently have or have you had any conditions in the past that would require you to take antibiotics prior to your dental visit?
Please circle all that apply or describe other \_\_\_\_\_

- Artificial heart valve Endocarditis Congenital heart defect Artificial/replacement joint Organ transplant

Our Office Guidelines: Our appointment schedule is arranged to respect your time and for your convenience. Your appointment has been designed and reserved exclusively for your treatment needs. A fee may be charged for changes to our schedule with less than 24 hours notice, as well as for missed appointments. We will make every effort to contact you to verify your appointments and confirm your intention to be here. As such, we do require a call back or email response to hold your place in our schedule. If you are unable to confirm, your appointment may be given to another patient.

Consent: I give permission for Dr. Pate and his clinical team to take any necessary x-rays, study models or photographs to make a complete diagnosis of my dental needs. I authorize Dr. Pate and his clinical team to perform necessary treatment and therapy and to share my information with other professionals that may need to be involved with recommended treatment.

\_\_\_\_\_  
Patient (or parent/guardian) Signature Date

# Medical History



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

Physician's Name \_\_\_\_\_ Date of Last Exam \_\_\_\_\_ Age \_\_\_\_\_

**Do you have or have you had any of the following? Please check all that apply.**

- Snoring/Sleep Apnea       Asthma       Stroke       Heart ailments       Diabetes
- Recreational drug use       Thyroid       Hay Fever       High blood pressure       Ulcer/Colitis
- Neurological problems       Seizures       Pregnancy       Eye disorders       Chemotherapy
- Liver problems/hepatitis       HIV+       AIDS       STD       Tuberculosis
- Heart valve/vein replacement       Anemia       Arthritis       Mitral valve prolapse       Malignancies
- Artificial/replacement joint       Radiation       Sinus       Rheumatic fever       Bisphosphonate drugs  
(Fosamex / Actonel)
- Excessive bleeding       Emotional problems       Allergies to anesthetics
- Allergies to drugs (please list:)

Describe any current medical treatment, including drugs taken, even though not listed above and if any of the above are checked off, please give additional information: \_\_\_\_\_

What do you like **best** about your smile? \_\_\_\_\_

What do you like **least** about your smile? \_\_\_\_\_

## Dental History

**Do you have or do you use any of the following? Please check all that apply.**

- Sensitivity to hot/cold/sweets       Pain around the ear       Orthodontic treatment       Bad breath
- Bleeding gums       Clenching/grinding       Unpleasant taste       Dental floss
- Food impaction between teeth       Burning of tongue       Interdental stimulators       Mouth breathing
- Fluoride supplements       Blisters on lips/mouth       Complications from extractions
- Cigarettes/pipe/cigar/other       Periodontal treatment       Oral habits (fingernail biting, cheek biting)
- Unfavorable dental experience       Swelling/lumps       Unusual sounds in ear while chewing

## Insurance

***We are happy to assist you in obtaining maximum benefits from your insurance company. In order for us to accept payment directly from your insurance company, we require complete insurance information and will need to obtain your benefits booklet prior to the beginning of treatment. If your insurance company does not agree to send benefit payments to Dr. Pate, you will need to make arrangements to pay your entire balance at the time services are rendered.***

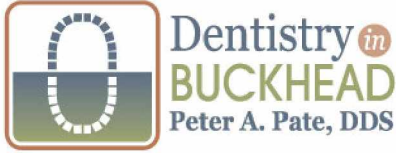
I assign dental benefit payments to be paid directly to Dr. Peter A. Pate from my insurance company. I understand that my insurance is an agreement between me and my insurance company. I also understand that I am responsible for my account regardless of my insurance.

## Payment Policy

I understand that I may be charged a 1.5% per month or 18% per year finance charge if my balance goes beyond 60 days. Charges may be incurred for returned checks as well as legal/collection fees. I have read, understand and agree to the above terms.

\_\_\_\_\_  
Patient (or parent/guardian) Signature

\_\_\_\_\_  
Date



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## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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\*You May Refuse to Sign This Acknowledgement\*

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

\_\_\_\_\_  
Please Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

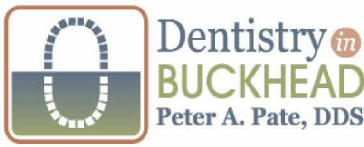
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For Office Use Only

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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 acknowledge
  - An emergency situation prevented us from obtaining acknowledgement
  - Other (Please Specify)
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## CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

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### Section A: Patient Giving Consent

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

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

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### 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: Ann C. Moore

Telephone: (404) 266-9424

Fax : (404) 261-4526

Email: [ann@patedds.com](mailto:ann@patedds.com)

Address: 3833 Roswell Rd. N.E Suite 100, Atlanta, GA 30342

**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 a personal representative on behalf of the patient signs this Consent, complete the following:

Personal Representative's Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

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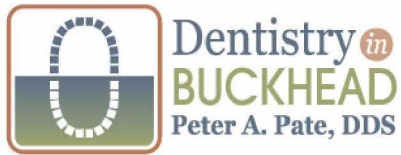
### REVOCAION OF CONSENT (Sign below ONLY if you intend to revoke consent).

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 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: \_\_\_\_\_

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.  
Include completed Consent in the patient's chart.**



## Notice of Privacy Practices Effective April 14, 2003

*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.*

### *Our Commitment to You*

Peter A. Pate, DDS, LLC (Pate DDS) values you as a patient and respects your right to privacy. We have established the following Notice of Privacy Practices to assure you that we are committed to protecting the privacy of your health information. This Notice will describe how Pate DDS protects, uses and discloses patient health information, as well as your rights concerning your health information. Health Information is defined for this Notice as individually identifiable health information that relates to past, present, or future health or payment information.

### *Uses and Disclosures of Health Information*

Our policy is to restrict all disclosures of patient health information to the minimum necessary disclosure required to accomplish the intended purpose. The following are examples of situations in which we are permitted to use and disclose patient health information.

**Treatment:** Pate DDS may use or disclose your health information to a physician or other healthcare provider in order to facilitate the care given to our patients.

**Payment:** Pate DDS may use and disclose health information to obtain payment for services.

**Operations:** Pate DDS may use and disclose health information in order to support our healthcare operations. This includes quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner or provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**Personal Representatives:** Pate DDS may share health information with other family members on your policy or with those who have a relationship with you that gives them the right to act on your behalf. Examples include spouses on the same plan, parents of an un-emancipated minor or those having a Power of Attorney. If you do not want your health information to be shared, please let us know in writing. 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.

**As Required By Law and Regulatory Oversight:** Pate DDS is required to disclose health information in order to comply with federal, state, or local law. This includes subpoenas, law enforcement, national security activities, state audits, and other healthcare oversight.

**Health Related Benefits:** Pate DDS will not use or disclose health information for marketing communications without your permission.

**Public Interest:** Pate DDS may also use or disclose health information in certain public interest situations. Examples include protecting victims of abuse or neglect, preventing a serious threat to health or safety, tracking diseases or medical devices, informing military authorities if you are an armed forces member, worker's compensation, national security, and coroners.

### *Uses and Disclosures Requiring Patient Authorizations*

Other uses and disclosures of patient health information will be made only after receiving signed authorization from the patient. Once a patient signs an authorization, they have the right to revoke it at any time by submitting a request in writing. That revocation of the authorization will not apply to any action taken previous to the revocation.

## *Patient Rights*

**Request Restrictions on Certain Uses and Disclosures of Health Information:** You have the right to request certain restrictions in the use or disclosure of your health information. Your request must be in writing and must include: (1) name and social security number, (2) information you wish restricted, (3) whether you want to restrict our use, disclosure, or both, (4) person or company to whom the restriction applies, for example, disclosure to a spouse, (5) expiration date, and (6) signature of patient.

Pate DDS is not required to agree to a request to restrict the use or disclosure of health information. However, if we do agree, we will not use or disclose patient health information in violation of that agreement unless it is required for emergency treatment. You may revoke a previously agreed upon restriction at any time, by writing to us.

**Request for Confidential Communication:** If receiving health information would endanger your life, you have the right to request that we communicate with you about your health information by alternative means or at an alternative location. For example, you may wish to receive email or phone calls at work, rather than at home. This request must be made in writing and state that receiving health information at your home would endanger your life. Pate DDS will accommodate all reasonable requests.

**Access to and Copy of Your Health Information:** You have the right to request access to and a copy of most of your health information that Pate DDS maintains. You must submit this request in writing. A charge may be applied to cover copying, mailing, and other associated costs. Our Records Request policy is available for your review. Under limited circumstances, Pate DDS may deny all or part of your request. If your request is denied, you may have the right to request a review of the denial in writing.

**Request to Amend Health Information:** You have the right to request that Pate DDS amend your health information maintained by Pate DDS if you feel it is incorrect or incomplete. This request must be made in writing, must describe the information you want amended, and must include the reason for the amendment. Pate DDS may deny your request if we determine the information is correct or as otherwise determined by law. If your request is denied, you have the right to file a letter of disagreement and have that letter included in your file of health information.

**Accounting of Disclosures:** You have a right to request a list of disclosures we have made of your health information. This request must be made in writing. All requests must state a time period, which may not exceed a date 6 years prior to the request and may not include dates before April 14, 2003. This right applies to all disclosures, except those made: for treatment, for payment, for health care operations, to you, by authorization, and all other types excluded by law. You have a right to one free accounting per year. Any additional requests may incur a charge.

**Notice of Privacy Practices:** You have a right to obtain a paper copy of this Notice of Privacy Practices at any time, even if you have previously agreed to receive this document electronically. To obtain a copy of this Notice, contact our Privacy Officer.

## *Our Responsibilities*

Pate DDS is required by law to maintain the privacy of patient health information, to provide you this Notice of our legal duties and privacy practices with respect to your health information, and to abide by the terms of the Notice currently in effect. We reserve the right to change the terms of this Notice and to make the new Notice effective for all patient health information currently maintained by Pate DDS, as well as any future health information. If we do change this Notice, you will receive a copy of the new version.

## *Complaints*

If you believe your rights under this notice have been violated, you have the right to file a complaint with Pate DDS, or with the Secretary of the Department of Health and Human Services. You will not be penalized or retaliated against in any way for lodging a complaint with us or the Secretary of Health and Human Services.

## *Contact Information*

If you have questions regarding this Notice, you wish to file a complaint, or you would like to exercise your rights outlined in this Notice, please contact:

Privacy Officer  
Peter A. Pate, DDS  
3833 Roswell Road, Suite 100  
Atlanta, GA 30342  
(404) 266-9424  
ann@patedds.com