

New Image Dental Group

Patient Information (CONFIDENTIAL)

Name: _____ Birthday: _____ SS#/SIN: _____

Address _____

City: _____ Zip Code: _____ E-Mail: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Person to Contact in Case Of Emergency: _____ Phone: _____

When was the last visit to the dentist?: _____

Whom May We Thank for Referring You? _____

Please circle: Minor Single Married Divorced Widowed Separated
If Student, Name of School/College: _____ City: _____ State: _____
Are you Over 18?: _____ Full time or part time _____

Responsible Party (if the patient is under 18 years old)

Name Of Responsible Party: _____ Relationship to Patient: _____

Address: _____ City: _____ Zip _____

Code: _____

Birthday: _____ SS#/SIN: _____ Driver License #: _____

Insurance Information (only for the patients with insurance)

Primary

Name of the Insured: _____ Relationship to Patient _____

Birthday: _____ SS#/SIN: _____

Name Of Employer: _____

Insurance Company: _____ Group #: _____ Policy _____

ID: _____

Ins Co. Address: _____ City: _____

State: _____

Secondary

Name of the Insured: _____ Relationship to Patient _____

Birthday: _____ SS#/SIN: _____

Name Of Employer:

Insurance Company: _____ Group #: _____ Policy
ID: _____
Ins Co. Address: _____ City: _____
State: _____

Please present your Insurance Card and your Driver's License to the Front Office when Finished.

Full Payment Required for Service Rendered.

Eaglesoft Medical History(Copy)

Patient Name:

Birth Date:

Date Created:

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

Are you under a physician's care now?
Have you ever been hospitalized or had a major operation?
Have you ever had a serious head or neck injury?
Are you taking any medications, pills, or drugs?
Do you take, or have you taken, Phen-Fen or Redux?
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?
Are you on a special diet?
Do you use tobacco?

Women: Are you...

Pregnant/Trying to get pregnant?
Nursing?
Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin, Metal, EPINEPHRINE, Penicillin, LATEX, Codeine, Sulfa Drugs, Acrylic, Local Anesthetics

Do you use controlled substances?
Other?

Do you have, or have you had, any of the following?

AIDS/HIV Positive, Alzheimer's Disease, Anaphylaxis, Anemia, Angina, Epilepsy or Seizures, Excessive Bleeding, Hypoglycemia, Sinus Trouble, Spina Bifida, Stomach/Intestinal Disease, Stroke, Swelling of Limbs, Thyroid Disease, Tonsillitis, Tuberculosis, Congenital Heart Disorder, Convulsions, Cortisone Medicine, Diabetes, Drug Addiction, Easily Winded, Emphysema, High Cholesterol, Hives or Rash, Asthma, Blood Disease, Blood Transfusion, Breathing Problems, Bruise Easily, Cancer, Chemotherapy, Chest Pains, Cold Sores/Fever Blisters, Heart Pacemaker, Heart Trouble/Disease, Hemophilia, Hepatitis A, Hepatitis B or C, Herpes, High Blood Pressure, Scarlet Fever, Artificial Joint, Fainting Spells/Dizziness, Frequent Cough, Frequent Diarrhea, Frequent Headaches, Genital Herpes, Glaucoma, Hay Fever, Heart Attack/Failure, Heart Murmur, Parathyroid Disease, Psychiatric Care, Radiation Treatments, Recent Weight Loss, Renal Dialysis, Rheumatic Fever, Arthritis/Gout, Artificial Heart Valve, Excessive Thirst, Irregular Heartbeat, Kidney Problems, Leukemia, Liver Disease, Low Blood Pressure, Lung Disease, Mitral Valve Prolapse, Osteoporosis, Pain in Jaw Joints, Ulcers, Venereal Disease

Have you ever had any serious illness not listed

Comments:

Empty text box for 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 changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date:

Welcome to our office, and thank you for choosing New Image Dental for your dental care. We are committed to giving you the best up to date dental care possible.

During your visit, we will assess your dental status, and if needed, produce a treatment plan that is tailored to restoring your teeth to a healthy state. With six month cleaning appointments and proper oral hygiene, we can help you keep your teeth healthy.

We encourage our patients to discuss any issue they may have concerning their teeth or financial assistance with our office staff. We are here to assist you through your procedure and we strive to reach a relationship that is beneficial to our patient and our office.

Hours:
Monday - Saturday 9 am to 5pm
Lunch 1 pm to 2pm

Appointment policy:

Your appointment is time that we have reserved for you on our schedule, and if you cancel or No Show within 24 hours, it is extremely difficult for us to fill your time slot. To avoid a \$40.00 No Show/Broken Appointment charge, please provide all phone numbers that our office can use to confirm your upcoming appointment. If we leave a message, we ask that you return our call to either confirm your appointment or reschedule if necessary, and if it is after our business hours, please leave a message on our answering machine. If you move **PLEASE** call and update all information.

Payment policy:

We accept cash, check, and debit, Discover, MasterCard, Visa, American Express and the Care Credit Payment plan. It is the responsibility of the patient to pay their portion at the time services are performed.

Insurance policy:

We accept PPO insurance and we submit claims on our patient's behalf. Please understand that any percentages or prices quoted are an estimate and subject to change. If MY DENTAL INSURANCE CARRIER PAYS LESS THAN THE ACTUAL BILL FOR SERVICE, I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

Thank you again for selecting our office. We hope you will find that your time spent with us today was a pleasant experience, and you will choose New Image Dental as your dental care provider.

SIGNATURE: _____ DATE: _____

Jonathan J. Hwang, DMD
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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.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we will ask you for special written permission.

We will ask for special written permission in the following situations: RELEASE OF CHART AND XRAYS.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- When a state or federal law mandates that certain health information be reported for a specific purpose;
- For public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- Disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- Uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;

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- Disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- Disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- Disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- Uses or disclosures for health related research;
- Uses and disclosures to prevent a serious threat to health or safety;
- Uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- Disclosures of de-identified information;
- Disclosures relating to worker's compensation programs;
- Disclosures of a "limited data set" for research, public health, or health care operations;
- Incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- Disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.

If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- Ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this Notice.
- Ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- Ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us. You may have to pay for photocopies in advance. If we deny your

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request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

Ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

Get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

Get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

I acknowledge that I received a copy of NEW IMAGE DENTAL GROUP Notice of Privacy Practices.

Patient name _____

Signature _____ DATE _____

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