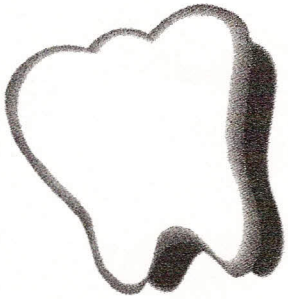

Welcome

Thank you for selecting us.

To help us meet all your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us and we will be happy to help.

Patient Information (Confidential)

Patient Number _____

Name _____ Date _____

SS# / SIN _____ Birthdate _____ Home Phone _____

Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Email _____ Cell Phone _____

Check Appropriate Box: ❑ Minor ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

If Student, Name of School / College _____ State/Prov. _____ ❑ Full Time ❑ Part Time

Patient or Parent / Guardian's Employer _____ Work Phone _____

Business Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Spouse or Parent / Guardian's Name _____ Employer _____ Work Phone _____

Person to Contact in Case of Emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Email _____ Cell Phone _____

Driver's License # _____ Birthdate _____ Financial Institution _____

Employer _____ Work Phone _____ SS# / SIN _____

Is this Person Currently a Patient in our Office? ❑ Yes ❑ No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

❑ Cash ❑ Personal Check Credit Card ❑ VISA ❑ MasterCard ❑ I wish to discuss the office's payment policy.

Referral Information

Whom may we thank for referring you to our practice? ❑ Patient _____ ❑ Friend _____

❑ Shopper _____ ❑ Newspaper ❑ Telephone Book ❑ Insurance Company ❑ Work ❑ Other _____

Name of Person or office referring you to our practice: _____

WPC 26-760 • Walker Printing • 1-800-423-0003

Patient Medical History

Physician_____ Office Phone_____ Date of Last Exam_____

		Yes	No
1.	Are you under medical treatment now?	❑	❑
2.	Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	❑	❑
	If yes, please explain_____		
3.	Are you taking any medication(s) including non-prescription medicine?	❑	❑
	If yes, what medication(s) are you taking?_____		
4.	Do you use tobacco?	❑	❑
5.	Do you use controlled substances?	❑	❑
6.	Are you wearing contact lenses?	❑	❑

8. Are you allergic to or have you had any reactions to the following:

	Yes	No
Local Anesthetics (e.g. Novocaine)	❑	❑
Penicillin or any other antibiotics	❑	❑
Sulfa Drugs	❑	❑
Barbiturates	❑	❑
Sedatives	❑	❑
Iodine	❑	❑
Aspirin	❑	❑
Any Metals (e.g. nickel, mercury, etc.)	❑	❑
Latex Rubber	❑	❑
Other_____	❑	❑

		Yes	No
9.	Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	❑	❑
10.	Women Only:		
	Are you pregnant or think you may be pregnant?	❑	❑
	Are you nursing?	❑	❑
	Are you taking oral contraceptives?	❑	❑

7. Do you have or have had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	❑	❑	Cardiac Pacemaker	❑	❑	Stroke	❑	❑
Heart Attack	❑	❑	Heart Murmur	❑	❑	Hay Fever/Allergies	❑	❑
Rheumatic Fever	❑	❑	Angina	❑	❑	Tuberculosis	❑	❑
Swollen Ankles	❑	❑	Frequently Tired	❑	❑	Radiation Therapy	❑	❑
Fainting/Seizures	❑	❑	Anemia	❑	❑	Glaucoma	❑	❑
Asthma	❑	❑	Emphysema	❑	❑	Recent Weight Loss	❑	❑
Low Blood Pressure	❑	❑	Cancer	❑	❑	Liver Disease	❑	❑
Epilepsy/Convulsions	❑	❑	Arthritis	❑	❑	Heart Trouble	❑	❑
Leukemia	❑	❑	Joint Replacement or Implant	❑	❑	Respiratory Problems	❑	❑
Diabetes	❑	❑	Hepatitis/Jaundice	❑	❑	Sinus Problems	❑	❑
Kidney Diseases	❑	❑	Sexually Transmitted Disease	❑	❑	Excessive Bleeding	❑	❑
AIDS or HIV Infection	❑	❑	Stomach Troubles/Ulcers	❑	❑	Mitral Valve Prolapse	❑	❑
Thyroid Problem	❑	❑	Chest Pains	❑	❑	Other_____	❑	❑
Heart Disease	❑	❑	Easily Winded	❑	❑			

Patient Dental History

Name of Previous Dentist and Location_____ Date of Last Exam_____

		Yes	No
1.	Do your gums bleed while brushing or flossing?	❑	❑
2.	Are your teeth sensitive to hot or cold liquids/foods?	❑	❑
3.	Are your teeth sensitive to sweet or sour liquids/foods?	❑	❑
4.	Do you feel pain to any of your teeth?	❑	❑
5.	Do you have any sores or lumps in or near your mouth?	❑	❑
6.	Have you had any head, neck or jaw injuries?	❑	❑
7.	Have you ever experienced any of the following problems in your jaw?		
	Clicking	❑	❑
	Pain (joint, ear, side of face)	❑	❑
	Difficulty in opening or closing	❑	❑
	Difficulty in chewing	❑	❑
8.	Do you have frequent headaches?	❑	❑
9.	Do you clench or grind your teeth?	❑	❑
10.	Do you bite your lips or cheeks frequently?	❑	❑
11.	Have you ever had any difficult extractions in the past?	❑	❑
12.	Have you ever had any prolonged bleeding following extractions?	❑	❑
13.	Have you had any orthodontic treatment?	❑	❑
14.	Do you wear dentures or partials?	❑	❑
	If yes, date of placement_____		
15.	Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	❑	❑
16.	Do you like your smile?	❑	❑

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____
Signature of patient (or parent/guardian if minor)

Doctor's Comments_____

_____

_____ Signature_____ Date_____

HAWKINSVILLE DENTAL ASSOCIATES, LLC

Clarence (Rence) F. Cheek, Jr., DMD
23 LOVERS LANE ROAD
HAWKINSVILLE, GA 31036
478-783-3390

Thank you for selecting us for your dental needs. Our primary mission at our office is to deliver the best and most comprehensive dental care available. An important part of this mission is making the cost of dental care as easy and manageable for our patients as possible.

To assist you with your dental care investment, we provide the following:

Payment Options

1. Our office accepts cash, check, Visa, MasterCard, Discover, and American Express.

2. A 5% bookkeeping discount is offered for cash or check payment in full for treatment over $1000 when paid at least 24 hours in advance of appointment.

3. You may set up a payment plan through our office, making a down payment at the start of treatment followed by monthly electronic payments through auto debit with your checking or savings account.

4. CareCredit – patient payment plans that allow you to pay over time with convenient low minimum monthly payments. "No Interest" or "Extended Payment" Plans are offered.

5. Partial Payments for multiple-appointment treatments over $1,000 – patient can make 2 payments, ½ payments on initial day and other ½ on completion date.

Insurance

1. We will file insurance claims as a courtesy to you. You are responsible for the estimated payment options in full when services are rendered by using one of the above.

2. You should be aware that the insurance agreement is between you and the insurance company. We will attempt to make a good faith estimate of your insurance benefits, but we cannot guarantee your insurance will pay as we estimate it. If the Insurance Company declines to pay its estimated portion, the patient is responsible for any remainder of the fee.

If you have questions, please feel free to talk with my Office Manager, Sherry Reeves.

HAWKINSVILLE DENTAL ASSOCIATES, LLC

Clarence (Rence) F. Cheek, Jr., DMD
23 LOVERS LANE ROAD
HAWKINSVILLE, GA 31036
478-783-3390

FINANCIAL AGREEMENT

To Patient, Parent, or Guardian:

Payment is expected in full at the time services are rendered. If you have insurance…we will gladly process your claim, but we request that you pay your estimated portion in full when services are rendered. Your insurance is an estimate of payment and any balance left will be the responsibility of the patient. We offer several methods of payments including: CASH, CHECK, CREDIT CARDS, and a DENTAL FEE PLAN (Care Credit). If your account becomes past due and collection procedures are rendered, you will be responsible for ANY and ALL cost.

Signature:_____

Date:_____

HAWKINSVILLE DENTAL ASSOCIATES, LLC

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 (MM/DD/YR), 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 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.

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 locate and 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.

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: Sherry C. Reeves

Telephone: 478-783-3390 Fax: 478-783-3381

E-mail address: sherryreeves@hawkinsvilledental.com

HAWKINSVILLE DENTAL ASSOCIATES, LLC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****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}

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)

_____

_____

_____