CORNERS DENTISTRY

New Patient Form

Welcome to Corners Dentistry! Please complete these confidential medical forms so that we can provide you with dental care in a safe and efficient manner.

Patient Name _____ Date of Birth _____

Street Address _____City_____State____Zip_____

Phone: Home _____ Cell _____ Work _____

Email _____ Social Security Number _____

Marital Status: ___single ___married ___divorced __separated

If applicable, spouse's name _____

Responsible party (if patient is a minor) _____

Emergency Contact:

Name_____Phone _____ Relation to patient_____

Whom may we thank for referring you? _____

If You Carry Dental Insurance:

Name of Employer _____

Primary Insurance Company _____ Group _____Subscriber_____

Secondary Insurance Company _____ Group _____Subscriber _____

I authorize the release of any dental or medical records to aid in my dental treatment.

Patient or Guardian Signature _____ Date _____

I understand that dental services furnished to me are charged directly to me and that I am responsible for payment. If I carry insurance, I understand that the office will help prepare my insurance forms to assist me in obtaining my benefits but the fee is ultimately my responsibility. Financial agreements must be made in advance. All emergency dental services, or any dental service performed without prior financial arrangements must be paid for at the time of service.

Assignment of Insurance: I hereby authorize release of any information needed/requested by my insurance carrier. I authorize my insurance company benefits to be paid directly to Corners Dentistry.

Patient or Guardian Signature _____ Date _____

John S. Hann, DMD
6175 Crooked Creek Rd
Peachtree Corners, GA 30092

(770) 449-5901
cornersdentistry.com
cornersdentistry@gmail.com

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New Patient Form

Why have you come in today? (cleaning, procedure, etc) _____

Are you having any pain/discomfort? Y N When was your last dental visit? _____

How often do you brush? _____ Do you floss? Y N If so, how often? _____

My gums bleed while brushing or flossing Y N My gums feel tender or swollen Y N

Have you ever had gum treatment? Y N If so, when? _____

Have you ever worn braces? Y N If so, when? _____

Have you ever bleached your teeth? Y N If so, when and how? _____

Do you clench or grind your teeth? Y N Do you wear a night guard Y N

Patient's Medical History

I consider my health to be (please check one) ___Excellent ___Good ___Fair ___Poor

Do you have (or have you had) any of the the following? *Please circle Yes or No.*

1. Y N Heart Disease (surgery, attack)
2. Y N Congenital Heart Disease
3. Y N Heart Murmur/Mitral Valve Prolapse
4. Y N Stroke
5. Y N Artificial Heart Valve
6. Y N Heart Pacemaker
7. Y N High Blood Pressure
8. Y N Prolonged Bleeding Disorder
9. Y N Anemia
10. Y N Tuberculosis or Lung Disease
11. Y N Asthma
12. Y N Sinus Trouble
13. Y N Ulcers
14. Y N Epilepsy or Seizures
15. Y N High Cholesterol
16. Y N Osteoporosis
17. Y N Liver Disease
18. Y N Thyroid Disease
19. Y N Hepatitis If yes, type: ___
20. Y N Diabetes
21. Y N Kidney Disease
22. Y N Herpes
23. Y N Arthritis
24. Y N Glaucoma
25. Y N STD/Venereal Disease
26. Y N AIDS/HIV Positive
27. Y N Cancer/Chemotherapy
28. Y N Radiation Treatment
29. Y N History of Drug Addiction
30. Y N Anxiety
31. Y N Psychological Care
32. Y N Do you smoke?
    How much? _____
33. Y N Other_____

Do you have Implants or Artificial Joints? Y N __Hip __Knee __Other

Do you have Allergies? Y N __Aspirin __Ibuprofen __Penicillin __Codeine __Sulfa __Latex

Women: Pregnant: Y N Nursing: Y N Taking Birth Control: Y N Reached Menopause: Y N

Please list all medications you are currently taking: _____

_____

Patient Signature: _____ **Date:** _____

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Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed as well as 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. This notice takes effect December 29, 2021 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 privileges 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 to 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.

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 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.

To Your Family and Friends: We must disclose your health information to you, as described in the Patients 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 to that.

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 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 references to your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written consent.

Required by Law: We may use or disclose your health information if 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 or other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or to the health and 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 offices health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment reminders: We may use or disclose your contact information to provide you with appointment reminders (such as text messages, emails and voicemails).

Computer Screens: We have computer screens in our operatories within view of our patients. We make every attempt to keep your computer information private.

E-mail: We use e-mail for confirm appointments or to answer any dental questions you may have. Additionally, we may contact our labs via e-mail. If you do not wish any e-mail communication about your dental care, please inform our front office.

Patient Rights

Access: You have the right to look at or get copies of your health information, with limited exemptions. You may require that we provide copies physically or digitally. We will use the format you request unless we cannot practicably do so. You must make a request in writing to access your health information.

Disclosure Accounting: You have the right to receive a list of instances in which we disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other related activities for the last 6 years.

Restrictions: You have the right to request that we place additional restrictions on our use and disclosure of your health information. We are not required to agree to these additional restrictions be if we do, we will abide by our agreement.

Alternative Communications: You have the right to request that we communicate with you about your health informations by alternative means or alternative locations. 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. We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our website or by e-mail, you are entitled to receive this Notice in written form.

Questions and Complaints

If you want more information about our privacy policy 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 to have us communicate with you by alternative method or at alternative locations, you may complain to us using the contact informations written below. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you that address upon request.

We support and respect your right to the privacy of your health information.

Contact Officer: John S. Hann, DMD

Phone: (770) 449-5901 **Fax:** (770) 449-7747

E-mail: cornersdentistry@gmail.com

Address: 6175 Crooked Creek Road, Peachtree Corners GA, 30092

Acknowledgment 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.

_____

Printed Name

_____ _____

Signature Date

FOR OFFICE USE ONLY.

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

_____ Patient refused to Sign
_____ Communication barriers prohibited obtaining the acknowledgment
_____ An emergency situation prevented us from obtaining acknowledgment

Other: _____

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