NAME _____ CELL PHONE _____ AGE _____ SEX _____

BIRTH DATE _____ SOCIAL SECURITY NO. _____ COUNTY _____

ADDRESS _____ CITY _____ ZIP _____ PHONE _____

EMPLOYED BY _____ ADDRESS _____ PHONE _____

SPOUSE'S NAME/GUARDIAN _____ EMPLOYED BY _____

ADDRESS _____ PHONE _____

REFERRED BY _____

PHYSICIAN _____ ADDRESS _____ PHONE _____

EMERG. CONTACT _____ PHONE _____

PREVIOUS DENTIST _____

EMAIL _____ BANKS _____

SIGNATURE OF PERSON RESPONSIBLE FOR PAYMENT OF TREATMENT _____
SIGNATURE

PLEASE CIRCLE – Do you prefer to pay by cash or check or credit card?

Dental Insurance (1) _____ (2) _____

MEDICAL HISTORY:

	Yes	No
Do you urinate frequently?	☐	☐
Are you taking medication?	☐	☐
Are you being treated by a physician?	☐	☐
Do you have any drug allergies?	☐	☐
When was your last physical exam?		
Are you pregnant?	☐	☐
When was your last visual exam?		
When was your last dental exam?		
Do you have shortness of breath?	☐	☐
Do you have popping in your jaw?	☐	☐
Do you bleed easily?	☐	☐
Do you have any head or neck pain?	☐	☐

Signature _____

Did you ever have any of the following?

	Yes	No
Hepatitis?	☐	☐
T.B.?	☐	☐
Rheumatic Fever?	☐	☐
Any heart condition?	☐	☐
Diabetes?	☐	☐
Sinus Condition?	☐	☐
V.D.?	☐	☐
Penicillin Allergy?	☐	☐
High Blood Pressure?	☐	☐
Asthma?	☐	☐
Epilepsy?	☐	☐
Hemophilia?	☐	☐
AIDS	☐	☐
Periodontal Disease	☐	☐
Other	☐	☐

CLINICAL EXAM:

Face _____ Lips _____

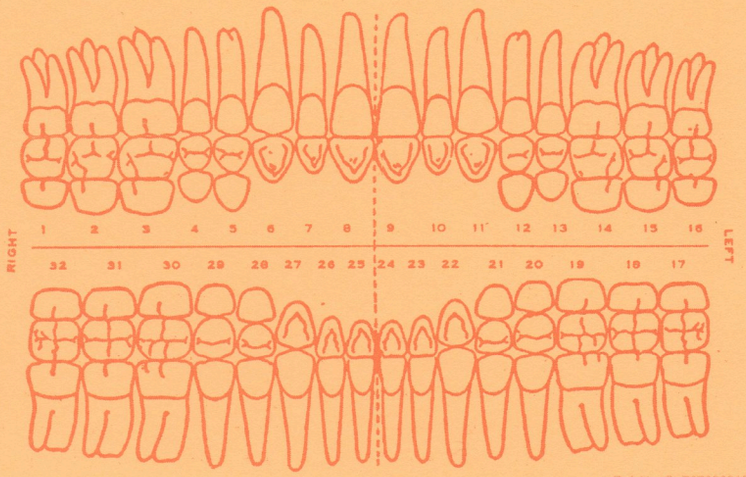
Tongue _____ Palate _____

Lymph Nodes _____ Mucous _____

Gingiva: Color _____ Texture _____ Form _____ Bleeding _____

CHIEF COMPLAINT: _____

PERIODONTAL EVALUATION _____



Office Protocol

Reserved appointment time in our office is limited and valuable. It is extremely important that all patients honor their reserved dental appointments. Failure to do so deprives other patients from receiving needed dental care in a timely fashion. Our office protocol stipulates that we require a **24 –hr notice to cancel appointments.** We reserve the right to apply a **broken appointment charge of $50.00** when this notice is not provided.

In order to protect all of our patients, our office uses great quantities of disposable supplies. In addition, all instruments are autoclaved and individually bagged. Many of the infection control procedures occur before you enter the treatment room, such as applying a barrier covering over the light handles, head- rest and x-ray unit. Each chair, countertop, light handle, and x-ray unit are cleaned with a hospital grade antiviral, antibacterial disinfectant that kills HIV. We have had extensive continuing education courses, OSHA training, and inspections.

In order to keep our billing costs under control, and ultimately your cost at a minimum, we are requiring patients to pay for all treatment rendered at the time of service. At your request, we will file all insurance for your reimbursement, at no additional charge to you. Any conflict with your insurance company is strictly between **you** and your insurance company.

Informed Consent

It is the intent of this office to deliver the highest quality dentistry available today, which is why we **DO NOT** place mercury-silver fillings. We will only place composite tooth colored resin material in our patients' teeth.

The undersigned hereby authorizes the Doctor to take radiographs, (x-rays) photographs, construct study models, or any other diagnostic aid deemed appropriate by the Doctor to make a thorough diagnosis of the patients dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with the dental need of the patient.

I further authorize that the Doctor choose and employ such assistance as he deems fit. I understand that the use of anesthetic agents embodies a certain risk. I understand that the responsibility for payment for Dental services provided in this office for me, and my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I understand that a finance charge of 1.5% per month (18% annually) will be added to any balance over 60 days.

In the event of default, I (we) promise to pay all legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Patient_____ Date_____

Parent or Responsible Party_____

Jay L. Rosenheck, D.D.S., P.C.

1000 Peachtree Industrial Blvd., Suite 10, Suwanee, GA 30024

Patient Name: _____ Date Of Birth: _____

Patient or Guardian: _____ Date: _____

Acknowledgment of Receipt of Notice of Privacy Practices & HIPAA Policies and Procedures

I have reviewed and/or received a copy of this office's:
___ Notice of Privacy Practices
___ HIPAA Privacy Policies and Procedures

Signature: _____ Date: _____

Patient Consent for Electronic Communication

If you provide us with your email address, you are able to take advantage of our practice's electronic services, including appointment confirmations and electronic delivery of any requested information about account details. By utilizing our practice's electronic services, you agree that ***Jay L. Rosenheck, D.D.S., P.C.*** may send to you any relevant information through the internet to the email address designated.

Please initial that you understand that:
____ All electronic communications from our practice will be encrypted
____ I am responsible for providing the dental practice any updates to my email address
____ I am able to receive information electronically and store it securely away from a public computer
____ You can remove your email address from our system at anytime by calling our office: 770-614-4666

I understand that electronic media, and delivery methods such as email, pose certain risks to the privacy and security of my Protected Health Information that may be beyond the control of Jay L. Rosenheck, D.D.S., P.C. I agree to assume such risks potentially, and hold Jay L. Rosenheck, D.D.S., P.C. harmless in the event my Protected Health Information is breached or compromised as a result of my directing and authorizing Jay L. Rosenheck, D.D.S., P.C. to transmit or deliver such information electronically.

Email address: _____

Signature: _____ Date: _____

Patient Consent for Use or Disclosure of Patients Protected Health Information (PHI)

I authorize ***Jay L. Rosenheck, D.D.S., P.C.*** to release relevant personal health information by phone, fax or mail for:
____ Dental Services claims information
____ Prescriptions, diagnostic, treatment and/or care management services
____ Reviews required by HHS or HIPAA compliant care operations

____ I understand that information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
____ I understand that this consent may be revoked by me at any time. I understand why I have been asked to disclose this information and am aware that my patient rights are identified in the Notice of Privacy Practices.

PHI may also be released to the following people (friend or relative): _____

OR

____ I refuse to permit use and disclose of my protected health information, and will be filing all dental insurance claims my self.

Signature: _____ Date: _____