CONFIDENTIAL INFORMATION QUESTIONNAIRE

PATIENT'S NAME LAST FIRST MIDDLE	DATE OF BIRTH	SEX	SOCIAL SECURITY #

PATIENT'S ADDRESS STREET APT# CITY STATE ZIP	EMAIL	HOME PHONE

MARITAL STATUS ❑ M ❑ S ❑ D ❑ W ❑ UNDER AGE 18	PATIENT'S/GUARDIAN'S EMPLOYER	OCCUPATION

WORK ADDRESS STREET CITY STATE ZIP	CELL PHONE	WORK PHONE	OK TO CALL WORK ❑ YES ❑ NO

SPOUSE'S NAME LAST FIRST MIDDLE	SPOUSE'S EMPLOYER	OCCUPATION

WORK ADDRESS STREET CITY STATE ZIP	CELL PHONE	WORK PHONE	OK TO CALL WORK ❑ YES ❑ NO

PERSON WE CAN CONTACT IN CASE OF AN EMERGENCY (OTHER THAN YOUR FAMILY HOME)

NAME	RELATIONSHIP	HOME #	WORK #	CELL #

OTHER FAMILY MEMBERS THAT ARE PATIENTS HERE	WHO CAN WE THANK FOR REFERRING YOU TO OUR OFFICE

INSURANCE COVERAGE ❑ YES ❑ NO	INSURANCE COMPANY NAME	ADDRESS	PHONE

SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER ❑ SELF ❑ SPOUSE ❑ DEPENDENT	SUBSCRIBER'S DATE OF BIRTH	SUBSCRIBER'S SSN

GROUP/PROGRAM NUMBER	EMPLOYER (IF DIFFERENT FROM ABOVE)	EMPLOYER ADDRESS

SECONDARY COVERAGE ❑ YES ❑ NO	INSURANCE COMPANY NAME	ADDRESS	PHONE

SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER ❑ SELF ❑ SPOUSE ❑ DEPENDENT	SUBSCRIBER'S DATE OF BIRTH	SUBSCRIBER'S SSN

GROUP/PROGRAM NUMBER	EMPLOYER (IF DIFFERENT FROM ABOVE)	EMPLOYER ADDRESS

ASSIGNMENT & RELEASE:

I hereby authorize my insurance benefits to be paid directly to the dentists. I am financially responsible for any balances due and authorize the dentists to release any information for this claim. I authorize that my records can be used by the doctor if he so determines.

In consideration of the services rendered to me by this dental office I am obligated to pay said office in accordance with its credit terms and policy.

I consent to the making of videotapes, photographs, and x-rays before, during, and after treatment, and to the use of same by the doctor in scientific papers or demonstrations.

I certify that I have read or had read to me the contents of this form and do realize the risks and limitations involved.

Signature ______________________________ Date ______________

Dental History

Patient Name: ____________________________ **Birth Date**______________________

Previous dentist___________________________ **How long** _____________________

Referred by _______________________________

Most recent dental exam ___________________ **Most recent dental x-ray**_______________

Most recent dental treatment _________________

How often do you have your teeth cleaned? ___3 months __4 months __6 months ___1 year or longer

WHAT IS YOUR IMMEDIATE DENTAL CONCERN?

____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

1. Unhappy with the appearance of your teeth................................ YES NO
2. Unfavorable dental experiences.. YES NO
3. Dental fears.. YES NO
4. Problems with effectiveness or bad reaction to dental anesthetic....... YES NO
5. Orthodontic treatment (braces) when?________________________ YES NO
6. Periodontal (gum) treatment, when?__________________________ YES NO
7. Bleeding gums.. YES NO
8. Avoid brushing any part of your mouth.................................. YES NO
9. Part of your mouth is sensitive to temperature............................ YES NO
10. Sore teeth.. YES NO
11. A burning sensation in your mouth....................................... YES NO
12. Difficulty swallowing.. YES NO
13. An unpleasant taste or odor in your mouth............................. YES NO
14. Dry mouth, throat, and or eyes.. YES NO
15. Jaw problems (temporomandibular joint)................................ YES NO
16. Difficulty opening your mouth widely.................................. YES NO
17. Stiff neck muscles.. YES NO
18. Awaken with an awareness of your teeth or jaws....................... YES NO
19. Tension headaches.. YES NO
20. Clench or grind your teeth.. YES NO
21. Jaw clicking or popping... YES NO
22. Lost any teeth.. YES NO
23. Do you sweat or tremble a lot during examination..................... YES NO

SUPPLEMENTAL DENTURE HISTORY:

If you are wearing a partial or complete artificial denture, please complete the following:
(please Circle Yes or No)

YES NO Has your present denture been relined? When? ______________________________

YES NO Is your present denture a problem? Describe_______________________________

YES NO Satisfied with the appearance? ____

YES NO Satisfied with the comfort? ____

YES NO Satisfied with the chewing ability? _______________________________________

When did you receive your first partial or complete denture? ___________________________

How long have you worn your present denture? ____________________________________

Patient Signature: _________________________________ Date ____________________

Doctor's Remarks: ____

Doctor's Signature _________________________________ Date ____________________

MEDICAL HISTORY

PATIENT NAME ______________________________ Birth Date ______________________

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 that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Question			
Are you under a physician's care now?	Yes	No	If yes, please explain: ____________
Have you ever been hospitalized or had a major operation?	Yes	No	If yes, please explain: ____________
Have you ever had a serious head or neck injury?	Yes	No	If yes, please explain: ____________
Are you taking any medications, pills, or drugs?	Yes	No	If yes, please explain: ____________
Do you take, or have you taken, Phen-Fen or Redux?	Yes	No	
Are you on a special diet?	Yes	No	
Do you use tobacco?	Yes	No	
Do you use controlled substances?	Yes	No	
Do you need to pre-medicate?	Yes	No	If yes, please explain: ____________

Women: Are you Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other If yes, please explain:

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

AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Renal Dialysis	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Rheumatic Fever	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Rheumatism	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Scarlet Fever	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Shingles	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	Hives or Rash	Yes	No	Sickle Cell Disease	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hypoglycemia	Yes	No	Sinus Trouble	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Irregular Heartbeat	Yes	No	Spina Bifida	Yes	No
Asthma	Yes	No	Fainting Spells/Dizziness	Yes	No	Kidney Problems	Yes	No	Stomach/Intestinal Disease	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Leukemia	Yes	No	Stroke	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Liver Disease	Yes	No	Swelling of Limbs	Yes	No
Breathing Problem	Yes	No	Frequent Headaches	Yes	No	Low Blood Pressure	Yes	No	Thyroid Disease	Yes	No
Bruise Easily	Yes	No	Genital Herpes	Yes	No	Lung Disease	Yes	No	Tonsillitis	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No	Mitral Valve Prolapse	Yes	No	Tuberculosis	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Pain in Jaw Joints	Yes	No	Tumors or Growths	Yes	No
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Murmur	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disorder	Yes	No	Heart Pace Maker	Yes	No	Radiation Treatments	Yes	No	Yellow Jaundice	Yes	No
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Recent Weight Loss	Yes	No			

Have you ever had any serious illness not listed above? Yes No If yes, please explain: ____________

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 ______________________ DATE ____________

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 July 21, 2021, and will remain in effect until we replace it.

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.

For more information about our privacy practices, or to request a copy of our Notice, please contact our office using the contact 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, 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. We may charge you a reasonable cost-based fee for expenses such as copies and staff time. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format.

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, 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 website 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 at the address or phone number provided at the bottom of this document.

If you are concerned that we may have violated your privacy rights, 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 on this document. 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. =-098

CONTACT US

Address:
Staton Family Dentistry
48 Haralson Place, Suite 4
Blairsville, GA 30512

Phone:
(706)745-9621

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Notice of Privacy Practices Acknowledgement—Staton Family Dentistry

Trevor Staton DMD

Ronnie Dyer DMD
48 Haralson Place, Suite 4
Blairsville, GA 30512
706-745-9621

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights of privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in my treatment plan—directly or indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: ______________________________

Relationship to Patient: ______________________________

Signature: ______________________________

Date: ______________________________

Office Use ONLY:
I attempted to obtain the patient's signature in acknowledgement of receipt of Notice of Privacy Practices, but was unable to do so as documented below:
Date: ______________ **Initials:** ________ **Reason:** ______________________________

Financial Policy Effective 7/21/2021

Non-Covered Services

Our providers follow appropriate, evidenced based treatment planning guidelines based on your oral health and needs. Please be aware that some of the services you receive may not be covered, in part or in full, based on the terms and benefits of your specific insurance plan. You will be financially responsible for the cost of services provided that are not covered by your insurance company. Treatment recommendations are based on "what is best for **your** oral health" as proposed by our providers, not based on policies adopted by insurance companies.

Secondary Insurance Plans

Beginning January 1, 2022, we will no longer be accepting or submitting claims with secondary insurance plans at Staton Family Dentistry. This decision was made in order to improve the efficiency of our insurance filing process. However, patients who hold secondary insurance plans may still choose to file their claims personally, and receive direct reimbursement from their insurance companies (often in the form of a check paid directly to the patient). We can provide you with printed statements and any information the secondary insurance company requires for claim processing.

Self-Pay

In order to address the needs of our patients with no insurance coverage, our office offers a 3% discount on crowns and bridges when paid in-full at time of service (**cash or check**).

Returned Checks

A $35.00 return check fee may be charged to your account for any checks returned for insufficient funds. The returned check fee is your financial responsibility and payment of any outstanding return check fees will be required prior to scheduling future appointments with our office.

Patient Statements & Patient Account Balances

Statements representing the patient responsibility portion of your account are generated and mailed approximately every sixty (60) days. This timeframe may be extended by us if the account has pending insurance claims. Please contact our office if you have questions about your patient statement. Patient statement balances are due as listed on the patient statement due date.

If you have received three (3) statements and have not paid your balance in full nor have you made a payment arrangement with our office, your account will be considered delinquent. Delinquent accounts may be forwarded to a collection agency. Patient accounts forwarded to a collection agency will be charged for all costs and expenses associated with the collection of your account including, but not limited to our reasonable attorney's fees. Additionally, if your account is forwarded to a collection agency, you may be dismissed from the practice due to a failed professional relationship.

CareCredit

CareCredit is a payment option for patients that qualify. CareCredit is used to make dental care affordable. For qualified cardholders, services provided that range from $200-$499 qualify for a 6-month interest deferred plan. Services over $500 qualify for a 12-month interest deferment. Be sure to ask our staff for additional information or to complete an in-office application. You can also visit them online at **www.carecredit.com** from your phone or home computer. It takes just a few minutes to apply and receive the results.

The cardholder whose name is printed on the card must be present in order to sign for payment.

Trust/Communication

Our goal is to provide the best care and dental experience possible. We put your oral health first and will make recommendations on what is best for you, not what insurance covers, etc. We feel trust and a clear understanding is essential to a successful professional relationship. If, at any time, you do not understand recommended treatment or the treatment process, please feel free to discuss. Our goal is to avoid any risk of miscommunication or loss of trust.

Due to change in practice ownership in 2021, you may be required to pay balances due to "Ronnie L. Dyer, DMD" separately from balances payable to "Staton Family Dentistry".

Financial Policy Effective 7/21/2021

Thank you for choosing our office to serve your dental needs. We are committed to providing you with the highest quality care. All recommended treatment is to ensure your optimum oral health. Your clear understanding of our financial policy, which is an agreement between you and our practice, is important to our professional relationship.

Appointments

Your appointment time has been reserved specifically for you. We require 24 hour notification/cancellation prior to your scheduled appointment time. Missed appointments represent a cost to us, to you, and to other patients who could have been seen in the time set aside for you. Patients that miss a scheduled appointment, without notifying our office twenty-four (24) hours prior to their scheduled appointment time, are subject to a $25.00 missed appointment fee that *may be* added to your account. Payment of any outstanding missed appointment fees will be required prior to scheduling future appointments with our office. Patients that miss three (3) appointments within a one (1) year period *may* be dismissed from the practice due to a failed professional relationship.

If you arrive more than ten (10) minutes after your scheduled appointment time, we will do our best to accommodate you. However, in the event we are unable to work you into the provider's schedule, it *will* be necessary to reschedule your appointment.

Primary Insurance Plans

We are considered an ***"out-of-network"*** provider. For most primary insurance plans, we will be happy to submit your claim for services provided. However, it is your responsibility to know what benefits your insurance plan provides. Insurance plans vary considerably, and we cannot predict *nor* guarantee what part of our services will or will not be covered by your insurance. It is your responsibility to verify that services received are covered. We will collect an *estimated* copay and deductible and time of service for most dental services.

Please note that many insurance plans will state "100% coverage", or another percent coverage, for different categories of dental care. This means they will cover that percentage of the insurance company's determined list of approved fee schedules, *not* on the actual fees charged by our office (remember- we are an "out-of-network" provider and do not have contracted fees with insurance companies). For example, if you have 100% coverage for preventative care, it does not mean your plan will cover the entire cost of a cleaning, exam, xray images, ect.

You are responsible for any remaining balance after payment is received from your insurance plan. If you receive payment directly from your insurance, often in the form of a check, you should notify our office and remit payment to us for services rendered. You may be required to pay in full on the date of service if you receive insurance reimbursement directly.

Patient Information/Proof of Insurance

It is your responsibility to provide us with accurate and timely insurance and demographic information. Upon arrival for every visit, you will be required to provide updated information regarding changes to your mailing address, contact numbers and insurance coverage. You will be required to provide us with a copy of your insurance card. This includes the insurance card and any other pertinent information that will assist in making sure that your visit is billed appropriately. *If services are denied or not covered as a result of inaccurate or untimely information provided to our staff, you will be responsible for that payment of all charges associated with that date of service.* Additionally, if services are retroactively denied for a previous date of service due to insurance eligibility issues, you will be responsible for the payment of all charges associated with that service. *We are not a Medicare or Medicaid provider.*

Insurance, Deductibles, Co-Insurance & Delinquent Patient Account Balances

At the time of your visit, you are responsible for the payment of all insurance deductibles and co-payments according to your specific insurance plan as well as any delinquent patient account balances. If you are unable to pay those amounts and prior financial arrangements have not been secured, your appointment *may* need to be rescheduled.

Trevor W. Staton, DMD

Financial Policy Agreement

I have read and received a copy of Staton Family Dentistry's financial policy statement. I understand if applicable, the details of my insurance coverage are my responsibility. I also understand I am responsible for any unpaid balance on my account.

Signature:______________________________ Date:_________________

706-745-9621-Office 48 Haralson Place, Ste 4, Blairsville, GA 30512 706-745-9622-Fax