Welcome

Thank you for selecting our dental health care team!
We will strive to provide you with the best possible dental care.
To help us meet all your dental health care needs, please fill out this form electronically (no form field means fill by pen). If you have any questions or need assistance, please ask us.
we will be happy to help.

Patient # _____

Soc. Sec # _____

Date _____

Name _____ *Birthdate* _____ *Home Phone* _____

Address _____ *City* _____ *State* _____ *Zip* _____

Check Appropriate Box ☐ *Minor* ☐ *Single* ☐ *Married* ☐ *Divorced* ☐ *Widowed* ☐ *Separated*

Patient's or Parents Employer _____ *Work Phone* _____

Business Address _____ *City* _____ *State* _____ *Zip* _____

Spouse or Parent's Name _____ *Employer* _____ *Work Phone* _____

If Patient is a Student of School/College _____ *City* _____ *State* _____ *Zip* _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ *Phone* _____

Responsible Party

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

Address _____ *Home Phone* _____

Driver's License # _____ *Birthdate* _____ *Financial Institution* _____

Employer _____ *Work Phone* _____

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

Insurance Information:

Dental:

Name of Insured _____ *Relationship to Patient* _____

Birthdate _____ *Social Security #* _____ *Date Employed* _____

Name of Employer _____ *Work Phone* _____

Address of Employer _____ *City* _____ *State* _____ *Zip* _____

Insurance Company _____ *Group #* _____ *Union or Local #* _____

Ins. Co. Address _____ *City* _____ *State* _____ *Zip* _____

How Much is your deductable? _____ *How Much Have You Used ?* _____ *Max. Annual Benefit* _____

_____

Medical:

_____

Name of Insured _____ *Relationship to Patient* _____

Birthdate _____ *Social Security #* _____ *Date Employed* _____

Name of Employer _____ *Work Phone* _____

Address of Employer _____ *City* _____ *State* _____ *Zip* _____

Insurance Company _____ *Group #* _____ *Union or Local #* _____

Ins. Co. Address _____ *City* _____ *State* _____ *Zip* _____

How Much is your deductable? _____ *How Much Have You Used ?* _____ *Max. Annual Benefit* _____

Over Please

1. *Are you having pain or discomfort at this time?* ..... YES ☐ NO ☐
2. *Have you been a patient in the hospital during the past two years ?* ..... YES ☐ NO ☐
3. *Have you been under the care of a medical doctor during the past two years ?* ..... YES ☐ NO ☐

Physician's Name _____ *Phone No.* _____

Address _____

4. *Have you taken any medication or drugs during the past two years ?* ..... YES ☐ NO ☐
5. *Are you now taking any medication, drugs or pills?* ..... YES ☐ NO ☐

If yes, please list: _____

6. *Are you aware of being allergic to or have you ever reacted adversely to any medication or substance ?* ..... YES ☐ NO ☐

If yes, please list: _____

7. *Indicate which of the following you have had or have at present. Circle "yes" or "no" to each item.*

Heart Failure ..... YES ☐ NO ☐	*Artificial Joints (hip, knee, etc.)* .... YES ☐ NO ☐	Hepatitis B *(serum)*..... YES ☐ NO ☐
Heart Disease or Attack ..... YES ☐ NO ☐	*Kidney Trouble* ..... YES ☐ NO ☐	*Venereal Disease* ..... YES ☐ NO ☐
Angina Pectoris ..... YES ☐ NO ☐	*Ulcers* ..... YES ☐ NO ☐	*A.I.D.S.* ..... YES ☐ NO ☐
Congenital Heart Disease ..... YES ☐ NO ☐	*Diabetes* ..... YES ☐ NO ☐	*H.I.V. Positive* ..... YES ☐ NO ☐
Heart Murmur ..... YES ☐ NO ☐	*Thyroid Problems* ..... YES ☐ NO ☐	*Cold Sores/Fever Blisters* ..... YES ☐ NO ☐
High Blood Pressure ..... YES ☐ NO ☐	*Glaucoma* ..... YES ☐ NO ☐	*Blood Transfusion* ..... YES ☐ NO ☐
Arteriosclerosis ..... YES ☐ NO ☐	*Cosmetic Surgery*..... YES ☐ NO ☐	*Hemophilia* ..... YES ☐ NO ☐
Mitral Valve Prolapse ..... YES ☐ NO ☐	*Emphysema* ..... YES ☐ NO ☐	*Anemia* ..... YES ☐ NO ☐
Artificial Heart Valve ..... YES ☐ NO ☐	*Chronic Cough* ..... YES ☐ NO ☐	*Sickle Cell Disease* ..... YES ☐ NO ☐
Heart Pacemaker ..... YES ☐ NO ☐	*Tuberculosis* ..... YES ☐ NO ☐	*Bruise Easily* ..... YES ☐ NO ☐
Heart Surgery ..... YES ☐ NO ☐	*Asthma* ..... YES ☐ NO ☐	*Liver Disease* ..... YES ☐ NO ☐
Rheumatic Fever ..... YES ☐ NO ☐	*Hay Fever* ..... YES ☐ NO ☐	*Yellow Jaundice* ..... YES ☐ NO ☐
Arthritis ..... YES ☐ NO ☐	*Allergies or Hives* ..... YES ☐ NO ☐	*Epilepsy or Seizures* ..... YES ☐ NO ☐
Rheumatism ..... YES ☐ NO ☐	*Sinus Trouble* ..... YES ☐ NO ☐	*Fainting or Dizzy Spells* ..... YES ☐ NO ☐
Cortisone Medicine ..... YES ☐ NO ☐	*Radiation Therapy* ..... YES ☐ NO ☐	*Nervousness* ..... YES ☐ NO ☐
Drug Addiction ..... YES ☐ NO ☐	*Chemotherapy* ..... YES ☐ NO ☐	*Psychiatric Treatment* ..... YES ☐ NO ☐
Stroke ..... YES ☐ NO ☐	Hepatitis A *(infectious)*..... YES ☐ NO ☐	Developmentally Disabled..... YES ☐ NO ☐

8. *When you walk up stairs or take a walk, do you ever have to stop because of pain in the chest.*

Shortness of breath, or because you are very tired? ..... YES ☐ NO ☐

9. *Do your ankles swell during the day ?* ..... YES ☐ NO ☐
10. *Do you use more than two pillows to sleep ?* ..... YES ☐ NO ☐
11. *Have you lost or gained more than 10 pounds in the past year ?* ..... YES ☐ NO ☐
12. *Do you ever wake up from sleep and feel short of breath?* ..... YES ☐ NO ☐
13. *Are you on a special diet ?* ..... YES ☐ NO ☐
14. *Has your medical doctor ever said you have a cancer or tumor ?* ..... YES ☐ NO ☐
15. *Do you have or have you had any disease, condition, or problem not listed ?* ..... YES ☐ NO ☐

If yes, please list: _____

FOR WOMEN ONLY:

Are you pregnant? ☐ *Yes, what month?* _____ ☐ *No* *Are you nursing?* ☐ *Yes* ☐ *NoAre you taking birth control pills?* ☐ *Yes* ☐ *No*

1. *I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.*
2. *The undersigned hereby authorizes doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis or the patient's dental needs.*
3. *I authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient)* _____
4. *I understand that a credit report may be utilized to establish any in office extended payment arrangements for treatment rendered.*
5. *I understand that the use of local anesthesia carries a risk of nerve damage that could lead to paresthesia (prolonged numbness).*
6. *Lastly, I understand that all responsibility for payment for dental services provided in this office for myself or my dependents in mine, due and payable at the time services are rendered, including any amount that is not covered by insurance, unless other arrangements have been made. In the event payments are not received by the agreed upon dates. I understand that a 1-1/2% finance charge (18% APR) may be added to my account.*

Patient _____ *Date* _____ *Witness*_____

Parent/Responsible Party _____ *Relationship to Patient*_____

** DO NOT SEND THIS FORM VIA UNENCRYPTED EMAIL AS IT CONTAINS SENSITIVE DATA**

DENTAL QUESTIONAIRE

We would appreciate your response to the following questions. Your response will help us serve your dental needs more effectively. Thank you for your time.

Dr. Thomas W. Kauffman

Why are you here? _____

What can you tell me about your past dental treatment?

_____

Do you have a history of trauma to your head, neck, and/or teeth, and/or headaches? If so, please give details:

_____

Are your teeth sensitive to hot or cold?

_____

Are you experiencing any discomfort with your teeth or gums?

_____

Are you interested in improving the appearance of your smile?:

_____

Are you anxious or fearful of treatment?

_____

Are you familiar with the benefits of implants?

_____

Who was your last dentist? What City/State?

_____

Is there anything else you need to tell me about yourself to assist me in providing your dental care?

_____

Sign and Date: _____

Thomas W. Kauffman, D.D.S., P.C.

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 law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 9-23-2013, 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 provide the new Notice at our practice location, and we will distribute it 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.

Your Authorization: Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Uses and Disclosures of Health Information

We use and disclose health information about you without authorization for the following purposes.

Treatment: We may use or disclose your health information for your treatment. For example, we may 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. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

All health information discussed while you are in our office will in every attempt be private. If at any time you feel the need to request more privacy due to the openness of our facility, please do so. We have a treatment room for your privacy. At times, you may overhear private conversations.

To You Or Your Personal Representative: 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 your personal representative, 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 absence or incapacity or in 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; and 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.

Disaster Relief: We may use or disclose your health information to assist in disaster relief efforts.

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.

Public Health and Public Benefit: We may use or disclose your health information to report abuse, neglect, or domestic violence; to report disease, injury, and vital statistics; to report certain information to the Food and Drug Administration (FDA); to alert someone who may be at risk of contracting or spreading a disease; for health oversight activities; for certain judicial and administrative proceedings; for certain law enforcement purposes; to avert a serious threat to health or safety; and to comply with workers' compensation or similar programs.

Decedents: We may disclose health information about a decedent as authorized or required by law.

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 the protected health information of an inmate or patient under certain circumstances.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

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. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying. If you request copies, we will charge you $0.75 for each page, $20.00 fee staff time to 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. If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

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. In most cases we are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in certain circumstances where disclosure is required or permitted, such as an emergency, for public health activities, or when disclosure is required by law). We must comply with a request to restrict the disclosure of protected health information to a health plan for purposes of carrying out payment or health care operations (as defined by HIPAA) if the protected health information pertains solely to a health care item or service for which we have been paid out of pocket in full.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and

provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

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. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice: You may receive a paper copy of this notice upon request, even if you have agreed to receive this notice electronically on our Web site or by electronic mail (e-mail).

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: Valerie Flowers-Gehl
Telephone: (404)524-1981
Fax: (404)524-8463
E-mail: twk@atlantasedationdentistry.org
Address: 133 Peachtree Street, NE Suite 4050 Atlanta, GA 30303

Thomas W. Kauffman, D.D.S., P.C.
133 Peachtree Street N.E., Suite 4050
Atlanta, GA 30303
(404)524-1981
(404)524-8463 Fax

Acknowledgement 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.

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)

REQUEST TO SHARE PHI

I, _____, hereby authorize and

Request that Dr. Thomas W. Kauffman share my PHI (protected health information) with

_____.

Patient_____

Date of Birth_____
SS#_____

Patient Signature_____

Authorized Person Name:_____

Authorized Person Signature: _____

Relation to Patient: _____

Date of Request_____

Witness Signature_____

THOMAS W. KAUFFMAN, DDS, PC

Dental Office Policy

48 Hours' Notice required to Cancel or Reschedule an appointment.

Our office has always been happy to accommodate patients covered by a dental benefit plan. This can be a great incentive to maintain a vital level of dental health. Most dental plans do not cover 100% of fees. Most dental coverage is in reality a partial help for basic preventative care.
Fees charged for services are the same for every patient, regardless of coverage. A given insurance policy, however, is based on a fixed fee schedule – "usual and customary" or UCR – that "usually" has nothing to do with the real world. Dentistry has changed very rapidly, insurance fee schedules have not. After all, insurance companies are profitable businesses, not dental benefactors.
We are happy to help you with any insurance related questions that have. We will try to maximize your benefits by utilizing our internal data of your insurance carrier.

We are a fee for service dental office. Partial payment is due at the time services are scheduled, and the remaining balance is due at the time services are rendered.

Please note the following:
Your employer and their insurance carrier have a legal, contractual agreement, which does not affect us. You are our patient and we have an obligation to treat YOU with the best, most appropriate care, not the minimal, patchwork treatment or no treatment your insurance carrier would prefer.
We cannot and do not warrant or in any way guarantee what your particular carrier will pay, even if your treatment is completed after a pre-determination of benefits has been received. Treatment plans are an estimate of what you insurance may pay for services that are to be rendered.
All claims are filed electronically on the date of service, and payment is normally received within 21 days. We request payment of any outstanding balance within 30 days.
In case of delayed or non-payment by any insurance carrier beyond 45 days from date of treatment, regardless of the reason for the delay, you the patient, will be required to make full payment. Reimbursements for any insurance over-payments are made promptly. Any patient that cannot comply with our insurance policy will be asked to pay in full at the time of service. We will provide you with an itemized statement that can be submitted to the insurance carrier for any eligible reimbursement.

BY SIGNING THIS DOCUMENT YOU AUTHORIZE US TO FILE YOUR DENTAL AND MEDICAL INSURANCE

We Look Forward to Providing You with Quality Care!

Signature:_____Date:_____

Georgia Pacific Center
133 Peachtree St, NE. #4050
Atlanta, GA 30303
(404) 524-1981
(404) 524-8463 Fax
twk@atlantasedationdentistry.org