Please fill out this form and save it to your computer. You can either print it out and bring it to your appointment or email it to drdentonhardie@bellsouth.net

J. DENTON HARDIE, D.M.D., P.C.
Master of Academy of General Dentistry
705 North Westover Blvd. • Albany, Georgia 31707
(229) 432-6641 • 800-510-8801

NAME _____ **SS#** _____ **DATE** _____

IT IS IMPORTANT THAT I KNOW ABOUT YOUR MEDICAL AND DENTAL HISTORY. THESE FACTS HAVE A DIRECT BEARING ON YOUR DENTAL HEALTH. THIS INFORMATION IS STRICTLY CONFIDENTIAL AND WILL NOT BE RELEASED TO ANYONE. THANK YOU FOR TAKING TIME TO COMPLETELY FILL OUT THIS QUESTIONNAIRE.

Street Address _____

Mailing Address (if different) _____

City _____ State _____ Zip _____

Birthdate _____ Home Ph. _____ Age _____

Single _____ Married _____ Divorced _____ Separated _____

Cell # _____

Special Interests or Hobbies _____

Employed By _____

Business Address _____

Present Position _____

Business Phone _____

Name of Spouse _____

Spouse Employed By _____

Business Address _____

Present Position _____

Business Phone _____

E-mail Address _____

Best Time and Number to confirm appointment _____

_____

Who should be notified in case of an emergency? _____

_____ Phone _____

Person responsible for Dental Investment _____

_____

Whom may we thank for referring you to this office? _____

_____

Purpose of your visit *(chief complaint)* _____

_____

Physician _____ Phone _____

MEDICAL HISTORY

1. Are you now under the care of a Physician? ☐ Yes ☐ No
2. If so, what is the condition being treated? _____

_____

_____

_____

3. Have you had any serious illness or operation? ☐ Yes ☐ No
   If so, explain _____

   _____
4. Are you taking any medications? ☐ Yes ☐ No
   If so, what _____

   _____

   _____

   _____
5. Have you ever taken bisphosphorates? (Fosomax, Actonel, Avedia, Zometa) ☐ Yes ☐ No
6. Are you allergic to any of the following? (Please check)
   a. Novocaine *(local anesthetic)* ☐ Yes ☐ No
   b. Penicillin *(or other antibiotics)* ☐ Yes ☐ No
   c. Sedative (Halcion) ☐ Yes ☐ No
   d. Latex ☐ Yes ☐ No
   e. Lysol ☐ Yes ☐ No
   f. Alleve, Advil, Motrin ☐ Yes ☐ No
   g. Other _____
7. Do you have or have you had any of the following?
   a. Prosthetic cardiac valve, Bacterial endocarditis, Congenital heart problems, Pulmonary shunts or conduits, Rheumatic heart disease, Hypertrophic cardiac myopathy, Mitral valve prolapse with regurgitation? ☐ Yes ☐ No
   b. Heart attack, high blood pressure, hardening of the arteries, or stroke? ☐ Yes ☐ No
   c. Allergy or drug reaction? ☐ Yes ☐ No
   d. Asthma or respirator problems? ☐ Yes ☐ No
   e. Fainting spells, seizures, or epilepsy? ☐ Yes ☐ No
   f. Diabetes? ☐ Yes ☐ No
   g. Hepatitis, jaundice, or liver disease? ☐ Yes ☐ No
   h. Stomach ulcers? ☐ Yes ☐ No
   i. Mental disorders? ☐ Yes ☐ No
   j. Venereal disease? ☐ Yes ☐ No
   k. Cancer or tumor? ☐ Yes ☐ No
   l. AIDS? ☐ Yes ☐ No
   m. Acid Reflux Disease? ☐ Yes ☐ No
   n. Other _____
8. Women: Are you pregnant? ☐ Yes ☐ No
9. Have you ever received an oral cancer screening exam? ☐ Yes ☐ No
10. Have you had surgery or x-ray treatment for a growth?

    _____
11. Do you smoke or chew tobacco? *(circle)* ☐ Yes ☐ No
12. Have you had abnormal bleeding with previous surgery, extractions or trauma? ☐ Yes ☐ No

(OVER)

DENTAL HISTORY

1. Last visit to the Dentist _____
2. Last cleaning appointment _____
3. Have you ever had x-rays of all your teeth? ☐ Yes ☐ No
4. Do you have your teeth cleaned on a regular basis? ☐ Yes ☐ No
5. Are any of your teeth sensitive to heat, cold, or chewing? (circle) ☐ Yes ☐ No
   Where? _____
6. Are you having any problems now? ☐ Yes ☐ No
   What? _____
7. Do your gums bleed when you brush your teeth? ☐ Yes ☐ No
8. Have you ever been told that you have gum disease? ☐ Yes ☐ No
9. Have you ever had gum (periodontal) treatment? ☐ Yes ☐ No
10. Has gum treatment ever been recommended to you? ☐ Yes ☐ No
11. Have you ever had instructions in the use of a toothbrush or dental floss? ☐ Yes ☐ No
12. How often do you brush your teeth? _____
13. Are you troubled with bad breath? ☐ Yes ☐ No
14. Do you use a soft toothbrush? ☐ Yes ☐ No
15. How often do you floss your teeth? _____
16. Do you feel apprehensive about dental visits? ☐ Yes ☐ No
17. Have you ever used nitrous oxide (laughing gas) to help relax during dental treatment? ☐ Yes ☐ No
18. Would you like to have the gas for dental treatment? ☐ Yes ☐ No
19. Do you have pain in or near your ears? ☐ Yes ☐ No
20. Do you have muscle soreness in the head and neck area? ☐ Yes ☐ No
21. Have you had any popping or clicking in your jaw? ☐ Yes ☐ No
22. Do you clench or grind your teeth? ☐ Yes ☐ No
23. Have you lost any teeth, other than wisdom teeth? ☐ Yes ☐ No
24. Have the lost teeth been replaced? ☐ Yes ☐ No
25. Has replacement been recommended to you? ☐ Yes ☐ No
26. Are you dissatisfied with the appearance of your teeth? ☐ Yes ☐ No
    If so why? _____
27. Do you eat peppermint candy, breath mints, chocolate or soft drinks on a daily basis? ☐ Yes ☐ No
    If so what?_____ and how often? _____

PLEASE RANK THE FOLLOWING IN THE ORDER IN WHICH THEY WOULD KEEP YOU FROM HAVING DENTAL TREATMENT (1st, 2nd, 3rd, etc.)

_____ Fear of pain
_____ Cost of treatment
_____ Trust
_____ Lack of concern
_____ Missing work

RANK IN THE ORDER OF IMPORTANCE OF YOUR DENTAL TREATMENT (1st, 2nd, 3rd, etc.)

_____ Appearance
_____ Longevity
_____ Quality
_____ Time Involved

28. Have you ever had a bad experience with any dental office personnel? ☐ Yes ☐ No
29. Have you ever had a BAD dental experience in the past? ☐ Yes ☐ No
30. Are you dissatisfied with any past dental treatment? ☐ Yes ☐ No
    Why? _____

In your own words, explain what causes tooth decay. _____

_____

_____

Is there any other medical or dental information that you feel Dr. Hardie should know about? _____

_____

_____

To the best of my knowledge the above medical and dental history is correct. I hereby consent to such examinations, x-rays, diagnostic test, and dental procedures agreed to be necessary and advisable including the use of local and/or inhalation anesthesia and prescribed medicines as deemed necessary for treatment.

Patient's Signature Parent (if child) _____ Date _____

Dentist's Signature _____ Date _____

J. Denton Hardie, D.M.D., P.C., M.A.G.D.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBED 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 heath 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 out healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence of qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certifications, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment of 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 heath 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 reasonably 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 Servies: 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 if instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operation 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're 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 he 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 COMPLAINS

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 Person: J. Denton Hardie, D.M.D., P.C., M.A.G.D.

Telephone: **(229)432-6641** **Fax: (229)432-6776**

E-mail: drdentonhardie@bellsouth.net

Address: **705 North Westover Blvd.**
Albany, GA 31707

J. Denton Hardie, D.M.D., P.C.

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
- □ Communication barriers prohibited obtaining the acknowledgement
- □ An emergency situation prevented us from obtaining the acknowledgement
- □ Other (Please Specify)

_____

_____

Updated 04/03/2003-form2a
My Documents_FORM - Hippa Acknowledgment
Front Right Computer

OFFICE PROCEDURES

Insurance:

While we are **not** providers for any insurance company, we do file insurance claims as a courtesy to our patients. Insurance is not a guarantee of payment and therefore, a co-pay is requested at the time services are rendered.

I understand that any fees incurred will be my responsibility and I will keep my account current. I also understand that after 45 days any balance is my responsibility and I will contact the insurance company regarding their payment.

Finance Charges:

A finance charge of 1.5% per month is assessed on accounts which are over 60 days.

Confirmation of Appointment:

We call, text, or email our patients 2 days prior to their appointment to confirm that they will be able to keep their appointment. If a message is left on an answering machine, please return our call either confirming your appointment or to cancel the appointment and reschedule. A reservation fee may be required for lengthy procedures.

Collection:

I understand that I will be responsible for any and all costs related to any collection fees including, but not limited to, the following: collection agencies, attorney's fees, and court costs.

NO-SHOW POLICY:

To cancel an appointment we request you call our office <u>PRIOR</u> to your appointment (229/432-6641) – if after business hours, please leave a message. If you do not call our office PRIOR to appointment, you will be considered a "NO SHOW". You will be charged/billed a $35.00 fee which will not be filed to your insurance.

If you "NO SHOW" three times within a year, you will be discharged from our practice except in extenuating circumstances, which will be determined by Dr. Hardie.

_____ _____

Patient Date

CREDIT CARD ON FILE AUTHORIZATION

Please complete this form to keep your credit card on file for future payments of services rendered which are outstanding after 60 days of treatment.

Cardholder Name:_____

Card Number: _____

Card Type: □ Visa □ MasterCard □ American Express

□ Discover □ CareCredit

Expiration Date:_____

Security Code: _____ (3 digits on back)

Billing Zip Code:_____

E-mail:_____

I, _____, authorize the dental practice of ***J. Denton Hardie, D.M.D., P.C.*** to charge the above credit card account for payments owed for services rendered at his office. I agree to update any information regarding this account. The above information is complete and correct to the best of my knowledge.

Cardholder Signature_____

Date:_____

Dental Insurance Information

Primary Insurance Carrier:

Name of Subscriber_____

Name of Insurance Carrier_____

Employer_____

Group # _____

Group Name_____

Member I.D.# _____

Subscriber Social Security #_____

Telephone Number for Providers_____

Secondary Insurance Carrier (if applicable):

Name of Subscriber_____

Name of Insurance Carrier_____

Group # _____

Group Name_____

Member I.D.# _____

Subscriber Social Security #_____

Telephone Number for Providers_____

PLEASE BRING YOUR DENTAL INSURANCE CARD TO APPOINTMENT