For Office Use:

Account # _____

1._____
2._____
3._____

Southern Smiles Dental Associates, LLC
Larry L. Webb, D.M.D.
770-968-1720

WELCOME!

Thank You for selecting our dental healthcare team! To help us meet all your dental needs, please fill out this form completely.

PATIENT'S FULL NAME _____ **NAME CALLED** _____

☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Minor (Child) (Please Check One)

Student Status: Full Time/ Part time/ None Name of School _____ City/State of School _____

Date of Birth ____/____/____ Social Security #____-____-____ Marital Status: S M D W Sex: M F

Address _____ Home Phone (____) _____

City _____ State _____ Zip _____ Cell Phone (____) _____

PATIENT'S EMPLOYER _____ Work Phone (____) _____

Employer Address _____

City _____ State _____ Zip _____

PERSON RESPONSIBLE FOR PAYMENT: (If different from Patient)
NOTICE - By state law, the parent who brings a child to our office is the responsible party.

Name _____ Name Called _____

Relationship to Patient _____ Social Security # ____-____-____ Marital Status: S M D W Sex: M F

Address _____ Date of Birth ____/____/____

City _____ State _____ Zip _____ Home Phone (____) _____

Employer _____ Work Phone (____) _____

Employer Address _____

City _____ State _____ Zip _____

GENERAL INFORMATION:

SPOUSE'S NAME _____ Work Phone (____) _____

Spouse's Employer _____ Home Phone (____) _____

In Case of Emergency, contact _____ Home Phone (____) _____

Reason for visit _____

How did you hear about our office? ☐ Person-_____ ☐ Other-_____

PRIMARY DENTAL INSURANCE COMPANY: _____ Group # _____

Claims Address _____ Ins. Phone(____) _____

City _____ State _____ Zip _____

Employee _____ Date Of Birth ____/____/____ ID# _____

Social Security # ____-____-____ Relationship to Patient _____

SECONDARY DENTAL INSURANCE COMPANY: _____ Group # _____

Claims Address _____ Ins. Phone(____) _____

City _____ State _____ Zip _____

Employee _____ Date Of Birth ____/____/____ ID# _____

Social Security # ____-____-____ Relationship to Patient _____

PLEASE COMPLETE BOTH SIDES OF THIS FORM ⇨

PRIMARY Physician _____ Phone (_____) _____

Specialist _____ Phone (_____) _____

Other _____ Phone (_____) _____

FOR OFFICE USE

Do you presently have OR have you ever had any of the following: PLEASE READ CAREFULLY

Yes	No	(Please check one)	Yes	No	
❑	❑	Heart Condition	❑	❑	Hearing Impaired
❑	❑	Heart Murmur/Rheumatic Fever	❑	❑	Lung Condition or Emphysema
❑	❑	Heart Attack	❑	❑	Asthma
❑	❑	Irregular Heart Beat	❑	❑	Sinus Condition
❑	❑	Heart Pacemaker	❑	❑	Tuberculosis
❑	❑	Damaged or Prosthetic Heart Valves	❑	❑	Do you use tobacco? Type _____
❑	❑	Stroke	❑	❑	Hepatitus or Jaundice Type _____
❑	❑	High Blood Pressure	❑	❑	AIDS, ARC, or HIV
❑	❑	Low Blood Pressure	❑	❑	Venereal Disease/STD
❑	❑	Chest Pain	❑	❑	Liver Condition
❑	❑	Anemia or Blood Disorder	❑	❑	Kidney Condition
❑	❑	Abnormal Bleeding/Clotting/Healing	❑	❑	Diabetes
❑	❑	Blood Transfusion	❑	❑	Hyperglycemia/Hypoglycemia
❑	❑	Anxiety/Depression/Other	❑	❑	Thyroid Condition
❑	❑	Alzheimer's Disease	❑	❑	Cancer - Type _____
❑	❑	Drug or Alcohol Addiction	❑	❑	Radiation Treatment
❑	❑	Convulsions/Fainting/Seizures	❑	❑	Arthritis or Rheumatoid
❑	❑	Head/Neck/Jaw Injury	❑	❑	Joint Replacement/Prosthesis
❑	❑	Glaucoma/Blindness	❑	❑	Stomach Ulcers/GI Condition/Reflux
❑	❑	Cold Sores/Fever Blisters/RAU	❑	❑	Osteoporosis/Bisphosphonate

REACTION or ALLERGY TO:

Yes	No	(Please check one)	Yes	No	
❑	❑	Codiene	❑	❑	Latex
❑	❑	Penicillin	❑	❑	Bleach
❑	❑	Novocaine/Anesthetic	❑	❑	Iodine

WOMEN: Are you currently

Yes	No	
❑	❑	On Birth Control
❑	❑	Pregnant-Due Date _____
❑	❑	Breast Feeding

❑ ❑ Other(please list) _____

Please List All Medications You Are Taking:

Medication	For Office use:	Medication	For office use:

Please list all medical or dental information which may affect your treatment: _____

- The above information is accurate to the best of my knowledge.
- I understand that all fees are to be paid at time of service, unless prior arrangements have been made.
- I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me (or my child) during the period of such dental care to third party payors and/or other health practitioners.
- I authorize the Insurance Company to pay Southern Smiles Dental Associates, LLC, directly for any benefits due to me for the treatment rendered.
- I permit a copy of these authorizations to be used in place of the originals.
- I understand that professional services are rendered and charged to the patient; therefore, I am responsible for my account, NOT the Insurance Company.
- In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to affect collection of this account or future outstanding accounts.

_____

Signature of Patient, Parent, and/or Responsible Party Date

PLEASE COMPLETE BOTH SIDES OF THIS FORM ⇨

SOUTHERN SMILES DENTAL ASSOCIATES, LLC
LARRY L. WEBB, D.M.D.
ACKNOWLEDGEMENT OF PRIVACY PRACTICES

**** You may refuse to sign this Acknowledgement****

Patient name: _____
(please print patient's name)

Patient's Date of Birth: _____

I, _____
(please print the responsible party's name)

Have received a copy of this office's Notice of Privacy Practices

_____
(signature of responsible party)

_____
(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 acknowledgement
___ An emergency situation prevented us from obtaining acknowledgement
___ Other (please specify)

SOUTHERN SMILES DENTAL ASSOCIATES, LLC
LARRY L. WEBB, D.M.D.
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 April 14, 2003, 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 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, 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 $0.20 for each page, $50.00 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 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. 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 Web site 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.
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: Linda Smith
Telephone: 770-968-1720 Fax: 770-968-1625
Address: 6612 Exchange Place, Morrow, GA 30260