PATIENT MEDICAL HISTORY

Date ______________________
MONTH DAY YEAR

Patient Name ______________________ Sex: M F
LAST FIRST MIDDLE

Signature ______________________ Email Address ______________________

Spouse Name ______________________ Children(s) Name(s) ______________________
LAST FIRST MIDDLE

Date of Birth ______________________ Age ______ S.S.# ______________________ Referred By ______________________
MONTH DAY YEAR

Address ______________________

City ______________________ State ______________ Zip ______________

Home Phone ( ) ______________ Business Phone ( ) ______________ Cell Phone ( ) ______________
area code area code area code

Marital Status: S M W D Employer ______________________ Occupation ______________________

Person responsible for payment __________ Address ______________ City ______________ State _____ Zip ________

Physician's Name, Address and Phone ______________________

Dental Insurance Carriers Name(s) ______________________ Group# ______________________

Welcome to our office. The following questions about your health will aid us in providing the best dental treatment for you. Please remember that the answers to these questions are held in strict confidence. If you have any questions, please feel free to ask. Thank you.

1. Date of last physical examination ______________________

	Circle	
2. Are you under any medical treatment now? If so, what?	yes	no
3. Have you ever been told to take antibiotics before dental treatment?	yes	no
4. Have you been hospitalized within the past 5 years?	yes	no
5. Have you had any major operations? If so, what?	yes	no
6. Have you had any abnormal bleeding after cuts, surgery, or dental extraction?	yes	no
7. Have you had surgery or X-ray treatment for a tumor, growth, or other condition?	yes	no
8. Are you employed anywhere that exposes you to X-rays or ionizing radiation?	yes	no
9. Are you now taking any drugs, medicine, or pills?	yes	no

If so, please list

Name	Dosage	Frequency	Date Started

Emergency Contact:

____

10. Do you have, or have you ever had: (check all that apply)

- ❑ heart ailment/murmur/angina
- ❑ rheumatic fever/rheumatic heart disease
- ❑ heart attack
- ❑ Mitral valve prolapse
- ❑ artificial heart valve or pacemaker
- ❑ congenital heart lesion
- ❑ chest pain
- ❑ shortness of breath
- ❑ high blood pressure
- ❑ respiratory or lung disease
- ❑ hepatitis-type________________
- ❑ scarlet fever or rheumatic fever
- ❑ asthma
- ❑ emphysema
- ❑ sickle cell disease
- ❑ G-6 PD Deficiency
- ❑ persistent cough
- ❑ recurrent sore throat
- ❑ sinus trouble
- ❑ hay fever
- ❑ arthritis
- ❑ skin rashes
- ❑ epilepsy or seizures
- ❑ faint spells
- ❑ liver disease
- ❑ yellow jaundice
- ❑ tuberculosis
- ❑ kidney disease
- ❑ cold sores (herpes)
- ❑ hemophilia
- ❑ blood transfusion(s)
- ❑ stroke
- ❑ HIV/ARC (AIDS)
- ❑ anemia
- ❑ blood disease or disorder
- ❑ diabetes - type ____________
- ❑ allergic to ____________
- ❑ prosthetic joint(s)
- ❑ venereal disease or syphilis
- ❑ stomach ulcer
- ❑ tumor or growth
- ❑ thyroid problem or hormone deficiency
- ❑ glaucoma or other eye problems
- ❑ steroid therapy
- ❑ kidney problems
- ❑ alcoholism
- ❑ unexplained weight change
- ❑ cancer/radiation

11. Are you allergic to, or have you ever reacted adversely to: (check any that apply)

- ❑ local anesthetic (such as Novicane)
- ❑ penicillin or other antibiotics
- ❑ sulfa drugs
- ❑ aspirin
- ❑ codeine
- ❑ sedatives, barbiturates, or sleeping pills
- ❑ iodine
- ❑ other

12. Is there any condition you feel your dentist should know about before undertaking dental treatment?

If so explain ____

____

13. Women: Are you pregnant or think you might be?..yes no

14. Are you taking birth control pills? ....yes no

15. What is the reason for this initial visit? ________________________________

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16. When was your last visit to the dentist? ________________________________

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History Review	Date
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History Review	Date
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NOTICE OF PRIVACY PRACTICE

THIS NOTICE DESCRIBES HOW DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Uses and Disclosures of Your Health Information

Treatment: Your health information may be used by staff members or disclosed to other healthcare professionals for the purpose of evaluating your health, diagnosing dental conditions, and providing treatment. For example, results of evaluations will be available in our dental record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment: Your health information may be used to seek payment from your dental plan and from other sources of coverage such as credit card companies that you may use to pay for services. For example, your dental plan may request and receive information on dates of service, the services provided, and the dental condition being treated.

If you personally pay for a procedure and ask that information about that procedure not be disclosed to your insurance carrier, so long as you, the patient, pay in full for the procedure, in a timely manner, the practice will not make the disclosure.

Health Care Options: Your health information may be used, as necessary, to support the day-to-day activities and management of this practice. For example, information on the services you received may be used to support budgeting and financial reporting and activities to improve quality.

Law Enforcement: Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.

Public Health Reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other Uses and Disclosures require Your Authorization: Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo the use of disclosure of information that occurred before you notified us of your decision.

Additional use of information:

Appointment Reminders: Your health information may be used by our staff to send you appointment reminders.

Information about treatments: Your health information may be used to send you information on the treatments and management of your dental condition and on new technology that you may find to be of interest. We may also send you information describing other health-related goods and services that we believe may interest you.

YOUR HEALTH INFORMATION RIGHTS: You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your health information

- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your health information
- The right to amend and/or submit corrections to your health information
- The right to receive an accounting of how and to whom your health information has been disclosed
- The right to receive a printed copy of this notice

OUR HEATLTH INFORMATION DUTIES: We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices that are outlined in this notice.

-Your information cannot be sold or used for marketing or fundraising purposes.

-You must be informed if there are any financial conflicts of interest with the dentist and any products or services utilized within the practice or as part of treatment.

-You will be notified of any breach of information in a timely manner.

OUR RIGHT TO REVISE PRIVACY PRACTICES: As permitted by law, we have the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. The revised policies and practices available at our facility will be applied to all protected health information that we maintain and will be available for you upon request.

REQUESTS TO INSPECT PROTECTED HEALTH INFORMATION: As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the practice's privacy officer.

COMPLAINTS: If you would like to submit a comment or complaint about our privacy practices or if you believe your privacy rights have been violated, you can contact the practice by sending a letter outlining your concerns to:

Dr. Curtis C. Williams III, DDS, MPH, LLC
2496 Jett Ferry Road
Suite 100
Dunwoody, GA 30338

You may also file a written complaint with the Office of Civil Rights.

Effective date: May 1, 2003
Revised date: January 1, 2019

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Name

____

Signature Date

Dr. Curtis Williams III, DDS, MPH
Comprehensive and Cosmetic Dentistry Financial Policy

- I understand that full payment is due at the time of service. We accept cash, checks, Visa, MasterCard, Discover, American Express and Care Credit.
- I understand that, as a courtesy, claims will be filed to my insurance carrier, but that I am ultimately responsible for payment of all fees generated by my treatment.
- I understand that the estimated patient copay and deductible for treatments rendered must be paid in full on the day of service.
- I understand that the insurance estimated portion may differ from what the insurance carrier ultimately pays. I will be responsible for any amounts not paid by my insurance for any reason.
- I understand that I am to give 24 hours advance notice when cancelling any scheduled appointments. If I do not cancel my appointment with 24 hours advance notice my account will be charged a cancellation fee of $42.00
- I understand that I will be charged a $35.00 non-sufficient fund returned check processing fee for all checks returned by the bank.
- I understand that it is my responsibility to notify this office of any changes to insurance coverage, personal address, phone number, work contact information or status.
- I understand that if I am late for my scheduled appointment time, my appointment may be rescheduled in order for our office to honor other appointment times and I will be charged a no show fee.
- I understand that Dr. Williams will see children under the age of 16, as long as they are capable of receiving cleanings and necessary radiographs. If they can't or need additional restorative work, the child will be referred to a pediatric dentist for further treatment.

Thank you for choosing Dr. Curtis Williams III, DDS, MPH, Comprehensive and Cosmetic Dentistry as your dental health care provider. We look forward to providing you with the highest quality dental care. I have thoroughly read, understand and agree to the above terms and conditions.

Signature (patient or responsible party) Date

CONSENT FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION BY NON-SECURE MEANS

Communication by Email, Text Message and Other Non-Secure Means

It may become useful during the course of treatment to communicate by email, text message (e.g. "SMS") or other electronic and nonelectronic methods. Be informed that these methods, in their typical form, are **not** confidential means of communication.

I, ____________________________________, direct Dr. Curtis C. Williams III, dental specialty providers and Insurance payers to disclose and release my protected health information described below:

Health Information to be disclosed upon the request of the person named above – (Check either A or B):

___ A. **Disclose** my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, recare and billing, for all conditions) **OR**

____B. **Disclose** my health record, as above, **BUT do not disclose** the following (check as appropriate):

_____Mental health records

_____Communicable diseases (including HIV and AIDS)

_____Alcohol/drug abuse treatment

_____Other (please specify):

____

Form of Disclosure (unless another format is mutually agreed upon between my provider and designee):

____An electronic record or access through an online portal

____Hard copy

____Recare notification

This authorization shall be effective until (Check One):

____All past, present and future periods, OR

____Date or event:____

Unless I revoke it. (**NOTE:** You may revoke this authorization in writing at any time by Notifying Dr. Curtis C. Williams III, DDS, MPH

____________________________________ ____________________

Name of the Individual Giving this Authorization Date of birth

____________________________________ ____________________

Signature of the Individual Giving this Authorization Date

Note: HIPPA Authority for Right of Access: 45 C.F.R. & 164.524