

PATIENT NAME: _____ DATE: _____
 Mailing Address: _____ City: _____ State: _____ Zip: _____
 E-Mail Address: _____
 Birthdate: _____ Age: _____ Single Married Divorced Widowed
 Home phone: _____ Work: _____ Ext: _____
 Cell: _____ Employed Student Homemaker Retired
 Soc. Sec #: _____ Employer: _____
 Dental Insurance: _____ Spouse/Partner (or other person responsible for payment) :
 Name: _____ Address: _____
 City: _____ State: _____ Zip: _____ Spouse Work#: _____ Spouse DOB: _____
 Employer: _____ Insurance Company: _____
 Nearest relative not living with you:
 Name: _____ Phone #: _____
 Referred by: Another patient Dental office doctor or staff member Name of person who referred _____

DENTAL HISTORY

Have you been having any specific problems? Yes No. Describe: _____
 Last dental visit: _____ Purpose: _____ Last exam: _____
 Has fear of discomfort kept you from regular visits? Yes No How would you describe your health?
 Good Fair Poor Do you think you have active dental disease: Decay? Yes No
 Homecare: Brush? Yes No Floss? Yes No. Gum Disease? Yes No. Do your gums ever bleed?
 Yes No. How often? _____ Are you troubled with bad breath? Yes No
 How do you feel about ever losing your teeth? _____
 Have you had any unusual effects from previous dental treatment? Yes No. Describe: _____

MEDICAL HISTORY (Confidential. Repeated every two years.) Month/Day/Year: _____

Medical doctor's name: _____ Last physical exam: _____
 (Women) Are you pregnant? Yes No Expected delivery date: _____

Are you under a doctor's care now? Yes No If so, for what? _____
 Are you taking any medications, pills or drugs? Yes No Please list _____
 Do you smoke Yes No How often? _____ Do you drink alcohol? Yes No How often? _____
 Have you ever had any of the following? Indicate YES check mark.
 Any heart problems Measles Diabetes Hepatitis Prosthetic valves/joints
 High blood pressure Mumps Arthritis Aids Allergy to anesthetics:
 Low blood pressure Scarlet fever Malignancies Venereal Disease _____
 Circulatory problems Typhoid fever Radiation TX Herpes Allergy to medicines:
 Excessive bleeding Nervous problems Asthma Tuberculosis _____
 Anemia Psychiatric care Stroke Sinus problems Other allergies:
 Rheumatic fever Hospitalization Ulcer Tonsillitis _____
 Have you had any other serious illness? Yes No Please list: _____
 Have you been hospitalized in the last two years? Yes No Why? _____
 Have you ever had difficulty with anesthetics? Yes No Explain: _____
 Do you wish to talk to the doctor about any problems not listed? Yes No Comments: _____

AUTHORIZATION: I here authorize the doctor(s) and/or staff of this dental office to administer such medications and to perform such diagnostic and therapeutic procedures as may be necessary for proper dental treatment. I state that my medical history is correct to the best of my knowledge. I understand that payment is due when services are rendered. Interest is charged on any unpaid balance over 30 days. You are responsible for your total fees whether you have dental insurance or not. Please note that our office requires a 24 hour notice for changing an appointment or there will be a \$50.00 broken appointment fee.

Patient Signature: _____ Date: _____

Reviewed by: Doctor: _____ Date: _____

MEDICAL HISTORY UPDATE FOR SUBSEQUENT VISITS: I have read my MEDICAL HISTORY dated _____
 And confirm that it adequately states past and present conditions.

DATE	EXCEPTIONS	PATIENT SIGNATURE	B.P.	REVIEWED BY
_____	_____	_____	_____	_____

Email	Athena Dental Associates	Website
athenadent@bellsouth.net	1020 Hawthorne Avenue. Athens, GA. 30606 OFFICE: (706) 546-7390 FAX: (706) 546-0806	athenadental.com

Financial Options

We are pleased that we can help you with your dental needs. Financially, you are expected to pay for dental services as they are rendered. When a child visits our office for dental care, the party responsible for the fee incurred by that child is the adult that brings the child in for their visit(s). (Regardless of whom is truly responsible in their individual family situation). We cannot bill another parent or guardian. We will be happy to provide you with a receipt of your service and payment at your visit. We do not send out monthly statement from this office. We offer several payment options for your convenience:

1. When you have dental treatment totaling \$300 or more and pay in full by cash or check at the time of service, we are able to extend to you a 5% bookkeeper's allowance for patients without insurance. This nice benefit is available to all patients.
2. You may use your VISA, MASTERCARD, AMERICAN EXPRESS or DISCOVER card.
3. If you would prefer an extended payment plan, you may use our Care Credit plan. It is especially designed for our patients. There is no down payment and no interest for 6 months.
4. IF YOU HAVE DENTAL INSURANCE, we will be more than happy, as a service to you, to file your insurance and accept payment from your dental insurance company. At the time of your treatment you will be expected to pay any deductible that you may have and the percentage that your insurance is not expected to pay. IF FOR ANY REASON YOUR DENTAL INSURANCE HAS NOT PAID IN 90 DAYS, YOU ARE RESPONSIBLE FOR YOUR PAYMENT ON YOUR SERVICES. We do not file secondary insurance. If for any reason you have a balance after your insurance has paid you will be responsible for the remaining balance. For any major work, when you have dental insurance, we will do a pre-treatment estimate for you. When we receive the pre-treatment estimate back from your insurance company we will be able to begin your work. YOU ARE RESPONSIBLE FOR YOUR TOTAL FEE WHETHER YOU HAVE DENTAL INSURANCE OR NOT.
5. If you are changing dentists and you would like to have your records and x-rays sent to new dentist we would be glad to make copies and send. There will be a charge of \$32.00 for duplication fee.
6. Please note that our office requires a 24-hour notice for changing an appointment or there will be a \$50 broken appointment fee.

Please direct your financial questions to us during our normal business hours Monday-Thursday 8:00 a.m. to 5:00 p.m. and Friday 8:00 a.m. to 12:00 p.m.

Sincerely,

Mark H. Blankenship, D.M.D.
Lane V. Barker, D.M.D.

Patient Signature

Date

ATHENA DENTAL ASSOCIATES

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 practice 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 or 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 an authorization you may revoke it in writing at any time. Your revocation will not affect any use or discloses permitted by your authorization while it was in effect. Unless you give 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 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 person responsible for your care, of your location, your general condition or death. If you are present then prior to use or disclose of your health information, we will provide you with an opportunity to object to such uses or discloses. 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 officials having lawful custody of protected health information of inmate or patients 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 practically 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 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 .10 cents for each page, .30 cents 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 COMMUNICATIONS: 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 writing 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 disclose of your health information or to have us communicate with you by alternate 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 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 Officers: Betty Staines or Alison Foster

Telephone: (706) 546-7390 Fax: (706) 546-0806

Email: athenadent@bellsouth.net

Address: 1020 Hawthorne Ave. Athens, GA 30606

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ATHENA DENTAL ASSOCIATES

Patient Name: _____

Address: _____ City: _____ Zip: _____

I have agreed to let certain individuals participate in discussions and decisions related to my medical/dental care. Therefore, I hereby give permission for Athena Dental Associates and staff to disclose my personal dental/medical information to the following individual(s):

Name: _____ Relationship to Pt: _____

Name: _____ Relationship to Pt: _____

Name: _____ Relationship to Pt: _____

Conditions for Disclosure. Check the item(s) that apply:

The practice may disclose my personal health information to the individual(s) above **only** in my presence.

The practice may disclose my personal health information to the individual(s) above when I am not physically present, including disclosures by telephone, answering machine, facsimile, e-mail or regular mail.

Other Conditions of Disclosure:

I understand that this consent maybe revoked by me at any time by written notice to the practice.

Patient Signature:

Date of Signature: _____

Witnessed by: _____ Title/Position: _____

Print Name of Witness: _____

Date: _____