Print Form

Priluck Nordone

Dentistry with a Difference

To Our Patients:

Welcome to our office. Our first responsibility to you and your family is to provide the utmost in dental care. We would appreciate your furnishing us with the following information, which will be used in strict confidence to prepare your clinical records.

Patient Information (Confidential)

Patient's Name _____ Preferred? _____ Birth Date _____

Patient's Address _____ SSN _____

City _____ State _____ Zip _____

Home # _____ Work # _____ Mobile# _____ Email Address _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Other

Responsible Person Information

Person Responsible for Account _____ Birth Date _____ SSN _____

Responsible Person's Employer _____ Phone # _____ Work # _____ Mobile # _____

Business Address _____

City _____ State _____ Zip _____

Spouse/Domestic Partner (If different than above) _____ Birth Date _____ SSN _____

Spouse/Domestic Partner's Employer _____ Work # _____

Business Address _____ City _____ State _____ Zip _____

Emergency Contact Name _____ Phone Number _____

General Information

Were you referred to Dentistry with a Difference by another patient? ☐ Yes ☐ No

If yes, whom may we thank? (Please provide a phone number and address if possible) _____

If you were not referred by another patient, how did you hear about us? _____

What are your special interests and hobbies? _____

Insurance Information

Name of Insured _____ Birth Date _____ SSN _____

Employer _____ Work # _____ Mobile # _____

Name and Address of Insurance Company _____

Phone # _____ Group # _____ ID # _____ Cobra ☐ Yes ☐ No

If Patient is a current college student, name and address of school _____

Patient Medical History

Many medical conditions can affect your oral health. Kindly complete these confidential health questions so that we may better serve your needs.

Do you have or have you ever had any of the following?:

- ☐ AIDS/HIV
- ☐ Allergies (Seasonal)
- ☐ Allergies (Medications)
- ☐ Alzheimer's
- ☐ Anemia/Blood Disorder
- ☐ Asthma
- ☐ Blood Transfusions
- ☐ Cancer/Malignancies
- ☐ Cardiac Pacemaker
- ☐ Circulatory Problems
- ☐ Diabetes /Sugar Problems
- ☐ Eating Disorder
- ☐ Epilepsy/Seizures
- ☐ Excessive Bleeding
- ☐ Eye Problems/Glaucoma
- ☐ Facial/Head Injuries
- ☐ Fainting/Blackouts
- ☐ Headaches/Migraines
- ☐ Heart Attack/Murmur
- ☐ Hepatitis/Jaundice
- ☐ High/Low Bld Pressure
- ☐ Hyper/Hypo Glycemia
- ☐ Implants
- ☐ Immune Deficiency
- ☐ Joint Replacement
- ☐ Kidney Problems
- ☐ Lupus
- ☐ Nervous Disorder
- ☐ Osteoporosis
- ☐ Parkinson's
- ☐ Pregnant Now
- ☐ PreMed
- ☐ Radiation Therapy
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Smoking
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Ulcers
- ☐ Other _____

Please provide details concerning any of the above conditions: _____

_____

Physicians Name & Phone Number _____

Reason seen in last 2 years _____

Are you currently taking any medication? (Prescription and Over the Counter) ☐ Yes ☐ No If yes, please provide name and dosage:

_____

_____

Have you Noticed Any of the Following?

- ☐ Teeth tender to chewing
- ☐ Sensitivity to sweets
- ☐ Recurring sore in mouth
- ☐ Discomfort in face, neck
- ☐ Jaw clicking
- ☐ Difficulty opening jaw
- ☐ Food caught between teeth
- ☐ Sensitivity to hot / cold
- ☐ Sensitivity to pressure
- ☐ Bleeding or sore gums
- ☐ Swelling, lumps in mouth
- ☐ Grinding / Bruxism

Is there anything you would change about your teeth, mouth, lips? _____

Have you had any problems with previous dental treatment? _____

Do you have any particular areas of concern regarding your teeth, mouth, lips? _____

Guarantee of Account

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We emphasize that we are NOT a party to the contract which exists between the patient and the insurance company. Consequently, the patient, not his / her insurance carrier, is responsible for any charges incurred. Fees are due and payable at the time of treatment.

I guarantee full payment of all dental charges incurred.

Signed _____ Date _____

Parent or Guardian if Patient is a Minor

I give my consent to needed dental services recommended for my benefit (or for my minor) and accept full responsibility for payment of services.

Signed _____ Date _____

Dentistry With a Difference respects you and your time. Kindly reciprocate by providing us with 48 hours notice should you need to change your appointment. We reserve the right to charge for broken appointments.

Signed _____ Date _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address:_____

Telephone: _____ Email: _____

Patient # _____ Social Security #: _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Dr. Jeffrey G. Priluck, Dr. Albert P. Nordone
Telephone : 770-393-9450 Fax 770-392-0647
Email: DrPriluck@Dentistrydifference.com
Address: 5548 Chamblee Dunwoody Road, Dunwoody, GA 30338

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, please complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you receive this written Notice of Revocation. I also understand that you may decline to treat or continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

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 (email), 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 with 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: Dr. Jeffrey G. Priluck or Dr. Albert P. Nordone
Telephone: 770-393-9450 Fax: 770-392-0647
Email: DrPriluck@Dentistrydifference.com
Address: 5548 Chamblee Dunwoody Road, Dunwoody, GA 30338

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 acknowledgement
_____ Other (Please Specify)

_____
_____
_____
_____