Fred H. Simonton III, D.M.D., P.C.

First name _____ M.I. ____ Last name _____ Nickname_____
Address _____ City _____ State _____ Zip _____
Phone number you want to be contacted at:_____ Email_____
Employer _____ Occupation _____ Marital status _____
Date of birth _____ Sex: □ Male □Female Age _____ S. S.# _____

Person responsible for bill_____ Relationship to patient_____
Address if different from patient_____
Home phone ( ) _____ Work phone ( )_____ DOB_____
Employer _____ S. S. #_____

Reason for visit _____ Please Circle
Do you now or have you ever had pain, swelling, pressure, infection or bleeding from wisdom teeth? YES NO Upper left Upper right Lower left Lower right
Dentist _____ Physician _____ Referred by_____
Person to contact in case of an emergency _____Phone ( ) _____

HEALTH HISTORY *Please complete every line*

List **all** medications you are currently taking _____

List **all** previous surgeries and give dates_____

Are you allergic or have you reacted adversely to any of the following medications? Please circle all that apply.

Penicillin Demerol Tetracycline Darvon Eggs Erythromycin Local
Aspirin Latex Other antibiotics Percodan Codeine Valium anesthetic

Allergy to any other medication or substance? □Yes □No If yes, please list:_____
Patient's weight_____ Patient's height _____

Please circle YES or NO for the following questions:

HEART DISEASE
YES NO Congestive heart failure
YES NO Heart attack
YES NO Chest pain
YES NO High blood pressure
YES NO Murmur/valve disorder
YES NO Rheumatic fever
YES NO Mitral valve prolapse
YES NO Pacemaker
YES NO Heart surgery
YES NO Irregular heartbeat

LUNG DISEASE
YES NO Asthma
Date of last attack _____
YES NO Emphysema
YES NO Smoke tobacco
# of yrs _____ Packs/day _____
YES NO Sleep apnea
YES NO Chronic cough

ENDOCRINE DISEASE
YES NO Diabetes
YES NO Thyroid

INFECTIOUS DISEASE
YES NO HIV/AIDS
YES NO Hepatitis A/B/C
YES NO Tuberculosis
YES NO Venereal
YES NO Other

MUSCULOSKELETAL DISEASE
YES NO Fibromyalgia
YES NO Arthritis
YES NO Connective tissue disease
YES NO Lupus
YES NO Artificial joint
YES NO Osteoporosis
YES NO Jaw joint pain/dysfunction

NEUROLOGIC DISEASE
YES NO Neuromuscular
YES NO Stroke
YES NO Seizures, epilepsy
YES NO Migraine headaches

FEMALE ONLY
YES NO Birth control
YES NO Pregnant (Antibiotics may interfere with the effectiveness of oral contraceptives. Consult your physician for advice regarding other methods of birth control.)

BLOOD/CLOTTING DISORDER
YES NO Prolonged bleeding
YES NO Anemia
YES NO Hemophilia
YES NO Platelet disorder
YES NO Bruising
YES NO Aspirin usage

ANESTHESIA HISTORY
YES NO General anesthesia
YES NO Complications
YES NO Post-op nausea
YES NO High fever
YES NO Prolonged recovery

OTHER
YES NO Liver disease
YES NO Kidney disease
YES NO Cancer treatment
YES NO Chewing tobacco
YES NO Taking diet pills
YES NO Psychiatric care
YES NO Ulcers
YES NO Drug addiction
YES NO Alcohol use
YES NO High Cholesterol
YES NO Osteoporosis Meds

Is there any health condition not listed above? □ Yes or □ No. If YES, please list: _____

I have read, understand, and answered the questions above. I will not hold my surgeon, or any other member of his staff, responsible for any errors or omissions that I have made in completion of this form. I hereby assign all benefits to which I am entitled to Dr. Simonton. I authorize the release of all information my insurance company requests.

Signature of Patient/Guardian_____ Date _____

Financial Policy

To avoid any misunderstanding concerning fees, you will receive an **ESTIMATE** of the proposed services prior to treatment. The actual treatment may vary from the proposed plan due to unforeseen circumstances. **FULL PAYMENT OF YOUR ESTIMATED PORTION IS DUE AT THE TIME SERVICES ARE RENDERED.** We understand that some patients may not be able to pay cash for their treatment. We do offer and accept several alternative payment options:

1. Personal check (with a copy of driver's license)
2. Mastercard, Visa, Discover, American Express and Debit Cards
3. Care Credit

If you have insurance, we will be glad to call and check your benefits for you. **THE PERCENT NOT COVERED BY YOUR INSURANCE, ANY DEDUCTIBLE THAT HAS NOT BEEN MET AND ANY COPAYS WILL BE DUE THE DAY SERVICES ARE RENDERED.**
For many reasons, your insurance company may not cover the entire fee. **AFTER ALL INSURANCE PAYMENTS ARE RECEIVED, THE BALANCE IS THE PATIENT RESPONSIBILITY TO PAY WITHIN 60 DAYS OF THE TREATMENT DATE.**
We will be happy to bill your insurance company and accept assignment of benefits. We will file the claim **ONE TIME** to your insurance. **IT IS THE PATIENT'S RESPONSIBILTY TO FOLLOW UP WITH THE INSURANCE COMPANY TO ENSURE THAT THE CLAIM HAS BEEN PAID.**
A service charge of 1.5% per month will be added to any remaining balance if the claim was not paid or balance reduced within 60 days.
After 90 days of no payment activity, your account will be turned over to our collection agency and a 35% collection fee will be added to any outstanding balance.

In order for us to bill your insurance, it is your responsibility to provide all the information needed to file a claim. If you do not provide us the required information within 30 days of the date of service, your balance is then considered **due in full from you.** Georgia state law requires that insurance companies address all submitted claims within 30 days and keep the contract holder informed of the status of the claim. You should follow up with your insurance carrier after 30 days.
PLEASE UNDERSTAND that **we file insurance as a courtesy to our patients.** We do not have a contract with your insurance company, only you do. We are not responsible for how your insurance company handles its claims or for what benefits they pay on a claim. We can only assist you in estimating your portion of the cost of treatment; we at no time guarantee what your insurance will or will not do with each claim. We also are not responsible for any errors in filing your insurance; once again we file claims as a courtesy to our patients.

Our practice is committed to providing the highest quality of care to our patients at a reasonable cost. The amount of benefits paid by insurance carriers varies considerably. Their level of reimbursement may be less than the actual charges. **You will be responsible for all NON-COVERED charges as well as your percentage portion as defined by your insurance company.** Verification of benefits DOES NOT GUARANTEE PAYMENT or COVERAGE. **We are required by law to collect any and all copays and deductibles.**

I authorize Dr. Fred Simonton III, D.M.D., P.C. to furnish any and all information concerning my treatment to insurance carriers for claims submitted, pre authorizations, appeals, and/or other medical facilities/providers as necessary for treatment and to verify the employment or insurance coverage of myself and/or my spouse.

I understand the financial policy explained above and acknowledge that the fees for services rendered are my responsibility.

_____ _____
Patient/Parent/Guardian Signature if under 18 years old Date

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU. The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will elaborate on the meaning and provide more specific examples, if you request. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive at the practice may be billed to and payment may be collected from you, an insurance company, or a third party. For example: we may disclose your record to an insurance company, so that we can get paid for treating you.

For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at the practice or the hospital. For members, clergy, or other persons who are part of your care.

For Health Care Operations. We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run the practice and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other practice personnel for review and learning purposes. For example, we may review your record to assist our quality improvement efforts.

WHO WILL FOLLOW THIS NOTICE. This notice describes our practice's policies and procedures and that of any health care professional authorized to enter information into your medical chart, any member of a volunteer group that we allow to help you, as well as all employees, staff, and other practice personnel.

POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION. We create a record of the care and services you receive at the practice. We need this record in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the practice, whether made by practice personnel or by your personal doctor. The law requires us to: make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and to follow the terms of the notice that is currently in effect. Other ways we may use or disclose your protected health care information include: appointment reminders; as required by law; for health-related benefits and services; to individuals involved in your care or payment for your care; research; to avert a serious threat to health or safety; and for treatment alternatives. Other uses and disclosures of your personal information could include disclosure to, or for: coroners, medical examiners, and funeral directors; health oversight activities; inmates; law enforcement; lawsuits and disputes; military and veterans; national security and intelligence activities; organ and tissue donation; protective services for the President and others; public health risks; and worker's compensation.

Notice of Individual Rights

You have the following rights regarding medical information we maintain about you:

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, the practice. To request an amendment, your request must be made in writing and submitted to the Privacy Officer and you must provide a reason that supports your request. We may deny your request for an amendment.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. We may deny your request to inspect and copy in certain very limited circumstances.

Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

Right to Request Confidential Communication. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must make your request in writing and you must specify how or where you wish to be contacted.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. *We are not required to agree to your request.* If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer.

CHANGES TO THIS NOTICE. We reserve the right to change this notice. We will post a copy of the current notice in the practice's waiting room.

COMPLAINTS. If you believe your privacy rights have been violated, you may file a complaint with the practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the practice, contact Dana Adams, Privacy Officer, 770/531-1075. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION. Other uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time.

If you have any questions about this notice or would like to receive a more detailed explanation, please contact our Privacy Officer.

I acknowledge by signing below that I have read the above. EFFECTIVE DATE April 1, 2003

_____ _____

Patient or personal representative Date