PATIENT REGISTRATION

Norcross Dental Care
Anne Y. Na, DMD

Patient Name: _____
First Middle Last

SS# _____ **Birthdate** _____ **Age** _____

Marital Status: **Single** _____ **Married** _____ **Divorced** _____ **Widowed** _____

Sex: **Male / Female**

Home Address _____

City _____ **State** _____ **Zip** _____

Home Phone ( ) _____ **Work Phone** ( ) _____

Employer Name and Address

_____

_____

Occupation _____

Person Responsible for Account _____

Relationship _____ **Birthday** _____

Social Security # _____ **Home Phone** _____

Home Address (If different)

_____ **Zip** _____

Driver's License # and State _____

Occupation _____ **Work Phone** _____

Referred by: _____

Nearest Relative Not Living With You _____

Relationship _____

Address _____ **Zip** _____

Phone _____

Do you have Dental Insurance? **Yes** _____ **No** _____

Insurance Company Name & Address _____

Phone Number ( ) _____ **Contact #** _____

Group # _____ **Subscriber #** _____

Circle Yes or No to the following questions:

1. Are you presently under the care of a physician? Yes No
   Physician Name _____ Phone # _____
2. Have you ever had high blood pressure? Yes No
3. Has a physician ever said you had heart trouble? Yes No
4. Do you have Mitral Valve Prolapse? Yes No
5. Have you ever had abnormal bleeding following a cut or extraction? Yes No
6. Have you ever had anesthetic (either local or general)? Yes No
7. Has a physician or dentist ever said you had a tumor or cancer? Yes No
8. Are you allergic to Penicillin, Novocain or any other medicine? Yes No
9. Are you allergic to anything other than medicine? (e.g., latex or metals)? Yes No

   What medications are you currently taking: _____

_____

_____

Do you have or ever had:

Rheumatic Fever?	Yes	No	Rheumatic Heart Disease?	Yes	No
Anemia	Yes	No	Epilepsy or Convulsions	Yes	No
Asthma or hay fever	Yes	No	Tuberculosis	Yes	No
Diabetes	Yes	No	Kidney Trouble	Yes	No
Liver trouble or Jaundice	Yes	No	Thyroid Trouble or Goiter	Yes	No
Venereal Disease	Yes	No	Fainting or Dizziness	Yes	No
Glaucoma	Yes	No	Arthritis	Yes	No
HIV AIDS	Yes	No	Stroke	Yes	No
Stomach Ulcer	Yes	No	Heart Murmur	Yes	No
Prostate Trouble	Yes	No	Hepatitis	Yes	No
Eczema or Hives	Yes	No	Psychiatric Treatment	Yes	No
Cancer	Yes	No	Are you pregnant?	Yes	No

Are you taking:

Drugs for high blood pressure?	Yes	No	Drugs for sleep?	Yes	No
Cortisone, Steroids of ACTH	Yes	No	Anticoagulants or Blood Thinners	Yes	No
Tranquilizers or sedatives	Yes	No	Antibiotics	Yes	No
Insulin	Yes	No	Others?	Yes	No

Payment is Due at Time of Service. I will be paying today by:

Cash _____ **Check** _____ **Credit Card** _____

Date _____

Signature _____

NORCROSS DENTAL CARE
ANNE Y. NA, DMD
6139-B OAKBROOK PKWY
NORCROSS, GA 30093
(770) 448-7037

SECTION A: The Patient.

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number: _____

SECTION B: Acknowledgement of Receipt of Privacy Practices Notice.

I, _____ , acknowledge that I have received a Notice of Privacy Practices from the above-named practice.

Signature: _____ Date: _____

If a personal representative signs this authorization on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

SECTION C: Good Faith Effort to Obtain Acknowledgement of Receipt.

Describe your good faith effort to obtain the individual's signature on this form: _____

_____

_____

Describe the reason why the individual would not sign this form: _____

_____

_____

SIGNATURE

I attest that the above information is correct.

Signature: _____ Date: _____

Print Name: _____ Title: _____

Include this acknowledgement of receipt in the individual's records.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICES

[Insert Name of Practice]

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

Federal and state law requires us to maintain the privacy of your health information. That law also requires us 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 we describe 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 applicable law permits the changes. 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 health care operations. For example:
Treatment: We may use your health information for treatment or disclose it to a dentist, physician or other health care provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. We may also disclose your health information to another health care provider or entity that is subject to the federal Privacy Rules for its payment activities.

Health Care Operations: We may use and disclose your health information for our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. We may disclose your health information to another health care provider or organization that is subject to the federal privacy rules and that has a relationship with you to support some of their health care operations. We may disclose your information to help these organizations conduct quality assessment and improvement activities, review the competence or qualifications of health care professionals, or detect or prevent health care fraud and abuse.

On Your Authorization: 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 uses 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 may disclose your health information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care. Before we disclose your health information to these people, we will provide you with an opportunity to object to our use or disclosure. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We may 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. We may use or disclose information about you to notify or assist in notifying a person involved in your care, of your location and general condition.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters.)

Disaster Relief: We may use or disclose your health information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

Public Benefit: We may use or disclose your medical information as authorized by law for the following purposes deemed to be in the public interest or benefit:

- as required by law;
- for public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury;
- to report adult abuse, neglect, or domestic violence;