

Knox Winning Smiles

Dr. C. David Knox, P.A. Dentist
2404 Candler Road
Decatur, GA 30032-6409
404-289-5660
www.knoxwinningsmiles.com



Everyone wins at Knox Winning Smiles!

Refer a friend to us and they will receive a \$20.00 discount off any treatment on their first visit. For each referral resulting in an appointment, you will receive a \$10 credit on your account!

Give a copy of this page to your friends or visit knoxwinningsmiles.com to print a coupon.

Health History Form



American Dental Association
www.ada.org

E-mail:

Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name:			Home Phone: <i>include area code</i>		Business/Cell Phone: <i>include area code</i>	
Last	First	Middle	()		()	
Address:			City:	State:	Zip:	
Mailing address						
Employer:			Height:	Weight:	Date of birth:	Sex: M F
SS# or Patient ID:			Emergency Contact:	Relationship:	Home Phone: ()	Cell Phone: ()
			<i>include area codes</i>			
If you are completing this form for another person, what is your relationship to that person?						
Your Name			Relationship			
Do you have any of the following diseases or problems: (Check DK if you Don't Know the answer to the question) Yes No DK						
Active Tuberculosis			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
Persistent cough greater than a 3 week duration			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
Cough that produces blood			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
Been exposed to anyone with tuberculosis			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.						

Dental Information *For the following questions, please mark (X) your responses to the following questions.*

	Yes	No	DK		Yes	No	DK
Do your gums bleed when you brush or floss?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have earaches or neck pains?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to cold, hot, sweets or pressure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any clicking, popping or discomfort in the jaw?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does food or floss catch between your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you brux or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your mouth dry?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have sores or ulcers in your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any periodontal (gum) treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear dentures or partials?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had orthodontic (braces) treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you participate in active recreational activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any problems associated with previous dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a serious injury to your head or mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your home water supply fluoridated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date of your last dental exam:			
Do you drink bottled or filtered water?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What was done at that time?			
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY				Date of last dental x-rays:			
Are you currently experiencing dental pain or discomfort?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
What is the reason for your dental visit today?							
How do you feel about your smile?							

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

	Yes	No	DK		Yes	No	DK
Are you now under the care of a physician?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you had a serious illness, operation or been hospitalized in the past 5 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physician Name:				If yes, what was the illness or problem?			
Phone: <i>include area code</i>							
()							
Address/City/State/Zip:				Are you taking or have you recently taken any prescription or over the counter medicine(s)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you in good health?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:			
Has there been any change in your general health within the past year?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
If yes, what condition is being treated?							
Date of last physical exam:							

Medical Information Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

(Check DK if you Don't Know the answer to the question)			Yes	No	DK				Yes	No	DK												
Do you wear contact lenses?						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you use controlled substances (drugs)?														
Are you taking, or have you taken, any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine) or phen-fen (fenfluramine-phentermine combination)?						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you use tobacco (smoking, snuff, chew, bidis)?														
						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If so, how interested are you in stopping? (Circle one) VERY / SOMEWHAT / NOT INTERESTED														
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease?						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you drink alcoholic beverages?														
						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, how much alcohol did you drink in the last 24 hours?														
						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, how much do you typically drink in a week?														
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	WOMEN ONLY Are you:														
Date Treatment began:						Pregnant?						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>									
						Number of weeks:						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>									
						Taking birth control pills or hormonal replacement?						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>									
						Nursing?						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>									
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?												<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>									
Date:												If yes, have you had any complications?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>							
Allergies - Are you allergic to or have you had a reaction to:												Yes	No	DK	Yes	No	DK						
To all yes responses, specify type of reaction.																							
Local anesthetics						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Metals														
Aspirin						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Latex (rubber)														
Penicillin or other antibiotics						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Iodine														
Barbiturates, sedatives, or sleeping pills						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever/seasonal														
Sulfa drugs						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Animals														
Codeine or other narcotics						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Food														
						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other														
<small>Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.</small>																							
Yes			No			DK			Yes			No			DK								
Heart murmur			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic pain			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep disorder			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mitral valve prolapse			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood transfusion			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes Type I or II			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental health disorders			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Artificial heart valves			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, date:						Eating disorder			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Specify:					
Rheumatic fever			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Malnutrition			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent Infections			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	AIDS or HIV infection			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal disease			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Type of infection:					
Cardiovascular disease			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	G.E. Reflux/persistent			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney problems			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Angina			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Autoimmune disease			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	heartburn			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Night sweats			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arteriosclerosis			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid arthritis			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congestive heart failure			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Systemic lupus			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Persistent swollen glands			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coronary artery disease			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	erythematosus			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	in neck			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Damaged heart valves			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Severe headaches/			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis, jaundice or			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	migraines			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low blood pressure			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	liver disease			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Severe or rapid weight loss			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus trouble			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexually transmitted disease			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congenital heart defects			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells or seizures			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive urination			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer/Chemotherapy/			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurological disorders			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
Rheumatic heart disease			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Treatment			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, Specify:											
Abnormal bleeding			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain upon exertion			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>												
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?												<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>									
Name of physician or dentist making recommendation:												Phone:											
Do you have any disease, condition, or problem not listed above that you think I should know about?												<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>									
Please explain:																							

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian:

Date:

FOR COMPLETION BY DENTIST

Comments:

DR. C. DAVID KNOX DENTAL AND ASSOCIATES

WELCOME TO OUR OFFICE. WE WILL DO OUR BEST TO MAKE YOUR APPOINTMENTS AS CONVENIENT AND PLEASANT AS POSSIBLE. IF AT ANY TIME YOU HAVE ANY QUESTIONS REGARDING YOUR TREATMENT, YOUR APPOINTMENTS OR FEES, PLEASE FEEL FREE TO ASK.

FOR ALL PATIENTS

THE UNDERSIGNED PATIENT AGREES TO PAY FOR ALL SERVICES AT THE TIME RENDERED. ANY UNPAID BALANCE IS SUBJECT TO A SERVICE CHARGE OF 1 AND ½ % PER MONTH OF THE DELINQUENT BALANCE, OR THE MAXIMUM ALLOWED BY LAW, WHICHEVER IS LESS.

THE UNDERSIGNED AGREES TO PAY ALL CONSEQUENT COLLECTION FEES, IN THE EVENT THE AMOUNT BECOMES DELINQUENT.

THE PATIENT HERBY ACKNOWLEDGES THAT THE SERVICES RENDERED AT THIS DENTAL OFFICE ARE NOT PAYABLE BY INSTALLMENTS, UNLESS OTHER SPECIFIC ARRANGEMENTS HAVE BEEN MADE IN WRITING AND SIGNED.

SIGNED _____ DATE _____
PATIENT (IF MINOR, PARENT/GUARDIAN)

PATIENTS WITH DENTAL INSURANCE

I HERBY AUTHORIZE DR. C. DAVID KNOX TO FURNISH MY INSURANCE COMPANY WITH ANY INFORMATION AND COPIES OF RECORDS HE MAY HAVE CONCERNING MY DENTAL HEALTH. A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.

SIGNED _____ DATE _____
PATIENT (IF MINOR, PARENT/GUARDIAN)

I ALSO AUHTHORIZE AND REQUEST THAT PAYMENT BE MADE DIRECTLY TO DR. C. DAVID KNOX D.D.S. P.A. FOR THE AMOUNT DUE ON ANY PENDING CLAIM OR DENTAL TREATMENT, BY REASON OF SUCH TREATMENT OR SERVICES RENDERED.

SIGNED _____ DATE _____
PATIENT (IF MINOR, PARENT/GUARDIAN)

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY

SIGNED _____ DATE _____



LET US CREATE A WINNING SMILE FOR YOU

C. DAVID KNOX, D.D.S. P.A.

WHAT IT MEANS TO BE A PATIENT AT OUR DENTAL PRACTICE

Our purpose is to provide the highest quality dental care to as many people as is possible, with very special attention given to your friends and family. In order to achieve that purpose we ask certain things of you.

- A. Since you are under our care and your dental health is our responsibility (as well as yours) we need to know of any problems or changes in your dental health. Always call our office anytime you have a question or a problem regarding the care of your teeth and gums. We are quite happy to provide you with the information you need, and no question is unimportant.
- B. Many Dental problems that exist are not visible to the eye. The Doctor is always looking for symptoms of problems below your gum and in hidden places. This is where x-rays and exams come in. It is a policy of our office that you have a 6-month exam. This is the only way we can be responsible for your teeth and gums, and give you the best care possible.
- C. Your 6-month exam will be done at your 6-month cleaning appointment. Once your full treatment is done you will be given a cleaning appointment 6 months from the last cleaning appointment. You will receive a reminder card in the mail, as well as a phone call one week prior to your scheduled time. It is our policy to confirm all appointments one day in advance. You are expected to arrive on time, as we have set aside this time for you. If any problems should arise, please give a 24 hours notice if the time needs to be changed. This way you can have a smooth and swift appointment.
- D. Our patients keep their **APPOINTMENTS ONCE MADE**. The doctor and staff have set the time for you and they have laid out a carefully prepared treatment plan for you. So, do your part by arriving on time for your appointment and we thank you in advance.
- E. There is a \$50.00 broken appointment fee.



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C. DAVID KNOX, D.D.S. P.A.

F. It is our policy for our patients to pay for their service at the time it is given or in advanced if you wish. Our primary concern is that you complete your treatment plan. If financial arrangements are needed please see our Business Manager or Accounts Analyst. If you have dental insurance, you can utilize our service of having us fill out your insurance and file your claim. You sign the form authorizing the insurance company to pay us directly. However, if your insurance company fails to send payment on your behalf, the full debt of service is the patient's responsibility. Patients may also elect to pay us in full and have the insurance company reimburse them.

We have found that a great part of achieving our purpose mentioned above includes taking responsibility for the dental needs of your friends and family. Unfortunately, 50% of the population are not receiving dental care on a regular basis. A large part of this 50% are children. You can save someone else a lot on unnecessary pain and expense by telling them about our office, campaign, and purpose. Tell our staff about the people you know who need dental care. WE CAN HELP THEM! Welcome to our dental practice, we value you as one of our patients and will strive to give you optimum dental health.

I HAVE READ, "WHAT IT MEANS TO BE A PATIENT"

SIGNATURE

DATE



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C. DAVID KNOX, D.D.S. P.A.

Finance Policy

To our Valued Patients:

Today in our world of rising prices, we are trying to keep our fee increase to a minimum by implementing CLEAR and EXACT payment policies. This will help reduce our overhead, thus passing the savings along to our patients.

As in the past, and as a courtesy to you, we will continue to file your insurance claims. Our office will not file insurance claims for under \$100.00.

We offer the following payment policies:

- ◆ Cash, All Major Credit Cards, Checks.
- ◆ 10% Discount to all Senior Citizens (60 and over) on all services.
- ◆ Payment for services are made to the office at the time services are rendered.
- ◆ Patients having dental insurance will be required to pay their deductible and estimated portion of the fee at the time services are rendered. **You will be responsible for any balance remaining after the insurance company has paid. We "quote" you an estimate only from the insurance company.**
- ◆ If insurance has not made payment to this office within 45 days, then the responsibility of the debt falls to the patient to pay.
- ◆ We **do not** file secondary insurance claims, however we will be happy to show you how to file in order for you to be reimbursed.
- ◆ **A \$50.00 FEE WILL BE CHARGED FOR ANY APPOINTMENT CANCELLED WITHOUT 24 HOUR NOTICE.**
- ◆ **RESERVATION FEE OF \$50.00 OR 10% OF THE TREATMENT WILL BE REQUIRED IF PATIENT HAS A HISTORY OF NOT SHOWING FOR AN APPOINTMENT. If the patient makes his/her appointment, amount is applied to your balance; however if appointment broken, the fees are not applied or refundable.**
- ◆ Any account over 60-days that has not been paid will automatically be referred for legal collections. If that is necessary, please be advised the collection cost will be assessed to your balance and you will be responsible. **FYI, this cost can increase your balance to as much as 33% - 50% more than the original amount.**



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C. DAVID KNOX, D.D.S. P.A.

I have read the above policies and totally understand what is written. I agree to abide by these policies.

Date: _____

Signed: _____



C. DAVID KNOX, D.D.S. P.A.

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EMERGENCY PATIENT DISCLOSURE

DR KNOX'S OFFICE WILL MAKE EVERY EFFORT TO TREAT YOUR EMERGENCY. YOU WILL BE WORKED INTO A SCHEDULE THAT IS ALREADY FILLED. BECAUSE OF MEDICAL/DENTAL REASONS OR SIMPLY THE LACK OF TIME, IT IS NOT POSSIBLE FOR EVERY EMERGENCY PATIENT TO HAVE HIS/HER EMERGENCY HANDLED ON THIS VISIT. WITH EVERY EMERGENCY PATIENT THERE WILL BE A \$25.00 CHARGE FOR X-RAY AND A \$75.00 CHARGE FOR THE EMERGENCY EXAMINATION. IN THE EVENT THAT TREATMENT CANNOT BE UNDERTAKEN, MEDICATION TO CONTROL DISCOMFORT WILL BE PRESCRIBED. **ALL EMERGENCY FEES ARE PAID IN ADVANCE OF TREATMENT. NO EXCEPTIONS.**

I UNDERSTAND THAT THE ACT OF SEEING ME IN MY STATE OF EMERGENCY WITH A FILLED SCHEDULE IS A CARING ONE, AND I ACCEPT THE ABOVE CONDITIONS.

SIGNATURE
(EMERGENCY PATIENT, PARENT, OR GUARDIAN)

DATE

C. DAVID KNOX, D.D.S. P.A.

Patient Consent to receive mail and/or Telephone Messages

Please Print (Last Name) (First Name) (M.I.)

Do we have your permission to:

Send a recall appointment reminder to your home Y____N____

Leave appointment, billing or dental information on
Your answering machine/Voice Mail/E-Mail Y____N____

I give permission to share appointment, billing or dental information with the
person named below

Name: _____

Signature of Patient / Patient or Legal Guardian Date

Acknowledgement of Receipt of Notice of Privacy Practice

I have received a copy of the Notice of Privacy Practices with an effective date of

Signature of Patient / Parent or Legal Guardian 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 acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

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 (MM/DD/YY), 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 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 and 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 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 use 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 must disclose your 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 another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. 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 official having lawful custody of protected health information of inmate or patient 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 a 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 \$0.____ for each page, \$____ 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 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 (e-mail), 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 to 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: Office Administrator

Telephone: (404) 289-3660 Fax: (404) 289-1992

E-mail:

Address: P O Box 3190978 Decatur, GA 30037