Tejal A Kakade
DMD, MAGD, PC
personalized dentistry
516 Newnan Street
Carrollton, GA 30117

Patient Information & Insurance Form

Date _____ Patient Name _____Name you wish to be called _____
Address_____Cell Phone _____
City _____State _____ Zip _____Home Phone _____

How do you wish for us to contact you? Home Phone Cell Email

Social Security Number _____ Driver's License Number _____
Birthdate _____ Sex: Male Female Single-Married-Widowed-Separate-Divorced

Occupation _____Employer_____Employer Phone _____
Spouses Name _____Birthdate _____ Social Security Number _____
Spouse's Occupation _____Spouse's Employer _____

Whom may we thank for referring you: Patient _____ Newspaper Social Media Website Other
Who is financially responsible for this account? _____Relationship _____

IN CASE OF EMERGENCY CONTACT _____ Phone _____

Insurance Company _____Group # _____
Subscriber's Name _____Subscriber's Birthdate _____
Subscriber's SSN _____Relationship to Patient Father Mother Spouse Other

Is patient covered by Secondary Insurance? YES NO
Insurance Company _____Group # _____
Subscriber's Name _____Subscriber's Birthdate _____
Subscriber's SSN _____Relationship to Patient Father Mother Spouse Other

ASSIGNMENT OF BENEFITS AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage and assign directly to the doctor otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by the insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of the signature on all insurance submissions.

I understand that I may be charged a 1.5% finance charge per month (18% annually) if my balance goes beyond 90 days. I also understand that I am responsible for all fees pertaining to my unpaid balance and/or missed appointments. I give permission for my dentist and clinical team to take any necessary radiographs, study models, and photographs to make a complete diagnosis of my dental needs. I consent to the use and disclosure of my protected health information to obtain payment information in connection with my dental claims.

_____

Responsible Party Signature Relationship Date

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Patient Dental History Update

*TMJ/Head & Neck Muscles

Do you have muscle soreness in your head & neck? NO YES
Do you have clicking/popping in your jaw joint? NO YES
Do you /have you ever experienced lock jaw? NO YES
Do you have arthritis? NO YES
Do you have frequent headaches/migraines? NO YES
Have you ever been treated for TMD? NO YES

*Teeth/Oral Cavity

Do you have any teeth that currently hurt? NO YES **If yes, where?** _____
Do you have any loose or broken teeth? NO YES **If yes, where?** _____
Do you collect food in your teeth? NO YES **If yes, where?** _____
Do you have sensitivity? NO YES **If yes, where?** _____
Have you ever had orthodontic treatment? NO YES **If yes, when?** _____
Do you clench or grind your teeth? NO YES **If yes, when?** _____
Do you wear a night guard or bite appliance? NO YES **If yes, what time of day?**_____
Do you like your smile? NO YES **If no, what would you change?** _____
How often do you brush? _____
Dry mouth/decrease in saliva? NO YES
If yes, do you take anything to alleviate this? NO YES **If yes, what?** _____
(ex: Biotene, excessive gum chewing, over the counter or prescription medications?)
Do you get frequent blisters/ulcers? NO YES **How often?** _____
Do you have Burning Tongue? NO YES **How often?** _____
Bleeding or Swollen gums? NO YES **History of Periodontal Disease?** NO YES
Difficulty Swallowing? NO YES **Difficulty getting numb?** NO YES

*Oral Habits

Tongue Thruster? NO YES **Cheek/Lip Biting?** NO YES
Chewing Pens, Nails? NO YES **Thumb Sucking?** NO YES
Other, please describe _____

Patient Signature _____ **Date**_____

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Medical History Update

Who is your General Physician? _____Date of last visit? _____
Does your physician recommend an antibiotic prior to dental treatment or cleanings? _____
Have you had blood work done in the last two years? _____
Have you been hospitalized within the last year? _____

*Pulmonary

Do you have asthma?	**NO**	**YES**	**If yes, date of last attack _____**
If yes, do you use an inhaler?	**NO**	**YES**	
Do you experience shortness of breath?	**NO**	**YES**	**If yes, when?_____**

*Social History

Do you smoke?	**NO**	**YES**	**If yes, how often & long? _____**
Do you use smokeless tobacco?	**NO**	**YES**	**If yes, how often & long? _____**
Do you drink alcohol?	**NO**	**YES**	**If yes, how often? _____**

*Neurological

Are you under psychiatric care?	**NO**	**YES**	
Do you suffer from anxiety?	**NO**	**YES**	
History of stroke?	**NO**	**YES**	**If yes, date of stroke? _____**
History of seizures or epilepsy?	**NO**	**YES**	**If yes, date of last seizure? _____**

*Cardiovascular

Are you under the care of a cardiologist?	**NO**	**YES**	**If yes, who is your cardiologist? _____**
Hx of a heart attack within the last six (6) months?	**NO**	**YES**	**If yes, date? _____**
Do you wear a pacemaker?	**NO**	**YES**	
Do you have history of Atrial Fibrillation (A-Fib)	**NO**	**YES**	
Do you have hypertension/high blood pressure?	**NO**	**YES**	
Do you have diet restrictions?	**NO**	**YES**	
Heart Surgeries?	**NO**	**YES**	**If yes, what type and when? _____**
Do you suffer from any blood disorders?	**NO**	**YES**	**If yes, what type? _____**
(ex: deficiency, anemia, lymphoma, leukemia, thrombocytopenia, etc…)			
Have you been diagnosed with HIV or AIDS?	**NO**	**YES**	**If yes, do you know your CD4? _____**

*Endocrinology

Liver Disease	**NO**	**YES**	**Diabetes**	**NO**	**YES**	**(Current A1C _____)**
Jaundice	**NO**	**YES**	**Hepatitis**	**NO**	**YES**	
Thyroid Disease	**NO**	**YES**	**Kidney Disease**	**NO**	**YES**	**(dialysis? _____)**

Patient Signature _____ Date_____

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Medical History Update (Cont)

***Skeletal**

Do you have osteoporosis? **NO** **YES** **If yes, are you on meds for this? _____**
Joint replacements or artificial joints? **NO** **YES** **If yes, what type/when? _____**
Who is the doctor that performed your surgery? _____

***Cancer**

Do you or have you ever had cancer? **NO** **YES**
If yes, what type and when? _____
Any history of head or neck radiation? **NO** **YES**

***Sleep Assessment**

Do you snore? **NO** **YES**
Have you ever had a sleep study performed? **NO** **YES**
Were you diagnosed with sleep apnea? **NO** **YES** **If yes, do you wear a CPAP? _____**
If you wear a CPAP are you happy with it? **NO** **YES**

***Allergies (Please circle all that apply)**

Aspirin	**Local Anesthetic**	**Latex**
Barbituates	**Penicillin**	**Sulfa**
Codeine	**Iodine**	**Other**

If other, please list _____

***Medications (Please list all medications you are currently taking)**

Pharmacy Name _____Phone Number _____

***Females**

Are you currently pregnant? **NO** **YES** **If yes, when are you due? _____**
Are you currently nursing? **NO** **YES**
Are you currently on birth control pills? **NO** **YES**

Patient Signature _____Date_____
Reviewed by _____Date _____

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Epworth Sleep Scale

Patient Name:_____Date:_____

0 = would **never** doze
1 = **slight** chance of dozing
2 = **moderate** chance of dozing
3 = **high** chance of dozing

	Chance of Dozing
1. Sitting and reading	_____
2. Watching TV	_____
3. Sitting inactive in public	_____
4. Car passenger for more than an hour without a break	_____
5. Lying down in the afternoon	_____
6. Sitting quietly after lunch (with no alcohol)	_____
7. Stopped for a few minutes in traffic	_____
Total	_____

If you snore and you have a total score of 10 or more, you should consider having a sleep study to to determine if you have sleep apnea.

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Appointment Agreement

The first step towards a beautiful, healthy smile is to schedule an appointment. Because we are a small family owned and operated dental care provider, we do not double or triple book appointments like many other doctors, in order to keep your wait time for treatment in our office to a minimun. To maintain our high standards of quality care and services, we ask that you honor our Appointment Agreement. Thank-you for choosing us and it's a privilege to serve you!

1. Please notify us, prior to seeing the dentist or hygienist of any changes to your employment , insurance coverage, primary home address, phone numbers, marital status, medical situation, or medications taken.
2. A 24 hour notice is required to cancel an appointment. If we are given less than a 24 hour notice, it is considered a broken appointment. A broken appointment is subjected to a $75 fee charged to your account. Excessive "no-shows" or 3 or more cancelled appointments will be required to call or request appointment availabilty on the "day-of".
3. To prevent inconvenience to our "on-time" patients, "late" patients may need to be rescheduled, we will honor our next patient with his/her reserved appointment time. Please note we do not overbook our appointments and try very hard to stay within our patients appointment times.
4. A parent or guardian must sign for children under the age of 18 years. The parent or guardian that signs that patient in and/or makes the appointment is responsible for the minor patient's account regardless of any divorce/court orders.

Statement of Financial Policy

1. Fees are expected at the time services are rendered, unless other arrangements have bee made. We accept Cash, Visa/Mastercard, American Express, Discover, and CareCredit.
2. **We are not contracted (in-network) with your insurance company, but we will gladly file your insurance for you.** You are expected to pay your estimated out of pocket portion at the time of service. We are only able to estimate your out of pocket expenses based on the information provided by you and your insurance carrier, if you need a more detailed estimate of your benefits, please contact your insurance provider.
3. Insuarance covereage is determined by your contract with your insurance company. Often insurance companies will use the term "Usual and Customary", or similar such language when denying charges for dental care. The amount an insurance company reimburses for a procedure will vary with the company, the type and quality of policy, the zip code where charges were made, and sometimes even the age and health of the patient. Our fee schedule is the same for everyone regardless.
4. We allow a reasonable time for your insurance company to pay for dental services. We file insurance claims electronically on the day of service. Claims not paid within 30 days will automatically be re-filed. We allow 60 days for your insurance to pay the claim. After 60 days you are responsible for any unpaid balance in full.

_____

Patient Name (Print) Signature of Responsible Party Date

Tejal A. Kakade, DMD, FAGD, PC

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information

Patient Name: _____ DOB: _____

Name of parent or guardian (if different than patient): _____

1. I hereby authorize all health care providers to use and/or disclose the protected health information (''PHI'') described below to me or as directed below. The purpose of this request is for personal reasons.

2. I hereby authorize the release of PHI, defined here as the patient's complete dental record, including treatment, prognosis, financial, billing, and insurance information. I understand that my personal billing, financial and insurance information may be disclosed to those in paragraph 3 in order to be able to process claims with the insurance company and/or for personal reasons.

3. In addition to the authorization for release of my PHI described in paragraph 3 of this Authorization, I authorize disclosure of information regarding my/my child's billing, condition, treatment and prognosis to the following individual(s) (please include caregivers that may accompany children to appointments):

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

4. This medical information may be used by the persons I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until I am no longer a patient at this practice, or until such time as I render payment for my own treatment, or _____, (date or event) at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. Such revocation will not affect actions taken by the requesting person prior to the date he or she received the written revocation. I also understand information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and will no longer be protected by this rule.

7. I understand that my health care provider cannot condition treatment on whether I sign this Authorization. However, if I refuse to sign this Authorization, I understand that payment will be collected at the time services are provided and I will be responsible for filing any claims with my dental insurance company.

_____ _____

Signature of Patient Date

Tejal A. Kakade, DMD, FAGD, PC
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 protected health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 3/15/2013, 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 provide the new Notice at our practice location, and we will distribute it 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.

Your Authorization: In addition to our use of your health information for the following purposes, 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.

Security: You will be notified as soon as possible if the security of your personal health information is breached.

Uses and Disclosures of Health Information

We use and disclose health information about you without authorization for the following purposes.

Treatment: We may use or disclose your health information for your treatment. For example, we may disclose your health information to a physician, pharmacist, 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. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. For example, 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.

To You Or Your Personal Representative: 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 your personal representative, 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 absence or incapacity or in 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.

Disaster Relief: We may use or disclose your health information to assist in disaster relief efforts.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization. We will not use your information for fundraising purposes without authorization. We will disclose any financial conflicts of interests that may be involved with your treatment.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Public Health and Public Benefit: We may use or disclose your health information to report abuse, neglect, or domestic violence; to report disease, injury, and vital statistics; to report certain information to the Food and Drug Administration (FDA); to alert someone who may be at risk of

contracting or spreading a disease; for health oversight activities; for certain judicial and administrative proceedings; for certain law enforcement purposes; to avert a serious threat to health or safety; and to comply with workers' compensation or similar programs.

Decedents: We may disclose health information about a decedent as authorized or required by law.

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 the protected health information of an 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).

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 practicably 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. You may also request access by sending us a letter to the address at the end of this Notice. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying. If you request copies, we will charge you $0.25 for each page to 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. In most cases we are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in certain circumstances where disclosure is required or permitted, such as an emergency, for public health activities, or when disclosure is required by law). We must comply with a request to restrict the disclosure of protected health information to a health plan for purposes of carrying out payment or health care operations (as defined by HIPAA) if the protected health information pertains solely to a health care item or service for which we have been paid out of pocket in full.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation of 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.

Non-disclosure to insurance company: If you pay out of pocket, in full, for a service or a procedure or service; we will not submit the claim for that service to your insurance company upon your request.

Electronic Notice: You may receive a paper copy of this notice upon request.

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: Toffee Causey, Office Manager **Telephone**: 770-836-5313 **E-mail**: info@drtejal.com