

## PATIENT INFORMATION

**Patient Name** \_\_\_\_\_ **Date** \_\_\_\_\_  
Last First MI

**Gender**  Male  Female **Marital Status**  Married  Single  Child  Other

**Birth Date** \_\_\_\_\_

**Social Security #** \_\_\_\_\_ **Email Address** \_\_\_\_\_

**Home Number** \_\_\_\_\_ **Work Number** \_\_\_\_\_ **Ext** \_\_\_\_\_ **Cell Number** \_\_\_\_\_

**Address** \_\_\_\_\_ **Apt #** \_\_\_\_\_

**City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip Code** \_\_\_\_\_

### Emergency Contact Person Information

## Health Information

- |                                                          |                                                         |                                                     |
|----------------------------------------------------------|---------------------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> AIDS                            | <input type="checkbox"/> Fainting                       | <input type="checkbox"/> Nervous Disorders          |
| <input type="checkbox"/> Allergies _____                 | <input type="checkbox"/> Glaucoma                       | <input type="checkbox"/> Pacemaker                  |
| <input type="checkbox"/> <b>Codeine Allergy</b>          | <input type="checkbox"/> Growths                        | <input type="checkbox"/> Pregnant                   |
| <input type="checkbox"/> <b>Penicillin Allergy</b>       | <input type="checkbox"/> Hay Fever                      | <input type="checkbox"/> Radiation Treatment        |
| <input type="checkbox"/> Anemia                          | <input type="checkbox"/> Head Injuries                  | <input type="checkbox"/> Respiratory Problems       |
| <input type="checkbox"/> Arthritis _____                 | <input type="checkbox"/> Heart Disease                  | <input type="checkbox"/> Rheumatic Fever            |
| <input type="checkbox"/> Artificial Joints _____<br>Date | <input type="checkbox"/> Heart Murmur _____<br>Date     | <input type="checkbox"/> Rheumatism                 |
| <input type="checkbox"/> Asthma                          | <input type="checkbox"/> Hepatitis                      | <input type="checkbox"/> Sinus Problems             |
| <input type="checkbox"/> Blood Disease                   | <input type="checkbox"/> High Blood Pressure            | <input type="checkbox"/> Stomach Problems           |
| <input type="checkbox"/> Cancer _____<br>Date            | <input type="checkbox"/> Jaundice                       | <input type="checkbox"/> Stroke _____<br>Date       |
| <input type="checkbox"/> Diabetes _____                  | <input type="checkbox"/> Kidney Disease                 | <input type="checkbox"/> Tuberculosis _____<br>Date |
| <input type="checkbox"/> Dizziness _____                 | <input type="checkbox"/> Liver Disease                  | <input type="checkbox"/> Tumors                     |
| <input type="checkbox"/> Epilepsy _____                  | <input type="checkbox"/> Mental Disorder                | <input type="checkbox"/> Ulcers                     |
| <input type="checkbox"/> Excessive Bleeding              | <input type="checkbox"/> Mitral Valve Prolapse<br>(MVP) | <input type="checkbox"/> Venereal Disease           |

**Please list Medications:** \_\_\_\_\_

Have you ever had any complications following dental treatment?  Yes  No

**If Yes,** please explain: \_\_\_\_\_

Have you been admitted to a hospital or needed emergency care during the past two years?  Yes  No

**If Yes,** Please explain: \_\_\_\_\_

**Reason for today's visit** \_\_\_\_\_ **Date of last visit:** \_\_\_\_\_



**PATIENT INFORMATION**

**INSURANCE INFORMATION**

**(Primary) Employer:** \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Date of Birth \_\_\_\_\_ ID# \_\_\_\_\_ Group # \_\_\_\_\_

Employer Address: \_\_\_\_\_

Insurance Plan Name and Address  
\_\_\_\_\_  
\_\_\_\_\_

**(Secondary) Employer:** \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Date of Birth \_\_\_\_\_ ID# \_\_\_\_\_ Group # \_\_\_\_\_

Employer Address: \_\_\_\_\_

Insurance Plan Name and Address  
\_\_\_\_\_  
\_\_\_\_\_

**SIGNATURE ON FILE**

I authorize release of any information necessary to process my dental insurance claims, I understand that I am responsible for all cost of dental treatment.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
Patient Signature (guardian if a minor)

I hereby authorize **payment directly to Sharon S. Jordan, D.M.D.**, of this group insurance benefits otherwise payable to me.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

## **FINANCIAL POLICY**

Thank you for choosing the practice of Dr. Sharon S. Jordan. We are committed to providing you with quality dental care. Please understand that charges are to you, the patient, not to your insurance company. All payments are your responsibility. The following is a statement of our financial policy, which we require you to read and sign prior to treatment.

PAYMENT IS DUE AT THE TIME OF SERVICE  
WE ACCEPT CASH, MOST MAJOR CREDIT CARDS, PERSONAL & BUSINESS CHECKS  
WE OFFER AN EXTENDED PAYMENT PLAN THROUGH THE AMERICAN GENERAL COMPANY AND  
CARE CREDIT WITH PRIOR CREDIT APPROVAL

### **INSURANCE**

As a courtesy to our patients, we will file your insurance for you. You are required by contract with your insurance company to pay all co-pays and deductibles at the time of service. These payments are due at the time of your visit prior to treatment. Check with your insurance company if you do not know this information. If your insurance company has not paid your balance within 15-30 days, the total amount due becomes your full responsibility. If after 90 days, there has been no action on your account; it will become necessary for us to begin collection procedures. It is very important that you contact your insurance company to expedite processing of your claims.

### **USUAL & CUSTOMARY RATES**

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Due to your busy schedule as well as ours, it is very important for you, as our valued patient, to keep your scheduled appointment by calling us at (478) 743-3583 or emailing us at [sharonsjordanpc@yahoo.com](mailto:sharonsjordanpc@yahoo.com) to confirm or reschedule your appointment if necessary.

### **PATIENT STATEMENT**

As a condition of your treatment by this office, financial arrangements must be made in advance. All emergency dental services, or any dental services performed without prior financial arrangements, must be paid in cash at the time services are rendered. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patients account, however, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that the estimated fee for dental treatment can only be extended for a period of ninety (90) days from the date of the patient's examination. In consideration for the professional services rendered to me, by the doctor at my request, I agree to pay said services to said doctor, or her assignee, at the time said services are rendered. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. I grant my permission to you or your assignee, to telephone me at home or at work to discuss matters related to this form.

I have read the above conditions of treatment and agree to their content.

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

*Thank you for reading our financial policy. Please contact our Business Office with any questions or concerns.*

# CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

**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:

2614 Cherokee Ave, Macon, GA 31206

(478) 743-3583

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## 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. I have read and given consent for the use and disclosure of my health information

\_\_\_\_\_  
{Please Print Name}

\_\_\_\_\_  
{Signature}

\_\_\_\_\_  
{Date}

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### For Office Use Only

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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

## NOTICE OF PRIVACY ACT PRACTICES

**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. 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 \$ \_\_\_ 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 your request is for 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 our business associates or we disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last six (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 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, counterintelligence, and other national security activities). We may disclose to correctional institutions or law enforcement officials 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).

**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 a 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 Person: Cynthia D. Smith • 2614 Cherokee Avenue • Macon, GA 31204 • (478) 743-3583