PATIENT NAME______________________________ DATE ______________

Mailing Address______________________________

E-Mail Address______________________________ City:____________ State:_____ Zip:_________

Birthdate:______________ Soc. Sec.#______________ □ Single □ Married □ Divorced □ Separated

Home phone:______________ Work phone:______________ Cell phone:______________

□ Employed □ Student □ Homemaker □ Retired Employer:______________________

Dental Insurance: ______________________ Group# ______________

Spouse(or other person responsible for payment) Name:______________Soc. Sec.#__________

Address: ______________________________ City:____________ State:_____ Zip:_________

Spouse Work#:______________________Spouse DOB:__________Employer:__________

Insurance Company. ______________________________

Nearest relative not living with you:

Name: ______________________ Telephone Number #: ______________________

Referred by: □ Another patient, friend. □ Another patient, relative. □ Dental office doctor or staff member.

□ Other______________________ Name of person who referred me:______________________

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DENTAL HISTORY

Have you been having any specific problems? □ Yes □ No Describe: ______________________

Last dental visit: ______________ Purpose: ______________________ Last exam: __________

Has fear of discomfort kept you from regular visits? □ Yes □ No How do you describe your dental health?

□ Good □ Fair □ Poor Do you think you have active dental disease: Decay? □ Yes □ No

Homecare: Brush?: □ Yes □ No Floss?: □ Yes □ No Gum Disease? □ Yes □ No Do your gums ever bleed? □ Yes □ No How often? ______________ Are you troubled with bad breath? □ Yes □ No

How do you feel about ever losing your teeth? ______________________________

Have you had any unusual effects from previous dental treatment? □ Yes □ No Describe:______________

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MEDICAL HISTORY (Confidential. Repeated every two years.) Month/Day/Year______________

Medical doctor's name:______________________ Last physical exam:______________ Current age:________

(Women) Are you pregnant? □ Yes □ No Expected delivery date:______________________

Are you under a doctor's care now? □ Yes □ No If so, for what?______________________

Are you taking any medications, pills or drugs? □ Yes □ No Please list:______________________

Do you smoke □ Yes □ No How often?: ____________ Do you drink alcohol □ Yes □ No How often?:__________

Have you ever had any of the following? Indicate YES with check mark.

□ Any heart problems	□ Measles	□ Diabetes	□ Hepatitis	□ Prosthetic valves/joints
□ High blood pressure	□ Mumps	□ Arthritis	□ Aids	□ Allergy to anesthetics:
□ Low blood pressure	□ Scarlet fever	□ Malignancies	□ Venereal disease	______________
□ Circulatory problems	□ Typhoid fever	□ Radiation tx	□ Herpes	□ Allergy to medicines
□ Excessive bleeding	□ Nervous problems	□ Asthma	□ Tuberculosis	______________
□ Anemia	□ Psychiatric care	□ Stroke	□ Sinus problems	□ Other allergies:
□ Rheumatic fever	□ Hospitalization	□ Ulcer	□ Tonsilitis	______________

Have you had any other serious illness? □ Yes □ No Please list:______________________

Have you been hospitalized in the last two years? □ Yes □ No Why?:______________________

Do you prefer Nitrous Oxide Sedation (tranquilizing air) during your dental treatment? □ Yes □ No

Have your ever had difficulty with anesthetics? □ Yes □ No Explain:______________________

Do you wish to talk to the doctor about any problems not listed? □ Yes □ No Comments:______________

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AUTHORIZATION: I hereby authorize the doctor(s) and/or staff of this dental office to administer such medications and to perform such diagnostic and therapeutic procedures as may be necessary for proper dental treatment. I state that my medical history is correct to the best of my knowledge. I understand that payment is due when service is rendered. Interest is charged on any unpaid balance over 30 days. You are responsible for your total fees whether you have dental insurance or not. Please note that our office requires a 24 hour notice for changing an appointment or there will a $50.00 broken appointment fee.

For office use only

Patient Signature:______________________________ Date:______________

B/P________

Reviewed by: Doctor______________________________ Date:______________

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MEDICAL HISTORY UPDATE FOR SUBSEQUENT VISITS: I have read my MEDICAL HISTORY dated________ and confirm that it adequately states past and present conditions.

DATE	EXCEPTIONS	PATIENT SIGNATURE	B.P.	REVIEWED BY

E-mail
Athenadent@bellsouth.net

Athena Dental Associates
1020 Hawthorne Avenue
Athens, Ga 30606
OFFICE (706) 546-7390
FAX (706) 546-0806

Website
athenadental.com

Financial Options

We are pleased that we can help you with your dental needs. Financially, you are expected to pay for dental services as they are rendered. When a child visits our office for dental care, the party responsible for the fee incurred by that child is the adult that brings the child in for their visit(s). (Regardless of whom is truly responsible in their individual family situation). We cannot bill another parent or guardian. We will be happy to provide you with a receipt of your service and payment at your visit. We do not send out monthly statements from this office.
We offer several payment options for your convenience:

1. When you have dental treatment totaling $300 or more and pay in full by cash or check at the time of service, we are able to extend to you a 5% bookkeeper's allowance. This nice benefit is available to all patients.

2. You may use your visa, mastercard, American express card or discover.

3. If you would prefer an extended payment plan, you may use our American General plan. It is especially designed for our patients. There is no down payment and no interest for 3 or 6 months.

4. IF YOU HAVE DENTAL INSURANCE, we will be more than happy, as a service to you, to file your insurance and accept payment from your dental insurance company. At the time of your treatment you will be expected to pay any deductible that you may have and the percentage that your insurance is not expected to pay. IF FOR ANY REASON YOUR DENTAL INSURANCE HAS NOT PAID IN 90 DAYS, YOU ARE RESPONSIBLE FOR YOUR PAYMENT ON YOUR SERVICES. We do not file secondary insurance. If for any reason you have a balance after your insurance has paid, you will be responsible for the balance. For any major work, when you have insurance, we will do a pre-treatment estimate for you. When we receive the pre-treatment estimate back from your insurance company we will be able to begin your work YOU ARE RESPONSIBLE FOR YOUR TOTAL FEE WHETHER YOU HAVE DENTAL INSURANCE OR NOT.

5. If you are changing dentists and you would like to have your records and xrays sent to new dentist we would be glad to make copies and send. there will be a charge of $32.00 for duplication fee.

6. Please note that our office requires a 24 hour notice for changing an appointment or there will be a $50 broken appointment fee.

Please direct your financial questions to us during our normal business hours Monday - Thursday 8 a.m. to 5 p.m. Friday 8 a.m. to 12 p.m.

Sincerely,

Mark H. Blankenship D.M.D
Lane V. Barker, D.M.D.

Patient Signature Date

ATHENA DENTAL ASSOCIATES

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 April 14, 2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practice 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 or 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 an authorization you may revoke it in writing at any time. Your revocation will not affect any use or discloses permitted by your authorization while it was in effect. Unless you give 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 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 person responsible for your care, of your location, your general condition or death. If you are present then prior to use or disclose of your health information, we will provide you with an opportunity to object to such uses or discloses. In the event of your incapacity or emergency circumstances, we will disclose heath 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 officials having lawful custody of protected health information of inmate or patients 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 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 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 .10 cents for each page, .10 cents 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 COMMUNICATIONS: 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 Website or by electronic mail (e-mail) , you are entitled to receive this Notice in writing 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 disclose of your health information or to have us communicate with you by alternate 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 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 Officers: Betty Staines or Alison Foster

Telephone: (706) 546-7390 Fax: (706) 546-0806

Email: athenadent@bellsouth.net

Address: 1020 Hawthorne Ave. Athens, GA 30606

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This form is educational only, does not constitute legal advice and covers only federal, not state law. (August 14, 2002)

ATHENA DENTAL ASSOCIATES

Patient Name: ____

Address: ______________________________ City________________ Zip_____________

I have agreed to let certain individuals participate in discussions and decisions related to my medical/dental care. Therefore, I hereby give permission for Athena Dental Associates and staff to disclose my personal dental/medical information to the following individual(s):

Name: _________________________________ Relationship to Pt. ___________________

Name: _________________________________ Relationship to Pt. ___________________

Name: _________________________________ Relationship to Pt. ___________________

Conditions for Disclosure Check the item(s) that apply:

□ The practice may disclose my personal health information to the individual(s) above **only** in my presence.

□ The practice may disclose my personal health information to the individual(s) above in discussions when I am not physically present, including disclosures by telephone, answering machine, facsimile, e-mail or regular mail.

□ Other Conditions of Disclosure: ____

____

____

I understand that this consent maybe revoked by me at any time by written notice to the practice.

Patient Signature: ____

Date of Signature: ____

Witness by: _________________________________ Title/Position __________________

Print Name of Witness: ____

Date: ________________________

3/19/07