☐ *Sugarloaf Periodontics & Dental Implants*
1790 Atkinson Rd. Ste. G.
Lawrenceville, GA 30043

☐ *Snellville Periodontal & Dental Implants, LLC*
2088 Scenic Hwy
Snellville, GA 30078

John J. Lee, D.M.D.

Today's Date _____

PATIENT'S INFORMATION
(please print)

First Name & Middle Initial _____
Last Name _____
Street Address _____
City _____ State _____
Zip Code _____
Email Address _____
Home Phone # _____
Work Phone # _____
Work Extension _____
Soc Sec # _____
Cell Phone or Pager # _____
Date of Birth (MM/DD/YYYY) _____
Marital Status: Single Married
Sex: Male Female
Employer _____
Occupation _____
Employer Address _____

Is the patient the SAME person as the policyholder? (circle Yes or NO)
If "Yes", then skip the rest of this box.
If "No", what is the relationship of the patient to the policy holder?
(circle one) Husband Wife Son Daughter Other

POLICY HOLDER'S INFORMATION
(please print)

First Name & Middle Initial _____
Last Name _____
Street Address _____
City _____ State _____
Zip Code _____
Email Address _____
Home Phone # _____
Work Phone # _____
Work Extension _____
Soc Sec # _____
Cell Phone or Pager # _____
Policy Holder's Date of Birth (MM/DD/YYYY) _____
Marital Status: Single Married
Sex: Male Female
Employer _____
Occupation _____
Employer Address _____

INSURANCE INFORMATION

Policy Holder's Name _____
Primary Insurance Company _____ Policy # _____
Policy Holder's Name _____
Secondary Insurance Company _____ Policy # _____

Name of General Dentist _____
Who should we thank for this referral _____

IN CASE OF AN EMERGENCY, LIST YOUR NEAREST RELATIVE OR FRIEND NOT LIVING WITH YOU:

Name _____ Relationship _____
Address _____ Telephone #( ) _____

OUR PAYMENT POLICY

I authorize any insurance benefit payment due me be made directly to Dr. John J. Lee. A service charge of 1.5 % per month (18%) annually) will be automatically added to all delinquent accounts past 90 days. A thirty-five dollar ($35) accounting fee will be charged on all returned checks.

Payment is due as services are rendered. As a courtesy, we will gladly file with your PRIMARY Insurance Company.
* Evaluations and re-evaluations are due IN FULL the day of service regardless of insurance coverage.*
If you have insurance benefits, all other treatment will be filed with a 40% co-payment due the first day of treatment.
Remember, insurance is not a guarantee of payment. You are responsible for the balance of this account regardless of benefit coverage.

Signature _____ Date _____

PLEASE TURN THIS SHEET OVER AND FILL OUT THE MEDICAL HISTORY FORM

PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. When did you last receive dental treatment? _____
   What type of treatment? _____
2. Do you have dentures, partial dentures, bridges or crowns?
   If yes, when were they made? _____ Y N
3. Date of last physical examination _____
4. Have you been hospitalized during the past three years? Y N
5. Have you had any serious illnesses in the past three years? Y N
   If so, please explain _____
6. Are you under a physician's care? Y N
   If yes, for what condition? _____
7. Have you ever worn braces? Y N
8. Have you ever had gum surgery? Y N
9. Have you ever had any difficulty with any dental work or extractions? Y N
10. Have you had any surgical prostheses? Y* N
    (Joint replacements or implants)

Do you have or have you had any of the following conditions or diseases?

CARDIOVASCULAR

11. Rheumatic Fever Y* N
12. Congenital Heart Defect Y* N
13. Angina or Heart Attack Y* N
14. Heart Murmurs Y* N
15. Congestive Heart Failure Y N
16. Heart Surgery or Pacemaker Y* N
17. (High) or (Low) Blood Pressure (Circle One) Y N
18. Stroke Y N

RESPIRATORY DISEASE

19. Asthma or Bronchitis Y N
20. Emphysema Y N
21. Hay Fever or Sinusitis Y N

ENDOCRINE DISORDERS

22. Diabetes Y N
23. (Hyperthyroidism) or (Hypothyroidism) (Circle One) Y N

BLOOD DISORDERS

24. Anemia Y N
25. Do you bleed excessively when cut? Y N

KIDNEY DISEASE

26. Have you had any kidney infections? Y N
27. Have you had kidney surgery? Y N

INFECTIOUS DISEASES

28. Hepatitis Y N
29. Venereal Disease (Within the last 10 years) Y N
30. Tuberculosis Y N
31. HIV Positive Y N

MISCELLANEOUS DISEASES AND DISORDERS

32. Frequent Fainting Y N
33. Liver Disease Y N
34. Arthritis Y N
35. Ulcers Y N
36. Glaucoma Y N
37. Radiation Therapy for Cancer Y N
38. Epilepsy Y N
39. Cancer Y N
40. Do you smoke? Y N
41. Do you use any other form of tobacco? Y N

Are you currently taking any of the following drugs or medications?

42. Antibiotics Y N
43. Blood Thinners Y N
44. Steroids or Cortisone Y N
45. High Blood Pressure Medicine Y N
46. Tranquilizers Y N
47. Aspirin Y N

Please write down all of the prescribed medications you are currently taking:

_____
_____
_____

Do you have an ALLERGY or reaction to any of the following medications?

48. Local Anesthetics Y N
49. Penicillin Y N
50. Other Antibiotics Y N
51. Codeine Y N
52. Other Pain Medication Y N
53. Aspirin Y N
54. Barbiturates or Sedatives Y N
55. Other Medicines Y N
    If yes, what medicines? _____

Do you have any medical problem not listed above? Y N
If yes, please explain. _____
_____

WOMEN ONLY

56. Are you pregnant? Y N
    If yes, when are you due? _____

_____
PATIENT'S SIGNATURE **DATE**
(Parents must sign for their minor children)

* If you answer "Y" to any of the starred questions, current American Heart Association standards may require that you take antibiotics immediately before each dental appointment. If you fail to do so, we will be required to reschedule your appointment unless we receive a written exemption from a physician.

PATIENT'S INITIALS FOR UPDATE: **DATE:**
(Parents must sign for their minor children)

_____ _____
_____ _____
_____ _____
_____ _____

_____
DOCTOR'S SIGNATURE **DATE**

Sugarloaf Periodontics and Dental Implants
John J. Lee, DMD

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of this office's Notice of Privacy Practices.
Patient Name (Print)

_____ _____
Patient Signature/Parent or Guardian Date

_____
Parent or Guardian Name (Print)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of out Notice of Privacy Practices, but acknowledgement could not be obtained because:

- o Individual refused to sign.
- o Communications barrier prohibited obtaining acknowledgment.
- o And emergency situation prevented us from obtaining acknowledgement.
- o Other (Please Specify) _____
  _____

Sugarloaf Periodontics and Dental Implants
John J. Lee, DMD
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.

Sugarloaf Periodontics and Dental Implants
John J. Lee, DMD

Authorization for Release/Use of Protected Health Information In the Form of Photos, Radiographs, and Electronic Images

Your photos and x-rays are part of your diagnostic and clinical record and are considered to be protected health information under federal HIPAA Privacy Laws.

We make use of radiographs (x-rays), photographs, and digital images. These images may be used for diagnosis, documentation, reference, teaching, and research publication. Some cases that present exceptional results, particularly remarkable smiles, or interesting situations may be utilized for demonstration, education or advertising to potential and existing patients in our office either in print media, social media, television, on digital media and on our webpage. In some instances, you may be recognizable in some of these images.

By initialing and signing this form, you are authorizing us and releasing us from any liability resulting from the use/release of such images. Your authorization and release to use images will in no way affect the quality of your results in our office. We do our best to provide exceptional dentistry to all patients.

___ I authorize the use of my images where my face is identifiable

___ I authorize the use of my images where only my teeth are identifiable

___ I authorize the use of my radiographs

The purpose of this request to release and/or disclose the PHI described above is for personal reasons. I understand that I have the right to revoke this Authorization, in writing, at any time by notifying the office above. 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.

I understand that my health care provider cannot condition treatment on whether I sign this Authorization.

_____ _____

Patient Name (Print) Date of Birth

_____ _____

Patient Signature/Parent or Guardian Date

_____ _____

Parent or Guardian Name (Print) Relationship to Patient

Sugarloaf Periodontics and Dental Implants

John J. Lee, DMD

OFFICE PAYMENT POLICY

Payment is always due at the time services are rendered. We will ask you to take care of your portion BEFORE surgery and make any necessary post operative appointments.

If you have insurance, as a courtesy, we will gladly file with your PRIMARY insurance company.

Please remember that insurance is not a guarantee of payment. You are responsible for your account regardless of benefit coverage. It is important to remember we are a specialist office and most dental benefits are designed for your general dental maintenance. Please do not compromise your health based on insurance benefits.

If you are unable to keep a scheduled appointment, and cannot inform us with at least 48 hours notice a cancellation fee will be charged to you account. Charges will be based on the length and type of your appointment.

_____ _____

Print Name Date of Birth

_____ _____

Patient Signature/Parent or Guardian Date

_____ _____

Parent or Guardian Name Relationship to Patient