MARBLE HILL DENTISTRY

NAME: Tel: 770-893-1904

ARTISTRY • INTEGRITY • PASSION

171 FOOTHILLS PKWY STE 209
MARBLE HILL, GA 30148

PATIENT INFORMATION

Date: ☐NEW PATIENT ☐UPDATE

Patient:

LAST FIRST MI PREFERRED TITLE

☐MALE ☐FEMALE ☐CHILD* ☐STUDENT** ☐SINGLE ☐MARRIED ☐DIVORCED ☐WIDOWED

*IF CHILD, PROVIDE PARENT/GUARDIAN NAME(S) BELOW:

PARENT/GUARDIAN NAME(S)

**IF STUDENT, PLEASE COMPLETE: ☐FULL-TIME ☐PART-TIME

SCHOOL/LOCATION

Patient Date of Birth: Patient SSN:

Address:

ADDRESS LINE 1

ADDRESS LINE 2

CITY ST ZIP CODE

HOME:
CELL:
EMAIL:

Who can we thank for inviting you to our practice? ☐Friend or family (please provide name) ☐ Online Search

EMERGENCY INFORMATION

In case of emergency, please provide information for the nearest relative or designated contact person

NAME RELATIONSHIP Tel:

EMPLOYMENT INFORMATION

Employer: Occupation:

Address:

ADDRESS LINE 1

ADDRESS LINE 2

CITY ST ZIP CODE

WORK:
DIRECT:
OTHER:
PAGER:
FAX:

E-Mail:

DENTAL INSURANCE INFORMATION

Subscriber:

LAST FIRST MI PREFERRED TITLE

Subscriber Date of Birth: Subscriber SSN:

Subscriber Employer:

Patient Relationship to Subscriber: ☐SELF ☐SPOUSE ☐CHILD ☐OTHER

PRIMARY INSURANCE CARRIER:

Group/Policy No.: ID No.:

Address:

CITY ST ZIP CODE

TEL:
TOLL-FREE:
FAX:

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ACKNOWLEDGEMENT OF PRIVACY PRACTICES
Updated 2013

My signature confirms that I have been informed of my rights to privacy regarding my protected personal and health information, under the Health Insurance
Portability & Accountability Act of 1996 (HIPAA). I understand the terms in which my personal health and identification information may be used.
I have been informed of my dental provider's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected
health information. I have been given the right to review and receive a copy of such Notice of Privacy Practices. I understand that my dental provider has the right
to change the Notice of Privacy Practices and that I may contact this office at the address above to obtain a current copy of the Notice of Privacy Practices.
I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations
and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature: _____ Date:_____
RELATIONSHIP TO PATIENT: PATIENT__PARENT__ GUARDIAN__ OTHER__

Please list any dependent children under the age of 18 also covered by this acknowledgement:

I give permission for the following communications to be used by Marble Hill Dentistry (please check all that apply) :

Cell phone___ Text Message reminders___ Home phone___ Work E-Mail___ Personal E-Mail___

I am granting permission for Marble Hill Dentistry to disclose their identity to anyone who may answer my home, work or cell phone.

I am granting permission for Marble Hill Dentistry to leave a message with any person who may answer my phone or on my voicemail.

I would like to give permission for the following person(s) to have access to personal information including but not limited to appointments,treatment, and billing of me and any dependent children listed above:_____

For Office Use Only:
We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:
___The patient refused to sign
___Communication barriers
___Emergency situation
___Other – please list:

*Copy of Notice of Privacy Practices can be obtained at the front desk

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PATIENT CONSENT- PAYMENT AUTHORIZATION – SIGNATURE ON FILE

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status of if my medication changes, I shall inform the dentist and staff at the next appointment without fail.

I hereby authorize my insurance company to pay the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I hereby authorize Marble Hill Dentistry to release any information concerning my health or dental care, advice, treatment or supplies provided. This information is to be used in administering dental claims and/or discussing treatment options with other dental professionals.

I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered.

By signing below, I acknowledge that I have read and understand the statements mentioned above.

Signature: _____ Date: _____

PATIENT CONSENT FOR INTERNET COMMUNICATIONS

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any changes, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand the State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading y patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice cannot and does not assume any responsibility for my use or misuse of patient information transmitted, monitored, stored, uploaded or received using the site or the services.

By signing below, I acknowledge that I have read the information regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site.

Signature: _____ Date: _____

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Financial Guidelines

Our goal is to assist you in the financial aspect of your account with same quality and professionalism that our dental care provides. Your review of our financial guidelines at this time will help greatly to avoid future misunderstandings.

Our relationship and our contract with you is that of Dentist-Patient. We do not provide services to insurance companies and have no responsibility to assure that the insurance company is supportive of your dental care.

Although we are here to help you, any contract that exists between you and your insurance company for dental care reimbursement does not obligate us to comply with the provisions of your policy. We will assist you in filing your claims Services are rendered to you, which make you the responsible party. If you are unsure of any of the specific requirements of your insurance company please contact them directly.

Often insurance companies will use the term "usual and customary" or similar such language when denying charges for dental care. The implication is that the doctor charges too much for a given procedure or visit. Universal "usual and customary" fee schedules do not exist. The amount an insurance company reimburses for a procedure will vary with the company, the type and quality of the policy. Our fee schedule is the same for everyone.

Payment is expected at time of service for all procedures not covered by your insurance. When payment from the insurance company has not been received within 60 days of treatment, it will be your responsibility to contact the insurance company and to send office payment in full at that time. We accept cash, check, all major credit cards as forms of payment. In the event of account default, you will be responsible for said balance as well as any collection costs, including attorney and court fees. A delinquent account creates an uncomfortable environment for everyone.

We reserve time with the doctor or hygienist to serve your dental needs. ***If you are unable to make your reserved time, we require at least 24 hour notice to avoid a minimum charge of $50.00 per hour scheduled.*** We need time to care for each of our loyal patients. This broken appointment policy is out of courtesy to ALL of our patients who need appointments.

By signing this agreement, I understand the policy as defined above and agree to abide by it.

Signature: _____ Date: _____