

PLATINUM DENTAL GROUP LILBURN

609 BEAVER RUIN ROAD NW, SUITE A

LILBURN, GEORGIA 30047-3401

(770) 709-0000

ACCOUNT INFORMATION

Date: _____

Patient Information

Name _____
Date of Birth _____
Age _____
Address _____
City / State / Zip Code _____
E-mail Address _____
Employer _____
Occupation _____
Social Security # _____
Phone # (H) _____
Phone # (W) _____
Cell # _____

Guardian Information (if applicable)

Name _____
Address _____
Phone # (H) _____
Phone # (W) _____
Cell # _____
Occupation _____
Social Security # _____
Date of Birth _____
E-mail Address _____

Referred by _____
Best time of day to reach you and at what phone # _____

INSURANCE INFORMATION

Primary Insurance

Policy # _____
Group # _____
Union or Local # _____
Anniversary Date of Policy _____
Name of Policy Holder _____
Yearly Benefit Amt. _____
Social Security # _____
Primary Carrier _____
Policy # _____
Date of Birth _____

Medicaid / Peachcare Information

Medicaid # _____
Expiration Date _____
Peachcare # _____
Social Security # _____
Date of Birth _____

EMERGENCY INFORMATION

Who may we contact in case of an emergency? _____

Phone # _____ Cell # _____

Where may we contact you after working hours? Phone #? _____

Pharmacy phone # _____

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DENTAL HISTORY

Patient Name _____ Wish to be called _____

Date of last dental visit _____ Last dental cleaning _____ Last Full Mouth X-rays _____

Previous Dentist's Name _____ Phone # _____

Address _____ City _____ State _____ Zip Code _____

How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids do you use? Brush: Soft Medium Hard

Electric toothbrush Toothpick Fluoride rinse Other _____

Have you received any formal oral hygiene instruction?..... Yes No How long ago? _____

Would you like to keep all your teeth all your life?..... Yes No

Have you ever had:

Orthodontic Treatment Yes No

Endodontic Treatment (Root Canals) Yes No

Oral Surgery (Extractions) Yes No

Periodontal Treatment Yes No

Osseous Surgery Yes No

Gingival Grafts Yes No

Tissue Management (Scaling, Curettage) Yes No

Your gums hurt/bleed Yes No

Any mouth odor or bad taste Yes No

Any loose teeth Yes No

Change/shift in your bite Yes No

Food become caught in between your teeth Yes No

If yes, where? _____

A serious injury to the mouth or head Yes No

If yes, please describe including the cause: _____

Are any of your teeth sensitive to:

Hot or cold Yes No

Sweets Yes No

Biting or chewing Yes No

Do you:

Frequently get cold sores Yes No

Blisters or any other oral lesions Yes No

Clench or grind your teeth while awake or asleep Yes No

Bite your lips or cheeks regularly Yes No

Hold foreign objects with your teeth Yes No

Mouth breathe while awake or asleep Yes No

Smoke/chew tobacco Yes No

Wear a bite plate or mouth guard Yes No

Have you ever experienced:

TMJ/TMD Temporomandibular Joint Disorder Yes No

Occlusal equilibration/bite adjusted Yes No

Clicking or popping of the jaw Yes No

Pain (joint, ear, side, or face) Yes No

Difficulty in opening or closing the mouth Yes No

Difficulty in chewing on either side of the mouth Yes No

Tired jaws, especially in the morning Yes No

Frequent headaches Yes No

Sore neck and/or shoulder muscles Yes No

Excessive stress or pressure in your work or at home Yes No

If so, please describe _____

What is the reason for your visit today? _____

Do you feel nervous about having dental treatment? Yes No

Have you ever had an upsetting dental experience? Yes No

Is there anything else about having dental treatment that you would like us to know? Yes No

If yes to any of the above, please describe. _____

How do you feel about the appearance of your teeth? _____

What do you wish could be changed? _____

MEDICAL HISTORY

1. Have you been under the care of a medical doctor during the past two years?..... Yes No

If yes, for what? _____

Physician's Name _____ Phone _____

Address _____ City _____ State _____ Zip Code _____

2. Are you allergic to or have you had an adverse reaction to any of the following?

Local Anesthetic	<input type="checkbox"/> Yes <input type="checkbox"/> No	Penicillin	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other Medications	<input type="checkbox"/> Yes <input type="checkbox"/> No
Nitrous Oxide	<input type="checkbox"/> Yes <input type="checkbox"/> No	Erythromycin	<input type="checkbox"/> Yes <input type="checkbox"/> No	Latex	<input type="checkbox"/> Yes <input type="checkbox"/> No
Codeine/other narcotics	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tetracycline	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dental Gloves	<input type="checkbox"/> Yes <input type="checkbox"/> No
Aspirin	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sulfa Drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No	Costume Jewelry	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sedatives/tranquilizers	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other Antibiotics	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other Substances	<input type="checkbox"/> Yes <input type="checkbox"/> No

If yes, explain. _____

3. Do you or have you had?

Heart pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Congenital heart disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	High/Low blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No
Rheumatic fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Artificial heart valve	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart attack/Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mitral valve prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Artificial joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No

If yes, explain _____

4. Have you had abnormal bleeding associated with a previous extraction, surgery, cut or trauma?..... Yes No

If yes, explain. _____

5. Are you taking anticoagulants (Blood thinners, Coumadin, Aspirin) daily?..... Yes No

6. Have you or any family member had Tuberculosis (TB)?..... Yes No

7. Have you been in contact with anyone who has had Tuberculosis (TB)?..... Yes No

8. Have you had a productive (very deep) cough that has lasted more than three weeks?..... Yes No

During that period did you have	Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rapid weight loss	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Night Sweats	<input type="checkbox"/> Yes <input type="checkbox"/> No	General Malaise	<input type="checkbox"/> Yes <input type="checkbox"/> No

9. Indicate which of the following you have had or have at present:

A.I.D.S.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting or Dizzy spells	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No
HIV positive/exposure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood Transfusion	<input type="checkbox"/> Yes <input type="checkbox"/> No	Allergies or hives	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hepatitis A (infectious)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nervousness/anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hepatitis B (serum)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychological	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hay Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hemophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Eating disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach disorder (Ulcers)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alcoholism/drug abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Yellow Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No
Kidney trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors/Cysts/Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sickle cell disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diet (Special/restricted)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Neurological Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rapid weight loss/gain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Arthritis/rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No
Epilepsy or Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Contact Lenses	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cortisone medication	<input type="checkbox"/> Yes <input type="checkbox"/> No

10. Are you taking any medication, drugs or pills now? Yes No

If yes, please list name(s) and dosage(s). _____

11. Do you have or have you had any disease, condition or problem not listed?..... Yes No

If yes, explain. _____

12. Have you been a patient in the hospital or had a serious illness during the past five years?..... Yes No

Explain _____

13. Women, are you pregnant? Yes _____ months. No Nursing? Yes No Taking birth control pills? Yes No

Do you have PMS problems associated with your menstrual period?..... Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Parent/Guardian Signature _____ Date _____

Doctor Signature _____ Date _____

Remarks: _____

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LILBURN, GEORGIA 30047-3401

(770) 709-0000

APPOINTMENTS AND PAYMENTS

Platinum Dental Group Lilburn is happy to take care of your dental needs. Please help us by following our appointment and payment policies.

Broken or canceled appointments.

If you need to cancel an appointment, please notify us at least 48 hours in advance for Tuesday through Friday appointments and no later than 10:00 am Friday for Monday appointments. We charge \$50.00 for each canceled or broken appointment if you do not give us the required advance notice. Please notify us if an emergency makes it impossible for you to give 48 hours notice so we can discuss this with you.

Please do not cancel an appointment with a voice mail message. Instead, please talk to us during office hours to avoid confusion. Our office hours are Monday through Thursday from 8:00 am to 5:00 pm and Friday from 8:00 am to 12:00 pm.

Payment is due at the time of treatment.

Payment for treatment is due in full at the time of treatment, unless you have made other payment arrangements with us. If we are filing an insurance claim for you, please read the next section for an explanation of payment arrangements.

Insurance claims.

If we file an insurance claim for you, you will need to pay us at the time of treatment the expected insurance deductible and any amount that we expect insurance will not cover.

We try to get accurate information about insurance benefits and coverage before treatment, but we cannot be sure what the insurance company will pay, if anything, until the claim is submitted and the insurance company actually pays on the claim. It is not unusual for insurance companies to give us erroneous information about coverage or benefits. This is important because you are responsible for all treatment charges, whether or not your insurance company provides any benefits.

Returned checks.

Please take every precaution to avoid giving us a bad check. It is time consuming for our staff to deal with returned checks and this takes away from the more important job of providing dental services. For this reason, we charge \$30.00 for any check that is returned to us without payment. Also, if you have given us a bad check in the past, we will not accept a personal check from you in the future as payment for dental services.

Interest on late payments.

Please pay your charges on time. We rely on prompt payment from our patients and their insurance companies. We will charge your account 18% per year interest for charges not paid within 30 days. We recommend patients understand their insurance benefits and monitor their plans for prompt payment.

I agree to the above policies.

X _____

Date signed: _____

Signature of patient or responsible person

Name of patient: _____

Name of person responsible for patient charges, if different: _____

Platinum Dental Group Lilburn
609 Beaver Ruin Rd NW, Suite A
Lilburn, Georgia 30047
Office (770) 709-0000 Fax (770) 925-3302

Notice of Privacy Practices

Our initial notice was effective April 14, 2003. This revision is effective beginning September 24, 2009

This notice describes how health information about you may be used and disclosed and how you can get this information. Please read it carefully.

Who We Are

This notice describes the privacy practices of Platinum Dental Group Lilburn, located in Lilburn, Georgia. These privacy practices apply to our dental practice and to our staff, including our dentists, hygienists and other health care professionals working at our offices. Some of our dentists are independent contractors and are not our employees or agents.

Our Health Information Commitment

We are committed to protecting your health information. We create a record of the care and services you receive at our offices. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated or kept by our dentists, hygienists and other staff.

This notice will tell you about the ways we may use and disclose your health information. We also describe your rights and certain obligations we have concerning the use and disclosure of your health information.

We are required by law to:

- keep health information that identifies you private,
- give you this notice of our privacy practices and
- follow the terms of this notice, as we may change it from time to time.

How We May Use and Disclose Your Health Information

The following categories describe different ways that we use and disclose health information. For each category of uses or disclosures, we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed, but all of the ways we are permitted to use and disclose information will fall within one of the categories.

Treatment: We may use health information about you to provide you with dental treatment or services. We may disclose health information about you to dentists, dental assistants, hygienist, other dental office personnel or other health care providers who are involved in your treatment or care. For example, your dentist may need to disclose some of your health information to order tests or lab work to be performed at an outside laboratory or other outside health care provider.

Payment: We may use and disclose health information about your treatment and services to bill and collect from you, your insurance company or a third party payer. For example, we may need to give your health insurance plan information so that it will pay us or reimburse you for dental services. We may also tell your health insurance plan about a treatment you are going to receive to determine whether your plan will cover it.

Health Care Operations: We may use and disclose health information about you for office operations. These uses and disclosures are necessary to run our dental office and make sure that all of our patients receive quality care. For example, we may use your health information to review our treatment and services and to evaluate the performance of our staff in caring for you. Some of these reviews may be conducted by independent dentists who are members of our staff, but are not employees of the office. We may also combine health information about many of our patients to decide what additional services we should offer and what services are not needed. We may also disclose information to dentists, hygienists, dental assistants and other office personnel for review and learning purposes. We may also combine the health information we have with health information from other dental practices to see where we can make improvements. We may remove information that identifies you from this set of health information to protect your privacy.

Appointment Reminders: We may use and disclose health information to contact you as a reminder that you have an appointment for treatment at our office.

Treatment Alternatives: We may use and disclose health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Benefits and Services: We may use and disclose health information to tell you about health-related benefits or services that may be of interest to you.

Persons Involved in Your Care or Payment for Your Care: We may disclose your health information to a member of your family, your friend or another individual if the family member, friend or other individual is directly involved in the your care and the disclosure is necessary for your welfare. The practice will limit the health information disclosed to the family member, friend or other individual to health-related signs and symptoms and to information designed to help you deal with your condition or treatment, including setting and changing appointments, receiving instructions for post-visit care or picking up treatment-related items. We may also disclose a limited amount of your health information to locate you or to locate or notify your family member or friend. We will not make these disclosures to your friends and family if you tell us not to.

Business Associates: There are some services that we provide through contracts with business associates. For example, we use an outside copy service if needed to make copies of your x-rays. When these services are contracted, we may disclose your health care information to

our business associate so that the associate can perform the job we have asked the associate to do. To protect your health information, we require the business associate to safeguard the privacy of your information.

As Required by Law: We will disclose health information about you when required to do so by federal, state or local law.

To Avoid a Serious Threat to Health or Safety: We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Military and Veterans: If you are a member of the armed forces, we may release health information about you as required by military command authorities.

Workers' Compensation: We may release your health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness. Your written authorization to this release is required, but if you do not consent to a release of information your workers' compensation benefits may be denied.

Public Health Risks: We may disclose your health information for public health activities. These activities generally include the following:

- prevention or control of disease, injury or disability,
- reporting births and deaths,
- reporting abuse or neglect of children, elders and dependent adults,
- reporting reactions to medications or problems with products,
- notifying people of recalls of products they may be using or
- notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

Health Oversight Activities: We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request (which may include written notice to you) or to obtain an order protecting the information requested.

Law Enforcement: We may release health information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process,
- To identify or locate a suspect, fugitive, material witness or missing person,
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement,
- About a death we believe may be the result of criminal conduct,
- About criminal conduct at the hospital and
- In emergency circumstances to report a crime, the location of the crime or victims or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors: We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about patients of the hospital to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities: We may release health information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Protective Services for the President and Others: We may disclose health information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information about you to the correctional institution or law enforcement official if the release would be necessary for the institution to provide you with health care, to protect your health and safety or the health and safety of others or for the safety and security of the correctional institution.

Permission from you: Other uses and disclosures of health information not covered in the above categories will be made only with your permission. You may give permission with a written consent or authorization. If you provide us permission to use or disclose health information about you, you may revoke that permission at any time orally or in writing. If you revoke your permission, we will no longer use or disclose health information about you to the extent your permission is needed for the use or disclosure. You understand that we are unable to take back any disclosures we have already made with your permission and that we are required to retain our records of the care that we provide to you.

Your Health Information Rights

You have the following rights concerning health information we maintain about you:

Right to Inspect and Copy your Health Information: You have the right to inspect and copy your health information and to receive a written summary or explanation of your health information if you make a request in writing. If you want to inspect, copy or receive this information, please contact the privacy officer listed at the end of this notice to obtain and complete the required form. If you request a copy of your health information, we may charge a fee for the costs of copying and mailing your request or of preparing a written summary or explanation. We may deny your request in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. Another licensed health care professional chosen by the office will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Receive your Health Information in Electronic Form: If you make a request on or after February 17, 2010, for an electronic copy of health information that we maintain in electronic form, we will provide the information in electronic form to you or directly to a third party of your choice. For providing an electronic copy of your health information, we will charge you only our labor costs in responding to your request.

Right to Ask for Changes in Health Information: If you feel that health information we have about you is incorrect or incomplete, you may ask us to change or add to the information. You have the right to ask for a change or addition for as long as the information is kept by the office. You should contact the privacy officer listed at the end of this notice to get the form you will need to ask for a change or addition. You must give us a reason for your request. We may deny your request for a change or addition to your health information if it is not in writing or does not include an appropriate reason to support the request. In addition, we may deny your request if you ask us to change or add to information that:

- we did not create, unless the person or entity that created the information is no longer available to make the change or addition,
- is not part of the health information kept by the office,
- is not part of the information which you would be permitted to inspect and copy or
- is already accurate and complete.

Right to an Accounting of Disclosures: You have the right to request an accounting of disclosures. This is a list of the disclosures we made of your health information except for: disclosures made to carry out treatment, payment or health care operations, disclosures to you, disclosures made pursuant to your authorizations, disclosures to persons involved in your care and certain other special disclosures described in federal regulations. To ask for this list of disclosures, you should contact the privacy officer listed at the end of this notice to get the form you will need to fill out for this purpose. Your request must state a time period which may not be longer than six years before the date of the request. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a twelve month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care. Because any restrictions of your information may hinder the quality of care provided by our facility, according to the law, we reserve the right to deny your request. We do not have to agree to the restrictions that you request, but if we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you should contact the privacy officer at the address or number listed at the end of this notice to get the form you will need to fill out for this purpose. In your request, you must tell us:

- what information you want to limit,
- whether you want to limit our use, disclosure or both and
- to whom you want the limits to apply (for example, your spouse, your children, your parents or other involved in your care).

To be binding on us, any agreement to comply with special restrictions must be in writing signed by the privacy officer for our office.

Right to Request Confidential Communications: You have the right to request that we communicate with you about your health information in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the privacy officer listed at the end of this notice. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, please contact the privacy officer listed at the end of this notice or ask any of our staff members.

Right to be Notified if Breach of Security: You have the right to be notified if there is a breach of security with respect to your protected health information. In the event of such a breach, we will notify you directly in writing or, if your contact information is out of date, we will take steps to notify you by other means, such as a posting to our web site or notices in print or broadcast media.

Changes to this Notice

We reserve the right to change this notice and the revised or changed notice will be effective for health information we already have about you as well as any information we receive in the future. The current notice will be posted in our dental offices and will include the effective date.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with our dental office or with the Secretary of the Department of Health and Human Services. To file a complaint, contact the privacy officer listed at the end of this notice or ask any of our staff members. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Contact Information

Platinum Dental Group Lilburn, Privacy Officer: (770) 709-0000, mailing address: P.O. Box 1953 Lilburn, Georgia 30048-1953.

Acknowledgement of Receipt of Notice of Privacy Practices

Patient name: _____ Date of birth: _____

I have received either a paper or an electronic copy of the Notice of Privacy Practices for Platinum Dental Group Lilburn. I understand that I am entitled to receive a paper copy of the Notice if I ask for it, even if I have already agreed to receive only an electronic copy.

X _____ Date signed: _____

Signature of patient or personal representative

If applicable: Representative's relationship to patient: _____

Representative's name: _____ Phone: _____

Representative's address: _____

For office use only:

Please complete the following only if the acknowledgment section above has not been signed by the patient or the patient's personal representative: We made a good faith effort to obtain a written Acknowledgment of Receipt of Notice of Privacy Practices, but an acknowledgment could not be obtained because (please check one or more as appropriate):

- The patient or the patient's personal representative refused to sign.
- A communication barrier prevented us from obtaining an acknowledgment.
- An emergency situation prevented us from obtaining an acknowledgment.
- Other (please explain) _____

Completed by: _____ Position: _____

Staff member's initials: _____ Date completed: _____