

Columbia Dental Group P.C

Patient Name		Date	Today's Birthday	
Name of parent/Guardian	(If patient is under 18)			
Marital Status	Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>	Gender	Male <input type="checkbox"/> Female <input type="checkbox"/>	
Street Address				
City, State, Zip				
Telephone Number	Home		E-mail	
	Work			
	Cell		Occupation	
Employer			Position	
Employer Address				
Emergency Contact	In case of emergency, your nearest relative (other than spouse), neighbor or friend			
Name		Relationship		
Address		Phone #		
If Patient is covered by Dental Insurance, please fill out this section				
Name of Primary Holder		Social security Number		
Name of Insurance		Policy #		
		Group #		
Referral	How were you referred to us? (check one)			
	Friend or family member <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Web/internet <input type="checkbox"/> Insurance Company <input type="checkbox"/> News paper <input type="checkbox"/> Other <input type="checkbox"/>			
Release of Information/ Assignment of Benefits :				
X _____ Date: _____ Signed (patient, or parent/guardian if minor) *** 24hr. advance notice needed if you cannot keep the appointment. If not, a broken appointment fee of \$ 50.00 will be charged.*				
1 of 3				

Columbia Dental Group P.C

Medical History

Please answer **ALL** questions by **checking** either **YES** or **No**.

If you don't understand a question, go on to the next one, the doctor will review it with you. **ALL information is CONFIDENTIAL!!**

- 1) When did you **last** receive dental treatment? _____
 - a. What type of treatment? _____
- 2) Have you ever worn braces? **Yes** **No**
- 3) Have you ever had gum surgery? **Yes** **No**
- 4) Have you ever had any difficulty with any dental work? **Yes** **No**
- 5) Have you been hospitalized during the past three years? **Yes** **No**
 - a. If **Yes**, please explain _____
- 6) Have had any serious illnesses in the past three years? **Yes** **No**
 - a. If **Yes**, please explain _____
- 7) Are you under a physician's care? **Yes** **No**
 - a. If **Yes**, for what condition? _____
 - b. Physician's Name _____
 - c. Phone Number _____
- 8) Do you smoke? **Yes** **No**
- 9) Do you use any other form of tobacco? **Yes** **No**

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

- 1) Penicillin/ Other Antibiotics **Yes** **No**
- 2) Blood Thinners **Yes** **No**
- 3) Steroids or Cortisone **Yes** **No**
- 4) High blood Pressure Medicine **Yes** **No**
- 5) Tranquilizer **Yes** **No**
- 6) Immune Suppressant Drugs **Yes** **No**
- 7) Aspirin **Yes** **No**
- 8) Herbs/ Vitamins **Yes** **No**
- 9) Other medications: _____

Do you have an **ALLERGY** or **REACTION** to any of the following medications and materials?

- 1) Latex **Yes** **No**
- 2) Local Anesthetics **Yes** **No**
- 3) Penicillin/ Other Antibiotics **Yes** **No**
- 4) Sedative/ Sleeping pills **Yes** **No**
- 5) Codeine/ Other narcotics **Yes** **No**
- 6) Pain Medication **Yes** **No**
 - If **Yes**, what medication? _____
- 7) Other (Specify) **Yes** **No**
 - If **Yes**, _____

Columbia Dental Group P.C

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

<p style="text-align: center;">Cardiovascular</p> <p>Rheumatic Fever Yes <input type="checkbox"/> No <input type="checkbox"/> Congenital Heart Defect Yes <input type="checkbox"/> No <input type="checkbox"/> Congestive Heart Failure Yes <input type="checkbox"/> No <input type="checkbox"/> Heart Murmurs Yes <input type="checkbox"/> No <input type="checkbox"/> Heart Surgery Yes <input type="checkbox"/> No <input type="checkbox"/> High or low blood pressure Yes <input type="checkbox"/> No <input type="checkbox"/> Stroke Yes <input type="checkbox"/> No <input type="checkbox"/> Other _____</p>	<p style="text-align: center;">Infectious disease</p> <p>Hepatitis Yes <input type="checkbox"/> No <input type="checkbox"/> Venereal Disease Yes <input type="checkbox"/> No <input type="checkbox"/> Tuberculosis Yes <input type="checkbox"/> No <input type="checkbox"/> HIV Positive Yes <input type="checkbox"/> No <input type="checkbox"/> <p style="text-align: center;">Respiratory Disease</p> <p>Asthma or Bronchitis Yes <input type="checkbox"/> No <input type="checkbox"/> Emphysema Yes <input type="checkbox"/> No <input type="checkbox"/> Hay Fever Sinusitis Yes <input type="checkbox"/> No <input type="checkbox"/></p> </p>
<p style="text-align: center;">Endocrine Disorder</p> <p>Diabetes Yes <input type="checkbox"/> No <input type="checkbox"/> Hyperthyrodism (high) Yes <input type="checkbox"/> No <input type="checkbox"/> Hypothyrodiam (low) Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p style="text-align: center;">Blood Disorder</p> <p>Anemia Yes <input type="checkbox"/> No <input type="checkbox"/> Do you bleed excessively when cut? Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p style="text-align: center;">Kidney Disease</p> <p>Have you had any kidney infections? Yes <input type="checkbox"/> No <input type="checkbox"/> Have you had kidney surgery? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p style="text-align: center;">Miscellaneous</p> <p>Frequent Fainting Yes <input type="checkbox"/> No <input type="checkbox"/> Liver Disease/ Jaundice Yes <input type="checkbox"/> No <input type="checkbox"/> Arthritis Yes <input type="checkbox"/> No <input type="checkbox"/> Ulcer Yes <input type="checkbox"/> No <input type="checkbox"/> Radiation therapy for cancer Yes <input type="checkbox"/> No <input type="checkbox"/> Other _____</p>

***** Do you have any medical problem not listed above?** **Yes** **No**
 Please list _____

***** (Women only)**
 1) Are you pregnant? **Yes** **No**
 If so, when are you due? _____
 2) Are you taking hormonal therapy? **Yes** **No**

X _____ Date _____

Please Sign your name on the Line Above

Columbia Dental Group P.C

Norcross, GA 90092
770-559-3545/

Written Financial Policy

Thank you for choosing Columbia Dental Group & Georgia Dental Implant Center. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of our mission is making the cost of optimal care as easy and manageable as possible for our patients by offering several payment options.

Payment options:

You can choose from:

- Cash, Check, Visa, MasterCard, American Express or Discover Card
- Convenient Monthly Payment Options¹ from Care Credit Healthcare Credit Card

Columbia Dental Group & Georgia Dental Implant Center requires your co- payment at each of your appointments, if required by insurance. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received. For plans requiring more than 1 appointment, alternative payment arrangements may be provided. For larger, more comprehensive treatment plans of \$2000 or more, a 50% deposit is required to secure your initial treatment appointment.

For patients with dental insurance, we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.²

A fee of \$50 is charged for patients who miss or cancel more than 2 times in a calendar year without 24- hour notice.

Columbia Dental Care & Georgia Dental Implant Center charges \$35 for return checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

Patient, Parent or Guardian Signature	Patient Name	Date
--	---------------------	-------------

¹Subject to credit approval

²However, if we not receive payment form your insurance carrier within 90 days, you will be responsible for payment of your fees and collection of your benefits directly from your insurance carrier.

Notice of Privacy Practices

Columbia Dental Group & Georgia Dental Implant Center
5075 Peachtree Pkwy. #105 B, Norcross, GA 30092
Paul B. Kim D.D.S, Steve T. Hahn D.M.D

Columbia Dental Group P.C

info@columbiadentalga.com

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND/OR DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our practice. This notice describes how we protect your health information and what rights you have regarding it.

Treatment, Payment and Health care Operations

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care of services; or getting copies of your health information from another professional that you any have seen before us. Examples of how we use or disclose your health information for payment purposes are; asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). 'Health care operations:' mean those administrative and managerial functions that we have to do in order to run out office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we usually will not ask you for special written permission.

USES AND DISCLOSURE FOR OTHER REASONS WITHOUT PERMISSON

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all.

Such uses or disclosures are:

When a state or federal law mandates that certain health information be reported for a specific purpose; For Public health purpose, such as contagious disease reporting, investigation or surveillance; and notices to and from federal Food and Drug Administration regarding drugs or medical devices;

Disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;

Uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;

Disclosures for judicial and administrative proceedings such as in response to subpoenas or order of courts or administrative agencies;

Disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;

Disclosures to medical examiner to identify a deceased person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;

Uses or disclosures for health related research;

Uses and disclosures to prevent a serious threat to health or safety;

Uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign services;

Disclosures of de-identified information;

Disclosures relating to worker's compensation programs;

Disclosures of a 'limited date set': for research, public health or health care operations;

Incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;

Disclosures to "business associates" who perform health care operations for us and who commit to respect of privacy of your health information.

Unless you object, we will also share relevant information about your care with your family or friends who are

Columbia Dental Group P.C

helping you with your dental care.

Appointment Reminders

We may call or write to remind you of scheduled appointments, or that it is time to make routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and /or leave you a reminder message on your home answering machine or with someone who answer your phone if you are not home.

Other uses and disclosures

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation, you will give us a properly completed authorization form, or you can use one of ours. If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocation must be in writing. Send them to the office contact person named at the beginning of this Notice.

Your rights regarding your health information

The law gives you many rights regarding your health information. You can:

Ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or E-mail shown at the beginning of this Notice.

Ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E-mail to your personal E-mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax, or E-mail shown at the beginning of this notice. Ask to see or to get photocopies of your health information. By law, there are few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or 60 days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation and instructions on how to get an impartial review of our denial, if one is legally available. By law, we can have one 30days extension of time for us to give you access or photocopies, if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E-mail show at the beginning of this notice.

Ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the correct information to the person whom we know got the wrong information, and others that specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. One you statement of position and/or rebuttal is included in your health information; we will send it along whenever we make a permitted disclosure of your health information. By law we can have one 30days extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E-mail show at the beginning of this notice.

Get the list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include; disclosures with your authorization; incidental disclosure; disclosures required by law; and health care operations, disclosures with your authorization, incidental disclosure; disclosure required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists you will have to pay for them in advance. We will usually respond to your

request within 60 days of receiving it, but by law we can have one 30day extension of the time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E-mail show at the beginning of this Notice.

Get additional paper copies of this Notice of privacy practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the

Columbia Dental Group P.C

office contact person at the address, fax or E-mail show at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICE

By law, we must abide by the terms of this Notice of privacy practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that already have as well as to such information that we may generate in the future. If we change our notice of privacy practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS

If you feel that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, office for Civil rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E-mail show at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number show at the beginning of this Notice.

ACKNOWLEDGEMENT OF RECEIT

I acknowledge that I received a copy of Columbia Dental Group & Gentle Dental Care's Notice of Practices.

Patient Name: _____

Signature: _____ Date: _____