PATIENT INFORMATION: _____ Male ____ Female **Preferred Name:** _____

First Name: _____ **MI:** _____ **Last Name:** _____

Address: _____ **Address 2nd:** _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Email Address: _____ **Marital Status:** **Married** **Single** **Divorced**

Birth Date: _____ **Social Security Number:** _____ **Driver's Lic. St/#:** _____

RESPONSIBLE PARTY INFORMATION: (if different from patient information; or patient is under age 18)

First Name: _____ **MI:** _____ **Last Name:** _____

Address: _____ **Address 2nd:** _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Email Address: _____ **Relationship to Patient:** _____

Birth Date: _____ **Social Security Number:** _____ **Driver's Lic. St/#:** _____

INSURANCE INFORMATION: (if we are filling insurance for you as a courtesy)

Subscriber Name: _____ **MI:** _____ **Last Name:** _____

Birth Date: _____ **Social Security Number:** _____ **Relationship to Patient:** _____

Employer Name: _____ **Employer Phone Number:** _____

Insurance Co. Name: _____ **Insurance Phone Number:** _____

Insurance Claim Address: _____

Insurance City: _____ **State:** _____ **Zip:** _____

Subscriber ID #: _____ **Policy Group Number:** _____

Employment Status: ____ **Full Time** ____ **Part Time** **Student Status: Is the patient a student?** ____ **YES** ____ **NO**

If patient is a student: School Full Name: _____ **Student Status:** ____ **Full Time** ____ **Part Time**

UPDATES: (We require an update of information once every year and a complete new form be filled out every three years.)
Please review the above information and update any information needed and sign below.

1. **SIGNATURE:** _____ **DATE:** _____ **NO CHANGES:(INT)** _____
2. **SIGNATURE:** _____ **DATE:** _____ **NO CHANGES: (INT)** _____
3. **SIGNATURE:** _____ **DATE:** _____ **NO CHANGES: (INT)** _____

ALTHOUGH DENTAL PERSONNEL PRIMARILY TREAT THE AREA IN AND AROUND YOUR MOUTH, YOUR MOUTH IS PART OF YOUR ENTIRE BODY. HEALTH PROBLEMS THAT YOU MAY HAVE, OR MEDICATION THAT YOU MAY BE TAKING, COULD HAVE AN IMPORTANT INTERRELATIONSHIP WITH THE DENTISTRY YOU WILL RECEIVE. Thank you for answering the following questions.

Are you under a physician's care now? ___ YES ___ NO If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ___ YES ___ NO If yes, please explain: _____

Have you ever had a serious head or neck injury? ___ YES ___ NO If yes, please explain: _____

Are you taking any medications, pill, or drugs? ___ YES ___ NO If yes, please list all medications or attach list: _____

_____

Do you take, or have you taken, Phen-Fen or Redux? ___ YES ___ NO

Are you on a special diet? ___ YES ___ NO If yes, please explain: _____

Do you use tobacco? ___ YES ___ NO If yes, how many/often: _____

Do you use controlled substances? ___YES ___ NO If yes, please explain: _____

WOMEN ONLY: ARE YOU ___PREGNANT ___ TRYING TO GET PREGNANT ___ NURSING ___ TAKING ORAL CONTRACEPTIVES?

Are you allergic to any of the following? ___ Aspirin ___ Penicillin ___ Coedine ___ Acrylic ___ Metal ___ Latex ___ Local Anesthetics ___ Other: If yes, please explain: _____

Do you have, or have you had, any of the following? (please put a check mark or an X by all that apply)

___ AIDS/HIV Positive ___ Chest Pains ___Frequent Headaches ___ Irregular Heartbeat ___Scarlet Fever

___Alzheimer's Disease ___ Cold Sores/Fever Blisters ___Genital Herpes ___ Kidney Problems ___Shingles

___ Anaphylaxis ___Congenital Heart Disorder ___Glaucoma ___Leukemia ___ Sickle Cell Disease

___ Anemia ___ Convulsions ___ Hay Fever ___ Liver Disease ___ Sinus Trouble

___ Angina ___ Cortisone Medicine ___ Heart Attack/Failure ___ Low Blood Pressure ___Spina Bifida

___ Arthritis/Gout ___Diabetes ___ Heart Murmur ___ Lung Disease ___Stomach/Intestinal Disease

___ Artificial Heart Valve ___Drug Addiction ___ Heart Pace Maker ___ Mitral Valve Prolapse ___Stroke

___Artificial Joint ___ Easily Winded ___ Heart Trouble/Disease ___ Pain in Jaw Joints ___ Swelling of the Limbs

___ Asthma ___ Emphysema ___Hemophilia ___Parathyroid Disease ___ Thyroid Disease

___ Blood Disease ___Epilepsy or Seizures ___ Hepatitis A ___ Psychiatric Care ___ Tonsillitis

___ Blood Transfusion ___Excessive Bleeding ___ Hepatitis B or C ___Radiation Treatments ___Tuberculosis

___ Breathing Problem ___ Excessive Thirst ___ Herpes ___ Recent Weight Loss ___Tumors or Growths

___ Bruise Easily ___Fainting Spells/Dizziness ___High Blood Pressure ___Renal Dialysis ___Ulcers

___ Cancer ___Frequent Coughs ___Hives or Rash ___Rheumatic Fever ___ Venereal Disease

___ Chemotherapy ___ Frequent Diarrhea ___ Hypoglycemia ___ Rheumatism ___ Yellow Jaundice

Have you ever had any serious illness not listed above? ___ YES ___ NO If yes, please explain: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN: _____ DATE: _____

New Patient Survey

Your answers will enable us to help you with your dental concerns:

1. What do you most want to achieve from dental care?

2. Is there anything regarding your dental health that you would like to improve?

3. What concerns you most about your current dental health?

4. How did you hear about Lohmann Dental?

5. What prompted you to make an appointment to see us?

6. How would you describe the perfect dentist? Please be specific.

7. How would you describe the perfect dental office?

8. In your opinion, what are the most important factors to consider when choosing a dentist in today's economy?

9. What would have to happen for you to get all your needed dental treatment right now, instead of waiting?

FINANCIAL OBLIGATION STATEMENT

OUR COMMITMENT IS TO PROVIDE QUALITY DENTAL CARE TO YOUR ENTIRE FAMILY THROUGH EXCEPTIONAL SERVICE. PLEASE READ THE FOLLOWING POLICY CAREFULLY!

METHODS OF PAYMENT:

1. Cash, Check or Credit Card. We accept VISA, MasterCard, Discover and American Express.
2. Third Party Financing. We offer ChaseHealth, Citi Health Card, Care Credit, SpringStone Plan. Most of these plans offer zero percent interest plan over 6, 12 or 18 months.

DENTAL INSURANCE:

1. If you should have dental insurance to assist you with your dental needs, we will collect from you what we estimate the insurance company will not pay for your treatment. We call that amount the 'co-pay'. After the appointment we will file the insurance claim and specify that the insurance payment should come to our office. If the insurance pays more than our estimate, we will refund the difference to you that week. If the insurance pays less, we will send you a statement when the insurance check arrives at our office. Some insurance plans will only pay the patient whether or not we ask the insurance company to pay our office. In this (rare) case, we ask for payment in full.
2. Please note the following:
   a. We are not contracted or 'in-network' with any insurance company.
   b. Your insurance contract is between you and your insurance company. We are not responsible for and have no control over what your insurance company pays for our services. We will call your insurance company before the time of service to verify coverage and arrive at an estimate of the 'co-pay.' Some insurance companies will not share what will be reimbursed for our services. In this case we will make an estimate based on prior history with the insurance company.
   c. We are not able to accept DMO, DHMO, HMO or Discount Plans.

RELATED INFORMATION

1. Any returned checks or payments will be charged a $35.00 fee and payment for the full amount of the check plus the returned check fee will be due by cash or credit card means only. Any unpaid returned check payments will be forwarded to our collections agency in the event that immediate resolution is not made.
2. Interest will be charged to any unpaid balances at 1.5% monthly or 18% annually. A billing charge of $5.00 will be charged for any statement sent for balances of 30 days or older.
3. Any balance not paid within 60 days will be referred to our collections agency and you will be responsible for all fees incurred for collection agency fees, attorney fees and court costs in recovering monies owed by you to our office.

I HAVE READ THE ABOVE INFORMATION. I UNDERSTAND I AM RESPONSIBLE (REGARDLESS OF INSURANCE) FOR ALL CHARGES INCURRED FOR SERVICES RENDERED.

SIGNATURE: _____ **DATE:** _____

THIS FORM MUST BE FILLED OUT IN ITS ENTIRETY REGARDLESS OF ANY OTHER INSURANCE NOTIFICATION MADE TO US FOR THE PURPOSES OF FILLING YOUR CLAIM(S).

INSURED'S INFORMATION: (THIS IS THE PERSON WHO CARRIES THE INSURANCE.)

LAST NAME: _____ FIRST NAME: _____

EMPLOYERS NAME: (REQUIRED) _____

EMPLOYERS PHONE NO.: (REQUIRED)_____ HR CONTACT:_____

EMPLOYERS ADDRESS: _____

ADDRESS OF INSURED: (IF DIFFERENT FROM PATIENT) _____

HOME NO. OF INSURED: _____ CELL/ALT PHONE NO.: _____

EMAIL ADDRESS OF INSURED: _____

GROUP NO.: _____ MEMBER ID: _____ INSURED DOB:_____

INSURANCE COMPANY NAME:_____

INSURANCE COMPANY PHONE NUMBER: _____

PATIENT INFORMATION: (IF DIFFERENT FROM THE INSURED)

LAST NAME: _____ FIRST NAME: _____

DOB: _____ RELATION TO INSURED: _____

CONTACT PHONE NUMBER: _____ EMAIL ADDRESS: _____

WE WILL FILE YOUR FIRST CLAIM WITHOUT PAYMENT FROM YOU. IN ORDER TO DIRECT THE INSURANCE COMPANY TO PAY US DIRECTLY PLEASE SIGN THE 'ASSIGNMENT OF BENEFITS' CLAUSE BELOW.

I hereby instruct and direct _____(insurance co. name) Insurance Company to pay be check made out and mailed to: Lohmann Dental, 2221 Peachtree Rd NE, Suite L, Atlanta, GA 30309.

If my current policy prohibits direct payment to the doctor, I hereby also instruct and direct you to make out the check to me and mail it as follows:

2221 Peachtree Road NE Suite L
Atlanta, GA 30309
(404) 352-5578

For the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize the doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

SIGNATURE OF POLICY HOLDER/PATIENT: _____ **DATE:**_____

DENTAL INSURANCE AND FLEX BENEFITS

Dental fees are ultimately your responsibility however the payments reimbursed to you by your insurance company will reduce the final expense for your treatment. About 99% of our account problems are from patient misunderstandings involving insurance. We encourage you to familiarize yourself with your policy and plan guidelines to ensure you understand your benefits and the limitations of your policy. Our office will estimate your insurance benefit as much as possible but please note: Our office can NEVER guarantee insurance payment and have no control over when or how your insurance company makes payment to you. Your insurance policy is a contract between your employer (if your insurance is administrated by your employer), your insurance company, and you. We do not receive updates on your insurance, do not verify benefits, and insurance companies never guarantee benefits until they receive the claim after the dental service is performed.

Please be advised that whenever insurance is filed in our office we instruct the insurance company to pay the subscriber directly. Insurance payments do not come to our office. We will gladly file your claim and any supporting material your insurance may request to assist you in receiving reimbursement. You will be required to pay for your dental services in full at the time of scheduling your treatment.

We file insurance claims as a courtesy to our patients and will follow up with the insurance company to ensure they have all necessary information to process your claims for your reimbursement. We will file to any dental insurance based on the information you provide to us. Any changes in dental insurance must be brought to our attention by you to prevent a delay in your reimbursement.

Please also note: We are NOT in-network with any insurance company and are considered an out-of-network provider. If your insurance plan is an in-network only plan, i.e. DMO, DHMO, or Discount Plan, we will file the claim for you however your plan may not reimburse you for your dental services.

Our office works with flexible spending accounts daily and we will provide all patients with itemized receipts at each appointment to assist you in filing for your reimbursement but our office cannot file the claim directly for you. If your flexible spending account is set up with a debit card we are happy to accept it but not all FSA debit cards are set up to work for all locations. Alternative means of payment, if the FSA debit card declines, is expected at the time of service.

This policy is given to you in the interests of preventing any misunderstandings regarding patient/provider responsibilities. We want you to enjoy your dental visits as much as possible. If you need clarification on anything in this policy please do not hesitate to ask!

I have read, understand, and agree to comply with the office insurance guidelines.

Signature of Patient or Guardian _____ Date _____

NOTICE OF PRIVACY PRACTICES

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

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information used or disclosed to us in any form, whether electronically, on paper, or orally, to be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by law, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

1. Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. For example, we may need to share information with other health care providers or specialists involved in the continuation of your care.
2. Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. For example, we may disclose treatment information when billing a dental plan for your dental services.
3. Health Care Options include the business aspects of running our practice. For example, patient information may be used for training purposes, or quality assessment.

Unless you request otherwise, we may use or disclose health information to a family member, friend, personal representative, or other individual to the extent necessary to help with your health care or with payment for your health care. In the event of an emergency or your incapacity, we will use our professional judgment in disclosing only the protected health information necessary to facilitate needed care. In addition, we may use you confidential information to remind you of appointments by sending reminder postcards and/or leaving messages at home and /or work. Your protected health information may also be used by our office to recommend treatment alternatives or to provide you with information about health related benefits and services that may be of interest to you. In addition, we may disclose your health information for public health oversight activities, judicial or administrative proceedings, in response to a subpoena or court order, to military authorities of Armed Forces personnel, to federal officials for lawful intelligence, counterintelligence, and other national security activities, to correctional institutions, or law enforcement officials, and/or to report suspected abuse, neglect, or domestic violence. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regards to your protected health information, which you may exercise by presenting a written request to our Privacy Officer at the practice address listed below:

1. The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person indentified by you. We are, however, mot required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
2. The right to request to receive confidential communications of protected health information from us by alternative means or at alternative locations.
3. The rights to access, inspect, and copy your protected health information, with limited exceptions. A reasonable fee may be assessed.
4. The right to request an amendment to your protected health information. We may deny your request in certain situations.
5. The right to receive an accounting of disclosures of protected health information made outside of treatment, payment, or health care operations...or based on your previous authorization.
6. The right to obtain a paper copy of this notice from us upon request, even if you have agreed to receive the notice electronically.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as April 14, 2003, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

Your have the right to file a formal, written complaint with us at the address below, or with the Department of Health and Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices, please contact:

William T. Lohmann, D.D.S.
2221 Peachtree Road N.E., Suite L
Atlanta, GA 30309
(404) 352-5578
HIPAA Officer: Wendy Hiler, OM

For more information about HIPAA or to file a complaint:

The U.S. Department of Health and Human Services
Officer of Human Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
877-696-6775 (toll-free)

Patient Signature: _____ DATE: _____

INFORMED CONSENT

LOHMANN DENTAL, 2221 PEACHTREE RD, SUITE L., ATLANTA, GA 30309

Patient Name: _____ Date: _____

I give my consent for examination and treatment by the providers of William T. Lohmann, DDS, PC dba Lohmann Dental.

_____ _____

Patient Signature Date

I acknowledge that I have read a copy of the Notice of Privacy Practices of Lohmann Dental and have a right to a copy of the same.

_____ _____

Patient Signature Date

I acknowledge that I have read and signed the Financial Policies of the office and agree to the terms of payment and insurance handling.

_____ _____

Patient Signature Date