JASON C. CROFT, D.M.D.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

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

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

JASON C. CROFT, D.M.D.

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 health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect _ 04/14/03 _, 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 make the new Notice available 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.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician 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.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. 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.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, 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.

To Your Family and Friends: 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 a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, 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 incapacity or 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.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.___ for each page, $___ per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: JASON C. CROFT, D.M.D.

Telephone: 770-536-8871 Fax: _____

E-mail: _____

Address: 1975 Beverly Road
Gainesville, Georgia 30501

(This Form is educational only, does not constitute legal advice, and covers only federal, not state, law in effect or proposed as of March 27, 2002. Subsequent law changes may require Form revision.)

WELCOME TO THE OFFICE OF:

DR. JASON C. CROFT, D.M.D.

1975 BEVERLY ROAD

GAINESVILLE, GA 30501

Please fill out this form as completely as possible. If you have any questions or need assistance ask us. We will be happy to help.

Patient Information (Confidential)

Name _____ Birthdate _____ Soc. Sec. # _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Please Check One: ___Minor ___ Single ___Married ___ Divorced ___Widowed ___ Separated

Patient or Parent's Employer _____ Address _____

Spouse or Parent's Name _____ Employer _____ Wk. Phone _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ Phone _____

For your Convenience, we offer the following methods of payment.

Please check the option you prefer: ___Cash ___Personal Check ___Visa ___Mastercard

If Patient is a Minor

Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____ Work Phone _____

Employer _____ SS# _____ Cell Phone _____

Dental Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Soc. Sec.# _____ Work Phone _____

Name of Employer _____ Address _____

Ins. Co. _____ Group # _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Do you have any additional Dental Insurance? ___Yes ___ No

(OVER)

Patient Medical History

1.Do you have or have you had any of the following?

Heart Attack	Yes__No__	High Blood Pressure	Yes__No__	Fainting/Seizures	Yes__No__
Heart Disease	Yes__No__	Low Blood Pressure	Yes__No__	Convulsions	Yes__No__
Heart Murmur	Yes__No__	Diabetes	Yes__No__	Anemia	Yes__No__
Mitral Valve Prolapse	Yes__No__	Insulin Dependent	Yes__No__	Emphysema	Yes__No__
Rheumatic Fever	Yes__No__	Leukemia	Yes__No__	Hay Fever/Allergies	Yes__No__
Cardiac Pacemaker	Yes__No__	Glaucoma	Yes__No__	Tuberculosis	Yes__No__
Cardiac Defibrillator	Yes__No__	Cancer	Yes__No__	Respiratory Problems	Yes__No__
Swollen Ankles	Yes__No__	Radiation Therapy	Yes__No__	Stomach troubles	Yes__No__
Angina	Yes__No__	Chemo Therapy	Yes__No__	Joint Replacement/	
Chest Pains	Yes__No__	Arthritis	Yes__No__	Implants	Yes__No__
Liver Disease/Jaundice	Yes__No__	Kidney Disease	Yes__No__	Sexually Transmitted	
Hepatitis	Yes__No__	Thyroid Disease	Yes__No__	Diseases	Yes__No__
HIV positive	Yes__No__	Asthma	Yes__No__	**Osteoporosis**	Yes__No__
AIDS	Yes__No__	Stroke	Yes__No__		

2.Are you under medical treatment now? Yes__No__
If yes, please explain_____
_____

3.Have you ever been hospitalized for any surgical operation or serious illness within the last 5 yrs? Yes__No__
If yes, please list_____
_____

4.Are you taking any medication(s) including non-prscription medicine? Yes__No__
If yes, please list_____
_____

5.Do you use controlled substances? Yes__No__
6.Do you use tobacco products? Yes__No__
7.Are you wearing contact lenses? Yes__No__
8.Women Only:
a) Are you pregnant or think you may be? Yes__No__
b)Are you nursing? Yes__No__
c)Are you taking oral contraceptives? Yes__No__

9.Are you allergic to or have you had any reactions to the following?

Codiene	Yes__No_
Local Anesthetics (e.g. Novocaine)	Yes__No_
Sulfa Drugs	Yes__No_
Sedatives	Yes__No_
Aspirin	Yes__No_
Latex Rubber	Yes__No_
Barbiturates	Yes__No_
Iodine	Yes__No_
Penicillin	Yes__No_
Any Antibiotics	Yes__No_

Others (please list)_____

Physician_____Office Phone_____Date of last Exam_____

Patient Dental History

Name of Previous Dentist and Location_____Date of Last Exam_____

1.Do your gums bleed while brushing or flossing? Yes__No__
2.Are your teeth sensitive to hot or cold liquids/foods? Yes__No__
3.Are your teeth sensitive to sweet or sour liquids/foods? Yes__No__
4.Do you feel pain to any of your teeth? Yes__No__
5.Do you have any sores or lumps in your mouth? Yes__No__
6.Have you had any head, neck or jaw injuries? Yes__No__
7.Have you ever experienced any of the following problems in your jaw?
Clicking in joints Yes__No__
Pain (joint,ear,side of face) Yes__No__
Difficulty in opening or closing Yes__No__
Difficulty in chewing Yes__No__
8.Do you like your smile? Yes__No__
9.Do you have frequent headaches? Yes__No_
10.Do you clench or grind your teeth? Yes__No_
11.Do you bite your lips or checks? Yes__No_
12.Have you ever had any difficult extractions in the past? Yes__No_
13.Have you ever had any prolonged bleeding following extractions? Yes__No_
14.Have you had any orthodontic treatment? Yes__No_
15.Do you wear dentures or partials? Yes__No_
If yes, date of placement_____
16.Have you ever received oral hygiene instructions regarding the care of your teeth and gums? Yes__No_

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I understand that my dental insurance carrier may pay less than the actual bill of services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____Date_____
Signature of patient (or parent if minor)