SMILE ATL

Timothy P. Resula, DMD & Associates, LLC

Cosmetic, Implant, & Reconstructive Dentistry

Patient Information

Last Name:	First Name:	M.I.
Preferred Name	Birth Date __/____/____	☐ Male ☐ Female
Address:	City:	State: Zip:
Home Phone:	Work Phone:	Cell Phone:
E-mail:		
* Preferred Method of Contact:	Home Cell Work Text E-mail	
Marital Status: ☐Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
Emergency Contact:	Phone Number:	Relationship:
How did you hear about our office?		

Insurance Information

Insurance Company Name: Employer:		Subscriber/Member ID:
Group/Policy #:	Policy Holder's Name:	Policy Holder's DOB:
Policy Holder's SSN:		
Insurance Claims Address:	City: State:	Zip:
Provider Services Number:	Policy Holder's relation	

Responsible Party

Name:	Relationship:	
Address:	City: State:	Zip:
Home Phone:	Work Phone:	Cell Phone:

Dental History

Reason for today's visit: _____

Date of last dental visit: _____/_____/_____

Date of last full mouth x-rays: _____/_____/_____

How often do you brush? _____

How often do you floss? _____

Do you use mouthwash? ☐ Yes ☐ No If yes, what type: _____

Do you use an electric tooth brush? ☐ Yes ☐ No If yes, what type: _____ How often? _____

Do you smoke? ☐ Yes ☐ No

Do you chew tobacco? ☐ Yes ☐ No

Do you clench or grind your teeth? ☐ Yes ☐ No

Check if you have had any of the following:

- ☐ Bad breath
- ☐ Bleeding or sensitive gums
- ☐ Difficulty chewing
- ☐ Clicking or popping jaw
- ☐ Jaw pain
- ☐ Orthodontic Treatment
- ☐ Periodontal Treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores in mouth

Would you like for your teeth to be whiter? _____ Are you happy with your smile? _____

What type of dentistry would you like for us to recommend? ☐ Cosmetic ☐ Preventative ☐ Repairs only

Medical History

Physician's name: _____ Phone number: _____ Date of last visit: _____/_____/_____

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, please describe: _____

Are you Allergic to anything? _____

Please circle all of the following you have had or currently have:

- -Acid Reflux
- -Anemia
- -Angina
- -Arthritis/Rheumatism
- -Artificial heart valves*
- -Artificial joints*
- -Asthma
- -Back problems
- -Blood disorder
- -Cancer
- -Chemical dependency
- -Chemotherapy
- -Circulatory problems
- -Cortisone treatment
- -Diabetes (I or II)
- -Eating disorder
- -Emphysema or other respiratory illness
- -Epilepsy or Seizures
- -Fainting
- -Gastrointestinal disease
- -Glaucoma
- -Headaches
- -Heart murmur
- -Heart Surgery*
- -Hemophilia
- -Hepatitis
- -High blood pressure
- -HIV/AIDS
- -Infective Endocarditis*
- -Kidney problem
- -Latex sensitivity
- -Liver problems
- -Mitral valve prolapse
- -Neurological disorder
- -Pacemaker
- -Psychiatric care
- -Radiation treatment
- -Rheumatic fever
- -Scarlet fever
- -Shortness of breath
- -Sickle cell anemia
- -Sinus trouble
- -Stroke
- -Substance addiction
- -Swelling of feet and/or ankles
- -Thyroid problems
- -Tonsillitis
- -Ulcer
- -Other

*Conditions may require pre-medication

What medications are you currently taking?

_____

Women: Are you ☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

I understand that the above information is necessary to provide me with dental care in a safe and efficient manner, and that it will be held in the strictest confidence and only used to improve communication between the doctor and myself. I have answered all questions to the best of my knowledge and it is my responsibility to inform the dental office of any changes in my medical status.

Signature: _____ Date _____

(Parent or guardian if patient is a minor)

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions - We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
- We will not allow disclosure of your protected health information or personally-identifiable information except as permitted or required under Georgia Privacy, Security, Medical Records, and Identity Theft laws.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Updated October 2, 2015

Privacy Officer: Timothy P. Resuta, D.M.D.,J.D
(404) 351 – 1035

Changes to the Terms of this Notice - We can change the terms of this notice in accordance with law, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

I have received a copy of the Notice of Privacy Practices for **TIMOTHY P. RESUTA, DMD AND ASSOCIATES, LLC.**

Name: _____ Date: _____

Signature: _____

SMILE ATL
Cosmetic Dentistry
Timothy P. Resuta, DMD & Associates, LLC.

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Suite #339
Atlanta, GA 30327
(404)-351-1035
www.smileatl.com

FORTY-EIGHT HOUR NOTICE REQUIRED

We truly care for and value each and every one of our patients! Our goal is to provide you with exceptional care that exceeds your expectations. While we understand that personal schedules can be busy at times, we know that we cannot achieve this goal without a mutual commitment to your overall oral health. In order to provide you with the quality of care you deserve, we reserve individual appointments for each of our patients. We ask that both parties respect and value this time. If an appointment must be changed, a minimum of a **48-hour** notice is required. This will allow us to reschedule you for a more convenient time, as well as have sufficient time to offer your vacant appointment to another patient in need of care. A broken appointment fee of **$50.00** will be charged in the unlikely event that the required **48-hour** notice is not given. This policy will be enforced, except in extreme emergency situations.

Thank you for your efforts in ensuring you have a remarkable smile!

Print Name _____ **Date** _____

Patient / Guardian Signature _____

Parking Directions To Smile Atl **Suite 339 West Wing**:

3280 Howell Mill Rd NW
Suite 339
Atlanta, GA 30327

As you enter in between the two buildings, get a parking ticket.

Drive all the way up to level 7.

Park in the middle of the parking garage.

Enter 2nd automated Red door on the right side "West Wing".

Walk down the hallway and the office "Smile Atl Suite 339" is the 1st door on the left past the evaluators.