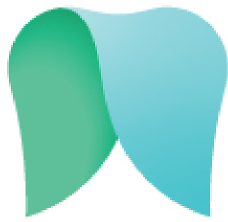

SMILE ATL™

Timothy P Resuta, 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	

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

*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:____________________________________

(Parent or guardian if patient is a minor)

Date______________________________

SMILE ATL™

Timothy P Resuta, DMD & Associates, LLC
Cosmetic, Implant & Reconstructive Dentistry

AUTHORIZATION TO USE, RELEASE & DISCLOSE HEALTH INFORMATION

TO: Practice Name: ______________________________

Address: ______________________________

City: ______________ State: ______________ Zip: ______________

Office Number: ______________ E-mail: ______________________________

RE: Patient Name: ______________ DOB: ______________ SSN: ____ - ____ - ____

Section I: Use or Disclosure of Health Information - By signing this Authorization, I authorize the release and disclosure of all of my individually- identifiable protected health information to:

NORTHWEST MEDICAL CENTER
3280 Howell Mill Rd. NW - Suite #339
Atlanta, GA 30327
Office: (404)351-1035 - Fax: (404)609-9221

**** PLEASE SEND AS DEXIS FILES IF POSSIBLE ****

**** Please return form & send patient records/x-rays to: specialtycorrespondence@smileatl.com ****

Section II: Scope and Use of Disclosure - Health information that may be used or disclosed through this Authorization is as follows:

□ All health information
□ Other: ______________________________
____

I, as indicated by my initials beside my choice below, DO NOT want the following information disclosed:

□ HIV status or testing □ Substance abuse records □ Mental health records
□ Other: ______________________________

Section III: Purpose and Use of Disclosure - The purpose of this Authorization is for the purpose of review and evaluation in connection with:

□ Continuation or coordination of care or treatment
□ Other: ______________________________

Section IV: Authorization Expiration -

□ This authorization is unlimited as to time, and a photocopying hereof is as valid as the original.
□ This authorization shall expire: ______________

Section V: Additional Acknowledgements - I understand the following, as located in CFR §164.508(c)(2)(i-iii):

a. I have a right to revoke this Authorization in writing at any time, except to the extent information has been released in reliance upon this Authorization.
b. The information released in response to this Authorization may be re-disclosed to other parties, in accordance with law.
c. My treatment or payment for my treatment cannot be conditioned on the signing of or refusal to sign this Authorization.

Signature: ______________________________ **Date:** ______________

Printed Name: ______________________________

Signature of Parent/Guardian if Minor: ______________________________

Witness signature: ______________________________ **Date:** ______________

Printed Name: ______________________________

SMILE ATL™

Timothy P Resuta, DMD & Associates, LLC

Cosmetic, Implant & Reconstructive Dentistry

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** per hour 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!

______________________________ ______________

Patient Name **Date**

______________________________ ______________

Patient Signature **Date**

TIMOTHY P. RESUTA, DMD & ASSOCIATES, LLC.
3280 HOWELL MILL RD. NW - SUITE #339
ATLANTA, GA 30327
(404) 351-1035

NOTICE OF PRIVACY PRACTICES
Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights: When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete.
- We may say "no" to your request, but we'll tell you why in writing within 30 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee for another within 12 months.

Get a copy of this privacy notice - You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- If you feel we have violated your rights, you can complain by contacting us.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices: For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you - We can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization - We can use and share your health information to run our practice, improve your care, and contact you when necessary.
Example: We use health information about you to manage your treatment and services.

Bill for your services - We can use and share your health information to bill and get payment from health plans or other entities.
Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Do research - We can use or share your information for health research.

Respond to organ and tissue donation requests - We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director - We can share health information with a coroner, medical examiner, or funeral director upon death.

Comply with the law - We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

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, DMD, JD
(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 & ASSOCIATES, LLC**.

Name: ____ Date: ______________

Signature: ____

SMILE ATL™

Timothy P Resuta, DMD & Associates, LLC

Cosmetic, Implant & Reconstructive Dentistry

Parking Directions to: SMILE ATL – WEST WING – SUITE #339

NORTHWEST MEDICAL BUILDING

3280 Howell Mill Rd. NW - Suite #339

Atlanta, GA 30327

- As you enter in between the two buildings, take a parking ticket
- Drive all the way up to **PARKING LEVEL G**
- Park in the middle of the parking garage
- Enter through the **2nd** automated **BLUE** door on the right -

  "**WEST WING**"

- Walk down the hallway & our office

  "**SMILE ATL - SUITE #339**" will be the 1st office on the left past the elevators