

Dr. Joel R. Benk, DDS, PC

PATIENT HISTORY

Today's Date: _____

GENERAL INFORMATION:

NAME: _____ AGE: _____ Date of Birth: _____

Address: _____ Apt# _____ City: _____ ZIP: _____

Home Phone () _____ Work () _____ Cell Phone () _____

Social Security Number: _____ Sex: _____ Marital Status: _____

Driver's License Number and State: _____ Email: _____

MEDICAL HISTORY:

Have you ever had any of the following medical conditions? (Check "yes" or "no")

CONDITION	YES	NO	DATE	CONDITION	YES	NO	DATE	CONDITION	YES	NO	DATE
Rheumatic Fever				Diabetes				Special Diets			
Heart Trouble/Pacemaker				Kidney Trouble				Psychiatric Problems			
High Blood Pressure				Urinary Problems				Arthritis			
Chest Pain				Cancer/Tumors				Frequent Headaches/Tension			
Shortness of Breath				Radiation Treatment				Major Operations			
Lung Disease				Hepatitis				Intestinal Problems			
TB or Emphysema				Liver Disease				WOMEN:			
Allergies				Venereal Disease				Are you pregnant?			
Sinus				Stomach Ulcers				Menstrual Problems?			
Asthma/Hay Fever				Anemia							
Epilepsy/Seizures				Clotting Problems							
Fainting Spells				Excessive Bleeding							

Are you under the care of a physician now? _____ For what reason _____

When was your last physical examination? _____ Weight _____

Have you been tested for the HIV (AIDS) Virus? Yes _____ No _____ If yes, results: Positive _____ Negative _____

Are you receiving any medication? _____ What? _____

Are you taking or have you ever taken Fosamaz, Boniva, Actenol, Aredia or Zometa? Yes ___ No ___ If so how long? _____

Do you have any allergies? _____ To what? _____

Are you allergic to or have adverse reaction to Novocain OR Latex? _____

DENTAL HISTORY:

Are you having problems with your teeth/mouth? _____ What problems? _____

Previous Dentist _____ Date and purpose of last dental exam _____

Have you ever had gum or periodontal treatment _____ Have you ever had orthodontics (braces) _____

Are you pleased with the appearance of your teeth? _____ If not, why? _____

PERSONAL INFORMATION:

Patient employed by _____ Spouse employed by _____

Business Address _____ Business Address _____

Occupation _____ Occupation _____

In case of emergency, notify: _____ Phone () _____

How did you hear about this office? _____

ADDITIONAL INFORMATION

Wife (Mom) _____ Social Security Number: _____

Husband (Dad) _____ Social Security Number: _____

Your nearest relative not living with you: _____ Phone () _____

Next closest relative not living with you: _____ Phone () _____

CONSENT FOR DENTAL TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. I agree to be responsible for all payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

5. I agree to have postcards mailed to me to remind me of my future appointments with the doctor and/or hygienist.

Patient's Signature _____ Date _____

Patient/Responsible Party's Signature _____

Relationship to Patient _____

FINANCE POLICY:

It is our office finance policy that our patients pay for their services at the time they are rendered or in advance, if you wish. We do accept dental insurance; however, the **full debt for services is the patient's responsibility**. At times financial arrangements may be needed. I hereby authorize this dental office to secure information which will help in the determination of financial arrangements. Our primary concern is that you complete your dental treatment plan so you can have the optimum dental health without financial stress.

Signature of person responsible for Payment: _____ Date _____

Please check: Cash ___ MasterCard ___ Visa ___ Other ___ Insured with _____

OUR FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered your responsibility. The following is a statement of our financial Policy, which we require that you read, agree to and sign prior to any treatment

All patients must complete our Patient Information Form before seeing the doctor.

FULL PAYMENT IS DUE AT TIME OF SERVICE.

RETURN CHECK will be sent to a National Collection Service to be presented electronically for collections and will assess a return check fee against your account in the amount of \$45.

How will you be taking care of your account? _____ cash _____ check _____ credit card

We accept Visa, MasterCard, American Express & Discover.

A credit report may be obtained. In the event payments are not received by agreed upon dates, I understand that a 1 1/2 service charge (18% APR) may be added to my account. If collection procedures are instituted because of failure to pay, I agree to pay all court costs and collection fees, including reasonable attorney's fees, to the extent permitted by applicable law.

REGARDING INSURANCE

Dental insurance is great! We will gladly help fill out all those complicated forms for you and even accept the assignment of insurance benefits so that your "out of pocket" can be minimized. We will even allow our office insurance "expert" to evaluate your particular insurance plan and work to get you the maximum reimbursement—all just for you! (Please bring all your Insurance information or insurance booklet with you to help us out) We cannot bill your insurance unless you bring all insurance information. Should you have any change in your insurance information please inform the practice before your appointment or any services rendered. You should remember that your insurance policy is a contract between you and your insurance company and we are not a party to that contract. What that means is our doctors work for and get paid by you, i.e., you are ultimately responsible for the payment of all fees for our service.

Concerning Insurance Co-Payments: You will need to pay any deductible and fee co-payments the day of your appointment with cash, check, or Credit Card. If your insurance company has denied or not paid your account in full in 75 days, the balance of your account will then become your responsibility to pay within 15 days. Please be aware some and perhaps all of the services provided may be "non-covered" service and not considered so-called reasonable and necessary under you insurance program.

Regardless of the insurance company's determination of usual and customary rates or amount of assignment, you are required to pay the full amount charged by our office. There are no write off of fees.

ADULT PATIENTS

Adult patients are responsible for full payment at time of service.

MINORS

The adult accompanying a minor and the parents or guardians is responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to a credit card or payment by cash or check at the time of service.

MISSED APPOINTMENTS

Unless you have cancelled at least 48 hours **in advance** our policy is to charge \$39.00 for missed appointments. Please help us serve you better by keeping scheduled appointments.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I have read, understand and accept this Company's Financial Policy as stated here.

Patient or Responsible Party _____ Date _____

FRIENDLY, GENTLE DENTISTRY

JOEL R. BENK, DDS

ASSIGNMENT OF BENEFITS FORM

Name: _____

Address: _____

I hereby authorize release of any medical information to any insurance carrier or attorney concerning my treatment and physical condition in order to process any claim for reimbursement of charges incurred at this office by me.

I hereby authorize you to pay directly to Dr. Benk benefits due me out of indemnity under the terms of my policy issued by your company.

Payment is authorized upon your receipt of the Doctor's itemized statement for services rendered to me. This policy was in full force and effect at the time services were rendered. Payment of this amount as herein directed, in whole or part, shall be considered the same as if paid by your company directly to me. You are directed not to mail payment for treatment by Dr. Benk to anyone other than Dr. Benk.

I hereby assign, and transfer to you, the cause of action that exists in my favor against any insurance company obligated by contractual agreement to make payment to me or to your office for the charges incurred. In the event any such company refused payment, you are authorized to prosecute said action either in my name or your name as you see fit and compromise, settle or otherwise resolve said claim as you see fit.

I understand I personally owe any amount, in whole or in part, for which the insurance carrier does not reimburse your office.

Signed: _____

Date: _____

FRIENDLY, GENTLE DENTISTRY

JOEL R. BENK, DDS

OUR POLICY REGARDING DENTAL INSURANCE

Our Policy Regarding Dental Insurance:

Whether you have purchased dental insurance on your own or your employer has provided it for you, you are fortunate to have it and we will go the extra mile to help you maximize your benefits provided by your specific plan. If you wish, we will also be glad to help you file your insurance forms, which will save you considerable time and trouble. Your insurance company will reimburse you or us if the benefits are assigned to us for the expenses they agree to pay. for the expenses they agree to pay. The insurance company usually only pays a percentage of the fee, and this varies from plan to plan. Your dental insurance is not designed to pay the entire cost of your treatment, but it is intended to help cover a certain portion of the cost. A better term for dental insurance may be "dental assistance".

Please remember, however, the financial obligation for dental treatment is between you and this office, and is not between us and the insurance company.

On rare occasions, a dental insurance plan will require a "predetermination" or "prior authorization" for treatment, though most insurance companies do not require this. If they do, we will be happy to submit a treatment plan to your insurance carrier on request.

In order for us to submit your form, we ask that you provide the following:

1. A copy of your insurance booklet or a copy of your insurance card.
- 2 The insured's birth date, social security number, group or ID number, and the name of employee, whichever is applicable.

I have read and understood the above.

Signature: _____ Date: _____

JOEL R. BENK, D.D.S., P.C.

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 (04/14/2003), 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. This could also include using and disclosing PHI to contracted third party companies to assist our office in activities relating to treatment, payment, and healthcare operations.

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 \$0.10 for each page, \$10.00 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: Debbie Benk
Telephone: 404-872-7755 Fax: 404-874-1512
E-mail: dsbenk@earthlink.net
Address: 620 Peachtree St. NE Suite 204 Atlanta, GA 30308

JOEL R. BENK, D.D.S., P.C.
620 Peachtree Street NE Suite 204
Atlanta, GA30308
(404) 872-7755

PATIENT ACKNOWLEDGMENT FORM

Patient Acknowledgment of Understanding of Joel R. Benk, DDS, PC's Privacy Practices

Patient's name: _____ Date of Birth: _____
Please Print Name

_____ SSN: _____
Address

I understand that the patient's health information is private and confidential. I understand that Dr. Benk, his Associates, and his staff work very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand that the office of Joel R. Benk, DDS, PC may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations. In general, there will be no other uses and disclosures of this information unless I permit it.

Joel R. Benk, DDS, PC has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting the patient's privacy and is available in the waiting room. I understand that I have the right to read the "Notice" before signing this Acknowledge. I may also request a copy to take home. This Acknowledgment and "Notice of Privacy Practices" may be updated. If I ask, Dr. Benk's staff will provide me with the most current "Notice of Privacy Practices".

Within this "Notice of Privacy Practices" is contained a complete description of my privacy/confidentiality rights. These rights include, but are not limited to, access to my medical records; restrictions on certain uses; receiving an accounting of disclosures as required by law; knowing in what ways my records are used by this practice; understanding how this office protects my privacy; and requesting communication by specified methods of communication or alternative location.

Joel R. Benk, DDS, PC has established procedures which help them meet their obligations to patients. These procedures may include other signature requirements, written acknowledgments, and authorizations; reasonable time frames for requesting information; charges for copies and non-routine needs; etc. I will assist Dr. Joel R. Benk, DDS, PC by following these procedures if I choose to exercise any of my rights described in the "Notice of Privacy Practices".

Patient or legally authorized individual signature Date Time

Relationship to patient if signed by anyone other than the patient (parent, legal guardian, etc.)

JOEL R. BENK, D.D.S., P.C.
ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of the 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 situations prevented us from obtaining acknowledgement
- Other (Please Specify)

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