PATIENT'S NAME_____Birthdate_____ Sex__ Marital Status_____

SSN_____Driver's License No._____E-Mail_____

Residence Address_____City_____State____Zip_____

How long at present address?_____ Phone:H_____W_____Cell_____

Employer_____Occupation_____

Address_____How long at present employer_____

Physician's Name_____Address_____Ph._____

GUARDIAN(if under 18) _____ Birthdate_____ Sex__ Marital Status_____

SSN_____Driver's License No._____E-Mail_____

Residence Address_____City_____State____Zip_____

How long at present address?_____ Phone:H_____W_____ Cell_____

Employer_____Occupation_____

Address_____How long at present employer_____

Do you have insurance?_____If not, how do you intend to pay? ____Cash ____Check____Credit Card

SUBSCRIBER_____ Birthdate_____ Sex__ Marital Status_____

SSN_____Driver's License Number_____

Residence Address_____City_____State____Zip_____

Employer_____Occupation_____

Address_____Phone_____

Insurance Company Name and address_____

_____

Plan Name/Group Number_____Ins. Ph._____Relation to Patient_____

Secondary Insurance_____

Person Financially responsible for this account_____

Nearest relative not residing with you_____

Relationship to you _____Phone_____

Who may we thank for referring you?_____

Address_____Phone_____

In case of an emergency please contact_____Phone_____

SIGNATURE_____

Patient Name:_____

MEDICAL HISTORY – Certain illnesses and drugs may make it necessary to alter our treatment. In our endeavor to render the best possible oral health care to you (or your child), it is necessary to have the following information. HAVE YOU EVER HAD OR HAVE:

	YES	NO
1. Asthma, hay fever sinusitis, or other allergies		
2. Allergy to penicillin, aspirin, local or general anesthetic, or other drugs; specify:		
3. Blood pressure or heart problems		
4. Rheumatic fever or heart murmur		
5. A pacemaker or open heart surgery		
6. Diabetes, liver, kidney, thyroid, or lung problems		
7. Ulcers or stomach problems		
8. Hepatitis or Jaundice		
9. Epilepsy or nervous disorders		
10. Bleeding or clotting disorders		
11. Arthritis		
12. Venereal Disease, Herpes		
13. Acquired Immune Deficiency Syndrome (AIDS)		
14. Any other illness		
15. Do any wounds heal slowly or persent complications?		
16. Are you presently taking any medicine? Specify:		
17. Are you presently under the care of a physician?		
18. When was your last physical exam?		
19. Have you ever been hospitalized? Date: Reason:		
20. Have you had X-ray treatments or chemotherapy?		
21. Are you presently on a diet?		
22. Women ( ) Are you taking birth control pills? ( ) Are you pregnant?		
23. Do you smoke? How long? How many packs per day?		
24. Do you have osteoporosis? If Yes, what medication are you taking?		

PATIENT SIGNATURE_____ DATE _____

DENTIST SIGNATURE_____ DATE _____

Please complete reverse side

DENTAL HISTORY

Patient Name:_____

DATE OF LAST DENTAL EXAM _____

DATE OF LAST FULL MOUTH X-RAY_____WHERE TAKEN_____

	YES	NO
1. Have you had trouble from previous dental care?		
2. Do you have pain in your jaw or near your ears?		
3. Do you have any unhealed injuries or inflamed areas in or around your mouth?		
4. Have you experienced any growths or sore spots in your mouth?		
5. Does any part of your mouth hurt when clenched?		
6. Have you ever had Novocaine or other local anesthetic?		
7. Have you ever had Nitrous Oxide (laughing gas)?		
8. Have you ever had general anesthesia?		
9. Have you ever had any reaction or allergic symptoms to Novocaine, local or general anesthetics?		
10. Have you ever had any difficult extractions in the past?		
11. Have you ever had prolonged bleeding following extractions in the past?		
12. Do your gums bleed?		
13. Do you have a bad taste in your mouth or mouth odor?		
14. Have you ever had instructions on the care of your gums?		
15. Have you ever been diagnosed with or treated with gum disease?		
16. Do you chew on only one sid of your mouth? If so, why?		
17. Do you habitually clench or grind your teeth during the night or day?		
18. Is any part of your mouth sensitive to pressures or irritants (hot, cold or sweets)?		

Is there any other problem not covered above that you would like to discuss?_____

_____

PATIENT SIGNATURE_____DATE_____

DENTIST SIGNATURE_____ DATE _____

Please complete reverse side

Village Green Family & Cosmetic Dentistry

3600 Dallas Highway, Suite 220
Marietta, GA30064

Dental Practice Policy

Dear Patient:
Please Read and sign at the bottom

- Welcome to our dental office. We appreciate the opportunity to assist with your dental needs and concerns. Our goal is to provide you with the best dental care available in an efficient and professional manner. Together we can accomplish this goal. Like any business we have office policies that we must adhere to so that we can operate in a manner that will benefit our relationship. We will define those policies in the next couple of paragraphs.

- We provide several payment options to fit your financial needs. We offer the convenience of credit card payments using Visa or MasterCard. We also provide low or no interest third party financial payment plans. **However, check will not be accepted on your first visit.** _____(initial)

- We must have 48-hour notice should you be unable to come to your appointment. We will make every effort to confirm your appointment with you. However it is your responsibility to keep up with your appointment time. **Failure to give us a 48-hour notice will result in a $40.00 broken appointment charge billed to your account.** We have reserved this time for you and must know if you will be unable to keep it. _____(intitial)

- All co-pays and deductible portions are due at prior to treatment. As a courtesy, we will be happy to file your insurance. **Please understand that all treatments are not contingent or dependent on payment by your insurance company. Fees quoted are an estimate based on information from your insurance carrier, not a guarantee of payment. In the event we do not receive payment from your insurance provider within 45 days of billing, the amount owing will be billed to you and payment expected within 15 days after billing.** We will be happy to provide you with a copy of the claim we submitted to your insurance carrier. _____(initial)

- It is the responsibility of the patient/guarantor to provide this office with any future changes in insurance plans, address and phone number prior to treatment, and to make certain that we are listed as your in-network provider.

- Our office accepts faxed eligibility. However faxed eligibility is not a guarantee of coverage. **It is your responsibility to verify your eligibility.** Should your insurance company deny the claim for any reason, **we will bill you our normal fees and all charges become your responsibility to pay.** _____ (initial)

- **Any accounts over 60 days will incur a 1.5% per month finance charge base on the unpaid balance. These charges will accrue each month there is an outstanding balance.** _____ (initial)

- **I understand that in the event any unpaid balance is placed for collections with any third party collection agency, a fee of 33% of the unpaid balance will be added to the total amount due. This amount shall be in addition to any other costs incurred directly or indirectly to collect amounts owed under this agreement such as court costs, attorney fees, and all other expenses so stated elsewhere. The authorized fee of 33% and the additional costs and charges listed above represent the actual costs incurred by our office to collect amounts owed under this agreement and a corresponding decrease in expected revenue resulting from this signers failure to pay as specified in this agreement.** _____ (initial)

- **Return checks, stop payments and credit card charge back incur a fee of $25.00 or 5% of the face amount, whichever is greater, and an amount equal to the charges incurred by our bank.** _____ (initial)

- We try very hard to adhere to a schedule. If you are more than 15 minutes late, we may have to reschedule your appointment. Sometimes an emergency will occur that will make us run behind, please be patient with us as it could be you with that emergency. We do respect your time and will make every effort to stay as close to your appointment time as possible. We thank you for choosing us and look forward to a long term relationship with you and your family.

_____(Patient/Guardian Signature if under 18) _____ (Date)

Assignment of Benefits

I (or if a legal guardian on behalf of the client), hereby assign my dental payment directly to the Ping Hai DDS & Associates, PC. I understand that I am (or if a legal guardian, the client is) financially responsible for the charges not covered by this assignment, or for any and all charges that the insurance carrier declines to pay. It is further agreed that any credit balance resulting from payment of insurance or payment from other sources may be applied to any other account(s) owed to the Ping Hai DDS & Associates, PC by the insured or the insured's family.

I also authorize Ping Hai DDS & Associates, PC to file complaints to Insurance Commissioner on my behalf for any reasons.

In case my insurance policy prohibits direct payment to my doctor, I hereby directly instruct my insurance company make the check payable to me as a patient and mail it to me as follows

c/o Ping Hai DDS & Associates, PC
3600 Dallas Hwy, Suite 220
Marietta, GA 30064

Patient Name (print): _____

Signature: _____

Legal Guardian Name (print) (if applicable)_____

Legal Guardian Signature:_____

Village Green Family & Cosmetic Dentistry

NOTICE OF PRIVACY PRACTICES
THIS NOTICE DESCRIBES HOW PERSONAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU. The following categories describe different ways that we use and disclose dental information. Not every use or disclosure in a category will be lised. However, all of the ways are permitted to use and disclose information will fall within one of the categories.
FOR PAYMENT: We may use and disclose dental information about you so that the treatment and services you receive at Village Green Family & Cosmetic Dentistry may be billed to, and payment may be collected from you, an insurance company, or a third party.
FOR TREATMENT: We may use dental information about you to provide you with dental treatment or services. We may disclose dental information about you to doctors, dentists, hygienists or other office personnel who are involved in taking care of you at Village Green Family & Cosmetic Dentistry. We also may disclose dental information about you to people outside the Village Green Family & Cosmetic Dentistry, who may be involved in your dental care, such as family members, clergy or other persons that are part of your care.
FOR DENTAL CARE OPERATIONS: We may use and disclose dental information about you for Village Green Family & Cosmetic Dentistry operations. These uses and disclosures are necessary to run the Village Green Family & Cosmetic Dentistry and ensure that all of our patients receive quality care. We may also disclose information to dentists, hygienist or other Village Green Family & Cosmetic Dentistry personnel for review and learning purposes.
WHO WILL FOLLOW THIS NOTICE: This notice describes our Village Green Family & Cosmetic Dentistry and that of any health care professional authorized to enter information into your Village Green Family & Cosmetic Dentistry records, all departments and units of the Village Green Family & Cosmetic Dentistry, as well as all employees, staff and other Village Green Family & Cosmetic Dentistry personnel. We reserve the right to change this notice and will post a revised copy of each notice. If we change this notice, we will make the new notice provisions effective for all protected dental information that it maintains.
POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION: We create a record of the care and services you receive at the Village Green Family & Cosmetic Dentistry. We need this record in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the Village Green Family & Cosmetic Dentistry, whether made by the Village Green Family & Cosmetic Dentistry personnel or by your personal dentist. Your personal dentist may have different policies or notices regarding the doctor's use and disclosure of your dental information created in the dentist's office or clinic.

The law requires us to: make sure that dental information that identifies you is kept private, give you this notice of our legal duties and privacy practices with respect to dental information about you; and follow the terms of the notice that are currently in effect.

Other ways we may use or disclose your protected healthcare information include disclosures to, or for: appointment reminders or instructions, compliance with the law, health-related benefits and services, the directory of patients, individuals involved in your case or payment for your care, research, or avert a serious threat to health or safety, as well as treatment alternatives.

Other uses and disclosures of your personal information could include disclosures to, for or about: coroners, medical examiners and funeral directors, health oversight activities, inmates, law enforcement, lawsuits and disputes, military personnel and veterans, national security and intelligence activities, organ and tissue donations, protective services for the president and other, public health risks and worker's compensation.

NOTICE OF INDIVIDUAL RIGHTS

You have the following rights regarding dental information we maintain about you:
Right to a Paper Copy of the Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.
Right to Inspect and Copy: you have the right to inspect and copy dental information that may be used to make decisions about your care. We may deny your request to inspect and copy in certain very limited circumstances.
Right to Amend: If you feel that dental information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the to request a amendment for as long as the information is kept by, or for, the Village Green Family & Cosmetic Dentistry. To request an amendment, your request must be made in writing and addressed to the Privacy Representative. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if we did not create the information, if it is correct, or if it is complete.
Right to Request Restrictions: You have the right to request a restriction or limitation on the dental we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the dental information we disclose about you to someone who is involved in your care or the payment of your care, like a family member of friend. For example, you could ask that we not use or disclose information about a surgery you had. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment.
Right to Request confidential communications: You have the right to request that we communicate with you about dental matters in a certain way or at a certain location. Your request must specify how or where you wish to be contacted.
Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosure." This is a list of the disclosures we make of dental information about you, but it does not include disclosures related to treatment, payment, operations, or disclosures made with your authorizations. To request this list or accounting of disclosures, you must address your request in writing to the Privacy Representative.

COMPLAINTS: If you believe your privacy right have been violated, you may file a complaint with the Village Green Family & Cosmetic Dentistry or with the Secretary of the Department of Health and Human Services. For assistance with filing a complaint, or to file a complaint with the Village Green Family & Cosmetic Dentistry, contact the Privacy Representative, write to the Village Green Family & Cosmetic Dentistry, 3600 Dallas Highway, Suite 220, Marietta, GA 30064, or call 770-428-5656. **You will not be penalized for filling a complaint.**

OTHER USES OF DENTAL INFORMATION: Other uses and disclosures of dental information not covered by this notice or the laws that apply to use will be made only with our written authorization. If you provide us permission to use or disclose dental information about you, you may revoke that permission in writing at any time.

I have reviewed a copy of the Privacy Practices Policy for Village Green Family & Cosmetic Dentistry.

Signature: _____ Date: _____

Printed Name: _____