

JASON C. CROFT, D.M.D.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement*

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)

© 2002 American Dental Association

All Rights Reserved

Reproduction and use of this form by dentists and their staff is permitted. Any other use, duplication or distribution of this form by any other party requires the prior
written approval of the American Dental Association.

(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.)

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

© 2002 American Dental Association

All Rights Reserved

Reproduction and use of this form by dentists and their staff is permitted. Any other use, duplication or distribution of this form by any other party requires the prior written approval of the American Dental Association.

(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/ Implants	Yes ___ No ___
Chest Pains	Yes ___ No ___	Arthritis	Yes ___ No ___	Sexually Transmitted Diseases	Yes ___ No ___
Liver Disease/Jaundice	Yes ___ No ___	Kidney Disease	Yes ___ No ___	Osteoporosis	Yes ___ No ___
Hepatitis	Yes ___ No ___	Thyroid Disease	Yes ___ No ___		
HIV positive	Yes ___ No ___	Asthma	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-prescription 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 ___	9. Do you have frequent headaches?	Yes ___ No ___
2. Are your teeth sensitive to hot or cold liquids/foods?	Yes ___ No ___	10. Do you clench or grind your teeth?	Yes ___ No ___
3. Are your teeth sensitive to sweet or sour liquids/foods?	Yes ___ No ___	11. Do you bite your lips or cheeks?	Yes ___ No ___
4. Do you feel pain to any of your teeth?	Yes ___ No ___	12. Have you ever had any difficult extractions in the past?	Yes ___ No ___
5. Do you have any sores or lumps in your mouth?	Yes ___ No ___	13. Have you ever had any prolonged bleeding following extractions?	Yes ___ No ___
6. Have you had any head, neck or jaw injuries?	Yes ___ No ___	14. Have you had any orthodontic treatment?	Yes ___ No ___
7. Have you ever experienced any of the following problems in your jaw?		15. Do you wear dentures or partials? If yes, date of placement _____	Yes ___ No ___
Clicking in joints	Yes ___ No ___	16. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	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 ___		

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)