Douglas Dental Care
Joel R. TIdwell, DDS
Dimitri Arfanakis, DMD
Patient Information and HIPPA

Patient name: ________________________ ________________________ ____ ____________________
Last First M Preferred Name

Gender: ☐ M ☐ F Status: ☐ Single ☐ Married ☐ Child ☐ Other

DOB: ____/____/____ SS/ID #: _______________________ (_______) _______-_________
Home Phone

Home Address: ____ (_______) _______-_________
Street Work Phone

____ (_______) _______-_________
City, State, Zip Mobile Phone

Employment Information

Acct. Guarantor: _____________________ _____________________ ____ DOB: ____/____/____
Last First M

Employer name: ____

Primary Dental Insurance

Name of insured: _____________________ _____________________ ____ DOB: ____/____/____
Last First M

Insured's address: ____
Street

____
City, State, Zip

Insured's employer: ____ (_______) _______-_________
Phone

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance plan name: ____ Group #: _______________________

Insured's address: ____ SS/ID #: _______________________
Street

____ Phone: (_______) _______-_________
City, State, Zip

Secondary Dental Insurance

Name of insured: _____________________ _____________________ ____ DOB: ____/____/____
Last First M

Insured's address: ____
Street

____
City, State, Zip

Insured's employer: ____ (_______) _______-_________
Phone

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance plan name: ____ Group #: _______________________

Insured's address: ____ SS/ID #: _______________________
Street

____ Phone: (_______) _______-_________
City, State, Zip

Method of Payment: ☐ Cash ☐ Check ☐ Charge
Would you like to learn more about applying for credit in our office? ☐ Yes ☐ No
We appreciate the confidence our patients have in our quality of dentistry. Whom may we thank for referring you to us? _________________________

Be advised that the responsibility for payment rests on the patient or person responsible for the account, regardless of insurance coverage. For your convenience, we gladly file dental insurance forms on your behalf. If, for any reason, your insurance company does not pay within 60 days, you are required to make full payment and have your insurance company reimburse you. You will be kept informed as to what treatment is needed and what it will cost. All fees are due at the time of treatment unless other arrangements have been approved in advance. Overdue payments will bear a late charge of 1.5% per month (18% per year) from the date the fees are charged until they are paid. Returned checks incur a $25 fee. If, for any reason, your account is turned over to a collection agency, then the agency's fees and any attorney fees will be applied to your account. In the best interest of your dental work, we ask that you keep all reserved appointments. If this is not possible, please give us at least 24 hours' notice so another patient may be scheduled. If insufficient notice is given, we reserve the right to charge a cancellation fee.

I understand the above information. I have provided information to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency for any pertinent information. I will notify Douglas Dental Care dentists and staff of any changes in payment information. I agree to the terms above.

Signature: ____**Date:** __________________

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Patient name: ______________________ ______________________ ____ ___________________
Last First M Preferred Name

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice is available. Please ask one of our staff members for a copy. A copy is also available online at www.douglasdentalcare.com. We encourage you to read it carefully and completely before this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Douglas Dental Care
Joel R. TIdwell, DDS
Dimitri Arfanakis, DMD
3668 Highway 5, Douglasville, GA 30135
770-949-1821

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to Dr. Joel R. Tidwell, DDS, PC. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Signature

I, ______________________________, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations

Signature: ____ Date: ______________

If this Consent is Signed by a personal Representative on behalf of the patient, complete the following:

Personal Representative's Name: ____ Date: ______________

Relationship: ____

I understand the above information. I have provided information to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency for any pertinent information. I will notify Douglas Dental Care dentists and staff of any changes in payment information. I agree to the terms above.

Signature: ____**Date:** __________________