Mall of Georgia
Sleep Therapy

Brian D. Vancil DMD
678.714.6343
3276 Buford Drive, Suite 101
Buford, GA 30519

HEADACHES ○ FACIAL PAIN ○ NECK PAIN ○ TMJ DISORDERS ○ SLEEP APNEA

○ Mr. ○ Mrs. ○ Ms. ○ Dr. ○ Other

First Name _____ Middle Initial _____ Last Name _____

Responsible Party: (If Someone Other than Patient) Name _____

Who is primary on Insurance: ○ Self ○ Spouse ○ Father ○ Mother Name_____

Date of Birth _____

Patient Information

Street Address: _____

City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Sex: ○ Male ○ Female Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Date of Birth:_____Age:____ Social Security Number:_____

Spouse Name:_____ Date of Birth:_____

E-Mail Address:_____@_____

○ Employed Student Status: ○ Full Time ○ Part Time

OFFICE USE ONLY:
I verify that I obtained a copy of the patient's photo ID and insurance card & made a copy of each for our records. Initial _____, Date_____

MEDICAL HISTORY QUESTIONNAIRE

ALLERGENS

- ◯ No known allergens
- ◯ Iodine
- ◯ Plastic
- ◯ Antibiotics
- ◯ Latex
- ◯ Sedatives
- ◯ Aspirin
- ◯ Local Anesthetics
- ◯ Sleeping Pills
- ◯ Barbiturates
- ◯ Metals
- ◯ Sulfa Drugs
- ◯ Codeine
- ◯ Penicillin

Other: _____

CURRENT MEDICATIONS

Medicine	Dosage/Frequency	Reason

MEDICAL HISTORY (CONT'D)

Medical Condition	Never	Current	Past	Date/Note
Acid Reflux	☐	☐	☐	_____
Anxiety	☐	☐	☐	_____
Anemia	☐	☐	☐	_____
Arthritis	☐	☐	☐	_____
Atherosclerosis	☐	☐	☐	_____
Asthma	☐	☐	☐	_____
Autoimmune Disorder	☐	☐	☐	_____
Bleeding Easily	☐	☐	☐	_____
Blood Pressure - High	☐	☐	☐	_____
Blood Pressure - Low	☐	☐	☐	_____
Bruising Easily	☐	☐	☐	_____
Cancer	☐	☐	☐	_____
Chemotherapy	☐	☐	☐	_____
Chronic Fatigue	☐	☐	☐	_____
Chronic Pain	☐	☐	☐	_____
COPD	☐	☐	☐	_____
Coronary Heart Disease	☐	☐	☐	_____
Current Pregnancy	☐	☐	☐	_____
Depression	☐	☐	☐	_____
Diabetes	☐	☐	☐	_____

Medical Condition	Never	Current	Past	Date/Note
Difficulty Sleeping	☐	☐	☐	_____
Dizziness	☐	☐	☐	_____
Emphysema	☐	☐	☐	_____
Epilepsy	☐	☐	☐	_____
Fibromyalgia	☐	☐	☐	_____
Glaucoma	☐	☐	☐	_____
Gout	☐	☐	☐	_____
Heart Attack	☐	☐	☐	_____
Heart Murmur	☐	☐	☐	_____
Heart Pacemaker	☐	☐	☐	_____
Heart Valve Replacement	☐	☐	☐	_____
Hemophilia	☐	☐	☐	_____
Hepatitis	☐	☐	☐	_____
Hypoglycemia	☐	☐	☐	_____
Immune System Disorder	☐	☐	☐	_____
Insomnia	☐	☐	☐	_____
Ischemic Heart Disease (reduced blood supply)	☐	☐	☐	_____
Kidney Problems	☐	☐	☐	_____
Liver Disease	☐	☐	☐	_____
Meniere's Disease	☐	☐	☐	_____
Mitral Valve Prolapsed	☐	☐	☐	_____
Mood Disorder	☐	☐	☐	_____

Medical Condition	Never	Current	Past	Date/Note
Multiple Sclerosis	☐	☐	☐	_____
Muscular Dystrophy	☐	☐	☐	_____
Nasal Allergies	☐	☐	☐	_____
Neuralgia	☐	☐	☐	_____
Osteoarthritis	☐	☐	☐	_____
Osteoporosis	☐	☐	☐	_____
Parkinson's Disease	☐	☐	☐	_____
Prior Orthodontic Treatment	☐	☐	☐	_____
Psychiatric Care	☐	☐	☐	_____
Radiation Treatment	☐	☐	☐	_____
Rheumatic Fever	☐	☐	☐	_____
Rheumatoid Arthritis	☐	☐	☐	_____
Sinus Problems	☐	☐	☐	_____
Sleep Apnea	☐	☐	☐	_____
Stroke	☐	☐	☐	_____
Tendency for Ear Infections	☐	☐	☐	_____
Thyroid Disorder	☐	☐	☐	_____
Tuberculosis	☐	☐	☐	_____
Tumors	☐	☐	☐	_____
Urinary Disorder	☐	☐	☐	_____
Wisdom Teeth Extraction	☐	☐	☐	_____
_____		☐	☐	_____

Surgical Operations

☐ Adenoids ☐ Heart ☐ Neck ☐ Appendectomy ☐ Hernia Repair

☐ Periodontal ☐ Back ☐ Jaw Joint ☐ Thyroid ☐ Ear ☐ Lung

☐ Tonsillectomy ☐ Gallbladder ☐ Nasal ☐ Uvulectomy (UPPP)

Other _____

Family History

Has any of your family (parent, sibling, or grandparent) had:

☐ Cancer ☐ Stroke ☐ Father Snores ☐ Heart Disease ☐ Sleep Disorder

☐ Mother Snores ☐ Diabetes ☐ Obesity ☐ Father has Sleep Apnea ☐ High Blood Pressure

☐ Thyroid Disorder ☐ Mother has Sleep Apnea

Other _____

Social History

Patient's Occupation:_____ Employer:_____

Tobacco Use: Cigarettes: ☐ Never Smoked ☐ Current Smoker ☐ Quit

# of pack per day _____ When did you quit?_____

# of years _____ _____

Other Tobacco: ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew

Alcohol Use: Do you drink alcohol? ☐ Yes ☐ No If yes, # of drinks per week:_____

Caffeine Intake: ☐ None ☐ Coffee/Tea/Soda # of cups per week _____

Regular Exercise: ☐ Yes ☐ No

WHAT ARE THE CHIEF COMPLAINTS FOR WHICH YOU ARE SEEKING TREATMENT?

Please <u>number</u> the complaints with #1 being the most important.

_____ Frequent heavy snoring

_____ which affects the sleep of others

_____ Significant daytime drowsiness

_____ I have been told that "I stop breathing" when sleeping

_____ Difficulty falling asleep

_____ Gasping when waking up

_____ Nighttime choking spells

_____ Feeling unrefreshed in the morning

_____ Morning hoarseness

_____ Morning headaches

_____ Swelling in ankles or feet

_____ Nocturnal teeth grinding

_____ Jaw pain

_____ Facial pain

_____ Jaw clicking

Other:_____

_____

INSURANCE POLICY

The Mall of Georgia Dentistry staff is always available to help you with insurance claims and paperwork. We will work with your insurance provider and make sure you understand your insurance benefits.

FINANCIAL POLICY

Fees are paid as services are rendered. We accept VISA, MASTERCARD, AMERICAN EXPRESS and/or CASH.

Payment plans for the estimated treatment may be made with our office. Several payment options, (with and without interest) are offered.

I will pay for the services rendered on the date of service. I acknowledge that I have read this form and that I fully understand its contents that I have been given ample opportunity to ask questions and that all questions have been answered satisfactorily.

THIS IS NOT A CONTRACT NOR AN AGREEMENT TO SEEK TREATMENT

Signature of patient:_____ Date:____/____/____
(Parent or guardian)

MALL OF GEORGIA DENTISTRY SLEEP THERAPY

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 protected health information. We are also required to give you the Notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 10/16/2015, 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 provide the new Notice at our practice location, and we will distribute it 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.

Your Authorization: In addition to our use of your health information for the following purposes, you may give us written authorization to use your health information or to disclose it to anyone for any purposes. 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.

Uses and Disclosures of Health Information

We use and disclose health information about you without authorization for the following purposes.

Treatment: We may use or disclose your health information for your treatment. For example, we may disclose your health information to a physician or other healthcare provider providing treatment for you.

Payment: We may use and disclose your health information to obtain payment for services we provided to you. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. For example, 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.

To You Or Your Personal Representative: 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 your personal representative, 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 absence or incapacity or in 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, xrays, or other similar forms of health information.

Disaster Relief: We may use or disclose your health information to assist in disaster relief efforts.

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.

Public Health and Public Benefit: We may use or disclose your health information to report abuse, neglect, or domestic violence; to report disease, injury, and vital statistics; to report certain information to the Food and Drug Administration (FDA); to alert someone who may be at risk of contracting or spreading a disease; for health oversight activities; for certain judicial and administrative proceedings; for certain law enforcement purposes; to avert a serious threat to health or safety; and to comply with worker's compensation or similar programs.

Decedents: We may disclose health information about a decedent as authorized or required by law.

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 the protected health information of an 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. You may also request access by sending us a letter to the address at the end of this Notice. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying. If you request copies, we will charge $.25 for each page, $30 per hour for staff time to 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 your health information 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, health care 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. In most cases we are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in certain circumstances where disclosure is required or permitted, such as an emergency, for public health activities, or when disclosure is required by law). We must comply with a request to restrict the disclosures of protected health information to a health plan for purposes of carrying out payment or health care operations (as defined by HIPPA) if the protected health information pertains solely to a healthcare item or service for which we have been paid out of pocket in full.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation of 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: You may receive a paper copy of this notice upon request, even if you have agreed to receive this notice electronically on our web site or by electronic mail (e-mail).

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 way 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 alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written 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 Office Manager: Allison Vancil
Email: office@mallofgeorgiadentistry.com
Telephone:678.714.6343 Fax: 678.714.6345
Address: 3276 Buford Dr Ste 101, Buford, GA 30519

Acknowledgement of Receipt of Notice of Privacy Practices

MALL OF GEORGIA SLEEP THERAPY
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

I,_____, have received a copy of office's Notice of Privacy Practices.

Print Name _____

Signature _____ Date _____

AUTHORIZATION FORM FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize the use and disclosure of individually identifiable medical/health information relating to me as described below. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPPA Privacy Regulations.

Specific Description of Information to Be Used or Disclosed: Medical and Dental health history, Clinical & Image Study Findings, Treatment Plans, Progress Report and Completion of treatment.

Purpose for Disclosure: To keep your health care provider informed of your treatment.

I authorize the following person(s) to make the requested use or disclosure of the above health information: Doctor and Staff at Mall of Georgia Sleep Therapy.

Person(s) Receiving My Authorized Information Include (Fill in names):

Medical Doctor:_____ Dentist _____

Referring Doctor: _____ Insurance Company:_____

Other:_____

I understand that I may revoke this authorization at any time by notifying Mall of Georgia Sleep Therapy in writing. If I choose to do so, my revocation will not affect any actions taken by Mall of Georgia Sleep Therapy before receiving my revocation.

I understand that I may refuse to sign this authorization; and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

This Authorization Expires on ☐ Continue Indefinitely ☐ Effective Only Until _____(date)

Signature of Patient or Patient's Personal Representative

_____ Date _____

If Personal Representative: Print Name _____

Signature _____ Relationship to Patient _____