BYRD DENTAL GROUP
Healthy. Beautiful. Affordable.

Welcome to Our Office!

We would like to take the time to "Thank You" for allowing us to take great care of you and provide you with excellent dental care.

Please take a moment to tell us how you heard about our office:

- **Points North**
- **AroundAbout TowneLaker**
- **Chapel Hill News & Views**
- **Insurance Company**
- **Website**
- **Google/Internet**
- **Social Media (Facebook/ Twitter)**
- **Current Patient**
- **Location**
- **Other_____**

"Family & Friends Program"

If you are happy with your treatment and experience with our Doctors and team, please join our

"**Family & Friends Program**"

Refer your family and friends to us! When they come in for their first visit, we will give YOU, YOUR FAMILY member and FRIEND a $50.00 credit on each of your accounts.

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Appointment Agreement

We are honored to have the opportunity to provide dental care to you. We appreciate the trust you have placed in us. We strive to give each patient the individual attention they deserve. In a sincere effort to acknowledge the importance of each patient's time, and to remain on time ourselves, we ask that you ensure that you arrive on time for your appointment. This will allow us to see all scheduled patients in a timely and efficient manner. When a patient is late or fails to keep their scheduled appointment, it affects all of the patients that are scheduled that day.

If you are late, and we are able to see you, we cannot guarantee that all treatment will be completed. If a patient misses their appointment, they will be rescheduled once. If a second appointment is missed, the patient may be dismissed from our practice.

- **Scheduling:** In order to facilitate access to the very best health care possible, **$50 or 10% of the total investment is due to reserve your appointment.** You may choose from any of the following (including any combination thereof): Cash, Visa, MasterCard, Discover, American Express, Checks, Citi-Financial or Care Credit Financing.

- *If necessary, patients may change their appointment BEFORE 9:30 AM up to two business days before the appointment*.

- **Appointment Guidelines**: Since we reserve appointments in our office exclusively for you, it is imperative that we are allowed the appropriate amount of time for any changes to those reserved appointments. We require a two business day notice for changes to treatment appointments. Should you not be able to keep an appointment, as per these guidelines, your reservation fee would be non-refundable.

- It is your responsibility to personally confirm your appointment. We will make every effort to reach you to confirm.

- All appointments must be CONFIRMED by 9:30 AM, two business days BEFORE the appointment date.

- *All **unconfirmed appointments** will be moved off of our schedule at 9:30 AM, two business days before to allow another patient to be seen by our office.*

- Appointments missed without providing notice, by 9:30 AM, two business days before, will be subject to a broken appointment fee of $50.00.

- We ask that you acknowledge our appointment policy by signing below.

_____ _____

Signature Date

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GENERAL DENTISTRY
INFORMED CONSENT

NAME _____

PLEASE SELECT OPTION IN #1. READ & INITIAL #2& #3. **Separate consent forms will be provided if additional treatment is necessary.**

1. WORK TO BE DONE
I understand that I am having the following work done. Exam, X-rays & cleaning _____, Fillings _____, Bridges _____, Crowns _____, Extractions _____, Root Canals _____, Impacted teeth removed _____, IV Sedation _____, Other _____

2. DRUGS AND MEDICATION
I understand that antibiotics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching,
vomiting and/or anaphylactic shock (severe allergic reaction).
(Initials _____)

3. CHANGES IN TREATMENT PLAN
I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were discovered during examination; the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make all/any changes and additions as necessary. (Initials _____)

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4. REMOVAL OF TEETH
Alternatives to removal have been explained to me (root canal therapy, crowns and periodontal surgery, etc.) and I authorize the Dentist to removed the following teeth _____ and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (Paresthesia) that can last for an indefinite period of time (days or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility. (Initials _____)

5. CROWNS, BRIDGES AND CAPS
I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to insure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge or cap (including shape, fit, size or color) will be before cementation. (Initials _____)

6. DENTURES – COMPLETE OR PARTIAL
I realized that full or partial dentures are artificial - constructed of plastic, metal and/or porcelain. The problems of wearing these appliances have been explained to me include looseness, soreness and possible breakage. I realize the final opportunity to make changes in my new denture (including shape, fit, size, placement and color) will be the "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after the initial placement. The cost for this procedure is not included in the initial denture fee. (Initials _____)

7. ENDODONTIC TREATMENT (ROOT CANAL)
I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extended through the root which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical treatment procedures may be necessary following root canal therapy. (Initials _____)

8. PERIODONTAL LOSS (TISSUE & BONE)
I understand that I have a serious condition, causing gum and bone inflammation or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition. (Initials _____)

Signature _____ Date _____

Doctor ____ Witness ___________________________

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To Our patients:

Thank you for choosing Byrd Dental Group as your provider for good oral health. Our mission is to deliver the highest quality of dental care in a warm, friendly environment. To accomplish this, we schedule each patient according to his or her personal dental needs. In order for our staff to provide each patient with the highest level of care needed, please observe the following office policies:

- A 48-business hour notice is required for cancelling appointments. Failure to give a 48-hour notice may result in a broken appointment fee of $50.00.

- If you are more than 15 minutes late for an appointment, we may have to reschedule your appointment in order to provide the appropriate time for your needs.

- Payment for your treatment is due at the time of service.

- Patients with PPO, Traditional and/or Indemnity Insurance: Please be advised that we will file a claim for services to your insurance company as a courtesy. To avoid any misunderstanding, it is the patient's responsibility to know the benefits, frequencies, maximums, deductibles or discounted fees associated with your insurance plan. In the event that your insurance company has not paid within sixty days after the claim has been filed, any unpaid charges will become the responsibility of the patient. It will then become the responsibility of the patient to follow up with the insurance company to procure payment after 60 days. Any dispute of payment is between the patient and the insurance carrier.

- Returned checks will incur a processing fee of $45.00

- We will honor all fees listed on your treatment plan for a period of 30 days from the date it is presented to you. After 30 days, treatment will be subject to current fees.

- Your signature below indicates your understanding and acceptance of the above policies, as well as your financial responsibility for any unpaid balances.

_____
(Patient / Guardian if under 18)

_____
Date

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HIPPA Notice of Privacy Practices

This Notice describes how your personal, dental and medical information may be used, disclosed and how you can get access to this information. Please review it carefully.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatments, payment for services and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information (PHI). PHI is information about you, including demographic information, that may identify you and that relates to your past, present or future oral and physical condition and related health care services.

USES AND DISCLOSURES of PROTECTED HEALTH INFORMATION

Your PHI may be used and disclosed by your dentist, the office & clinical staff and others outside our offices that are involved in your care and treatment for the purpose of providing dental services to you, to pay your dental care bills, to support the operation of the dentist's practice and any other use required by law.

TREATMENT: We will use and disclose your PHI to provide, coordinate or manage your dental care and any related service. This includes the coordination or management of your dental care to a third party. For example we would disclose your PHI, as necessary, third party payer, a dental lab, or specialty office that you have been referred to, that provides services to you. Only information that will be disclosed is that which is required to diagnose or treat you.

PAYMENT: Your PHI will be used, as needed to obtain payment for your dental services. Your PHI will be shared with your insurance carrier or any outside service necessary to collect payment for your dental services.

HEALTH CARE OPERATIONS: We may use or disclose, as needed, your PHI in order to support the business activities of your dentist practice. These activities include, but are not limited to, quality assessment activities, employee review activities, staff training, licensing and conducting or arranging for other business activities. We may use a sign in sheet at registration where you may be asked to sign your name and indicate your doctor; we may also call your name out in the reception room when your doctor or hygienist is ready to see you. We may also use your PHI, as necessary, to contact you to remind you of your upcoming appointment(s).

We may disclose your PHI in the following situations without your authorization. The situations include: as required by law, Public Health Issues; Communicable Diseases: Health Oversight; Abuse or Neglect; Food and Drug Administration Requirements: Legal Proceedings; Law Enforcements; Military Activity and National Security; Workers' Compensation; Under the law, we must disclose to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164-500.

Patient's authorization to release information to: I _____ authorize the release of my PHI to the following:

_____

_____

_____

I understand that unless listed above NO PHI can or will be released, under any circumstance unless listed above as an exception. Before any information may be release to a spouse, sibling, or friend they must be listed above or the patient listed above must notify the office IN WRITING of authorization to release your PHI.

I have read and understand the above statements.

_____ _____

Patient/or Guardian Date

BYRD
DENTAL GROUP

Towne Lake: 2035 Towne Lake Pkwy • Suite 130 • Woodstock, GA 30189 • 770-926-8200
Chapel Hill: 6740 Douglas Blvd. • Suite A • Douglasville, GA 30135 • 770-949-5600
North Point: 4000 North Point Pkwy • Suite 500 • Alpharetta, GA 30022 • 770-777-0911

PLEASE PRINT AND FILL OUT COMPLETELY.

PATIENT'S NAME_____ ADDRESS_____ APT#_____

CITY_____ STATE____ ZIP_____ PHONE-H_____ C_____ W_____ DOB_____

PATIENT'S SSN ____-____-____ SEX___ MARITAL STATUS____ EMPLOYER_____ OCCUPATION_____

Email_____

SUBSCRIBER'S NAME_____ ADDRESS_____ APT#_____

CITY_____ STATE____ ZIP_____ PHONE-H_____ C_____ W_____ DOB_____

SUBSCRIBER'S SSN ____-____-____ SEX___ MARITAL STATUS____ EMPLOYER_____ OCCUPATION_____

INS. CO_____PLAN NAME_____INS. PH_____RELATION TO PATIENT_____

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:

Please circle:	**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 present 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?		

PATIENT SIGNATURE DATE

DOCTOR SIGNATURE DATE

DENTAL HISTORY

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. Do you chew on only one side of your mouth? Is so, why?		
16. Do you habitually clench or grind your teeth during the night or day?		
17. Is any part of your mouth sensitive to pressures or irritants (hot, cold or sweets)?		
18. Are you interested in straightening your teeth? (If yes, ask us about **INVISALIGN**)		

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

_____

_____

_____ _____

PATIENT SIGNATURE DATE DOCTOR SIGNATURE DATE