PERIODONTICS & DENTAL IMPLANTS
ROBERT A. BRIDGES DMD, MS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

YOU MAY REFUSE TO SIGN THIS ACKOWLEDGMENT

I have been provided with a copy of this office's Notice of Privacy Practices.

_____

Print

_____

Sign

_____

Date

OFFICE USE ONLY:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- **Individual refused to sign**
- **Communication barriers prohibited obtaining the acknowledgment**
- **An emergency situation prevented us from obtaining acknowledgment**
- **Other:**

_____

Dr. Robert A. Bridges, DMD

330 Margie Dr., Warner Robins, GA 31088 • (478) 971-4242

Robert A. Bridges, DMD, MS
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 this 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 3/15/2013, 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 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.

Security: You will be notified as soon as possible if the security of your personal health information is breached.

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, pharmacist, 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. 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, x-rays, 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. We will not use your information for fundraising purposes without authorization. We will disclose any financial conflicts of interests that may be involved with your treatment.

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 workers' 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).

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 you $0.25 for each page 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 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. 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 disclosure of protected health information to a health plan for purposes of carrying out payment or health care operations (as defined by HIPAA) if the protected health information pertains solely to a health care 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.

Non-disclosure to insurance company: If you pay out of pocket, in full, for a service or a procedure or service; we will not submit the claim for that service to your insurance company upon your request.

Electronic Notice: You may receive a paper copy of this notice upon request.

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: Robert A. Bridges, DMD, MS **Telephone**: (478) 971-4242 **E-mail**: bridgesperio@yahoo.com

PERIODONTICS & DENTAL IMPLANTS
ROBERT A. BRIDGES DMD, MS

REFERRING DOCTOR: _____

PATIENT INFORMATION

NAME: LAST_____ FIRST_____ *PREFERRED*_____

DOB_____ SOCIAL SECURITY #_____

ADDRESS: STREET _____

CITY, STATE _____ ZIP_____

PHONE: HOME _____CELL_____

WORK _____EXT_____ OTHER_____

EMAIL_____

☐ MALE
☐ FEMALE
☐ SINGLE
☐ MARRIED
☐ CHILD

HEALTH HISTORY QUESTIONNAIRE

In order to evaluate your dental health thoroughly and completely, please complete the following examination questionnaire. This information will become part of your office record and will be held in strict confidence.

1. Are you experiencing any pain in your mouth at this time? If so explain: _____
2. Have you had previous periodontal treatment? (Yes / No) When? _____
3. Do your gums bleed? (Yes / No)
4. Have you noticed any loose teeth? (Yes / No) Shifting teeth? (Yes / No)
5. Have you noticed any bad odor or taste in your mouth? (Yes / No)
6. Are your teeth sensitive to hot, cold or sweets? (Yes / No)
7. How often do you brush your teeth? _____ Floss? _____
8. Have you had your teeth straightened? (Yes / No) When? _____
9. Are you aware of grinding your teeth in your sleep? (Yes / No)
10. Do you have headaches regularly? (Yes / No) Any particular time of the day? _____
11. Do you have a family history of diabetes? (Yes / No)
12. Have you ever been exposed to or tested positive to HIV (AIDS) Virus? (Yes / No)
13. Have you recently noticed any swollen glands in the neck? (Yes / No)
14. If you have had major surgery, please list when and what kind:
    _____
15. Were there any complications during the aforementioned procedures?
    _____
16. Please describe any current medical treatment, impending operation, or any other medical or dental information that may possibly affect you periodontal care: _____
17. Whom may we contact in case of an emergency?
    Name: _____ #: _____
18. Who is your medical physician?
    Name: _____ #: _____

19. **ARE YOU TAKING ANY MEDICATIONS, DRUGS OR PILLS REGULARLY?** (*please list them here, OR provide a list*):

_____

20. **Have you ever had, or do you now have any of the following?**

_____Anemia	_____ Sinus Trouble	_____ Liver Trouble
_____ Gland Trouble	_____ High Blood Pressure	_____ Radiation Therapy
_____ Hepatitis	_____ Low Blood Pressure	_____ Clotting
_____Bleeding Problems	_____ Malignancy	_____ Glaucoma
_____ Diabetes	_____ Thyroid Disease	_____ Rheumatism
_____ Epilepsy	_____ Arthritis	_____Drug or Alcohol dependency
_____ Heart Disease	_____ Blood Disease	_____ Cancer
_____ Kidney Disease	_____ Digestive Disease	_____ Asthma
_____ Veneral Disease	_____Heart Murmur	_____ Excessive Thirst
_____Tuberculosis	_____MVP	_____ Stroke
_____ Lung Trouble		

21. **Check the drug(s) you have reacted adversely to:**

_____ Darvon	_____ Antihistamines	_____ Aspirin	_____Codeine
_____ Latex	_____ Darvocet	_____ Demerol	_____Erythromycin
_____ Tetracycline	_____ Local Anesthetic	_____Barbiturate	Other:
_____ Iodine	_____ Sulfa	_____Penicillin	_____

22. **Are you taking any of the following?**

☐ DAILY ASPIRIN ☐ COUMADIN ☐ PLAVIX ☐ OTHER BLOOD THINNERS, list: _____

23. Are you being treated by a physician at this time? _____ Why? _____
24. Do you have **any stents or artificial joint replacements**? (Yes / No) Specify: _____
25. Do you **pre-medicate** prior to dental treatment? (Yes / No)
26. Do you smoke? (Yes / No) How often? _____

I have read and answered the above questions to the best of my knowledge. I authorize and request my insurance company to pay directly to the dentist. I authorize the doctor to release all information necessary to secure the payment benefits. I understand that I am financially responsible whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

_____ _____

Signature Date

INSURANCE

Primary Insurance Information

Insurance Company_____

Insurance Company Address _____

Group #_____ Insurance Company Phone #_____

Subscriber Name _____

Subscriber Birthday_____ SSN:_____

Secondary Insurance Information

Insurance Company_____

Insurance Company Address _____

Group #_____ Insurance Company Phone #_____

Subscriber Name _____

Subscriber Birthday_____ SSN:_____

We are NOT PROVIDERS for any insurance company. However; as a courtesy to you, we will file your claim. Please note that some insurance companies WILL NOT send payment to us since we are **OUT OF NETWORK PROVIDERS.** If this is the case with your insurance company we ask that you **PAY THE FULL FEE** at the time of your service. You will receive payment directly from your insurance company.

I have read and understand the filing insurance policy for the office of Dr. Robert Bridges, DMD.

Signature Date

RADIOGRAPH POLICY

Although we may receive radiographs from your referring dentist, Dr. Bridges takes his own digital x-rays so that we may have a copy in your electronic file. As a courtesy to you, we do not charge an additional fee since you have been charged at your general dentist's office.

However, if you request that our copies be forwarded to another office, you will be charged for them. After payment is received, x-rays will be sent to the requested doctor.

By signing below, you have read and understand our office radiograph policy.

_____

Signature **Date**