Upstate Periodontics

And Implant Dentistry

Welcome to our office. We hope that you will find our staff friendly, caring, and courteous as we assist you with your dental needs. Please feel free to ask any questions, at any time, concerning your treatment, our office policies, or any other needs that you may have.

We ask that you pay for services as they are rendered, and we accept cash, checks, Visa and MasterCard. If you desire, we can also assist you in obtaining financing through an independent, third-party lender that works with our office. We are happy to discuss this with you.

We realize that insurance can be daunting, and it is our pleasure to assist you with your specific company and their reimbursement to you. Please see our treatment coordinators for further information concerning your insurance and pre-estimate services.

If you have any questions at any time, please feel free to approach any member of our staff. We want the time you spend with us to be effective and as comfortable as possible.

We look forward to meeting you and assisting you with your periodontal needs.

Sincerely,

Dr. David C. Garrison

Dr. David C. Garrison, and Staff

By signing below, I acknowledge that I have read and understand the information written above.

Sign_____ Date_____

Upstate Periodontics, PA

DAVID C. GARRISON, D.M.D.

Periodontics and Implant Dentistry

Today's Date: _____

First Name: _____ Last Name: _____ Middle Initial: _____ Nickname: _____

Address: Street: _____ City/State: _____ Zip: _____

Home Telephone: _____ Work Phone: _____

Cell Telephone: _____ Email: _____

Sex: Male: _____ Female: _____ Marital Status: O Single O Married O Widowed

Birth Date: _____ SS#: _____

Dental Insurance: _____ Secondary Dental Insurance: _____

Dentist: _____ Telephone: _____

Medical Doctor: _____ Telephone: _____

In case of emergency contact: _____ Telephone: _____ Relationship to me: _____

Who may we thank for this referral?: _____

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? O Yes Please explain: _____

Have you ever been hospitalized or had a major operation? O Yes Please explain: _____

Have you ever had a serious head or neck injury? O Yes Please explain: _____

Do you now or have you ever taken bone density drugs? O Yes Please explain: _____

Are you taking any medications, pills, or drugs? O Yes Please list: _____

Do you use tobacco? O Yes _____

Do you use a controlled substance? _____

Women Are You

Pregnant/Trying to get pregnant? OYes O No Taking oral contraceptives? OYes ONo Nursing? OYes O No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive O Yes	Cortisone Medicine O Yes	Hemophilia O Yes	Renal Dialysis O Yes
Alzheimer's Disease O Yes	Diabetes O Yes	Hepatitis A O Yes	Rheumatic Fever O Yes
Anaphylaxis O Yes	Drug Addiction O Yes	Hepatitis B or C O Yes	Rheumatism O Yes
Anemia O Yes	Easily Winded O Yes	Herpes O Yes	Scarlet Fever O Yes
Angina O Yes	Emphysema O Yes	High Blood Pressure O Yes	Shingles O Yes
Arthritis/Gout O Yes	Epilepsy or Seizures O Yes	Hives or Rash O Yes	Sickle Cell Disease O Yes
Artificial Heart Valve O Yes	Excessive Bleeding O Yes	Hypoglycemia O Yes	Sinus Trouble O Yes
Artificial Joint O Yes	Excessive Thirst O Yes	Irregular Heartbeat O Yes	Spina Bifida O Yes
Asthma O Yes	Fainting Spells/Dizziness O Yes	Kidney Problems O Yes	Stomach/Intestinal Disease O Yes
Blood Disease O Yes	Frequent Cough O Yes	Leukemia O Yes	Stroke O Yes
Blood Transfusion O Yes	Frequent Diarrhea O Yes	Liver Disease O Yes	Swelling of Limbs O Yes
Breathing Problem O Yes	Frequent Headaches O Yes	Low Blood Pressure O Yes	Thyroid Disease O Yes
Bruise Easily O Yes	Genital Herpes O Yes	Lung Disease O Yes	Tonsillitis O Yes
Cancer O Yes	Glaucoma O Yes	Mitral Valve Prolapse O Yes	Tuberculosis O Yes
Chemotherapy O Yes	Hay Fever O Yes	Pain in Jaw Joints O Yes	Tumors or Growths O Yes
Chest Pains O Yes	Heart Attack/Failure O Yes	Parathyroid Disease O Yes	Ulcers O Yes
Cold Sores/Fever Blisters O Yes	Heart Murmur O Yes	Psychiatric Care O Yes	Venereal Disease O Yes
Congential Heart Disorder O Yes	Heart Pace Maker O Yes	Radiation Treatments O Yes	Yellow Jaundice O Yes
Convulsions O Yes	Heart Trouble/Disease O Yes	Recent Weight Loss O Yes	

Have you ever had any serious illness not listed above? O Yes O No Please explain: _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN _____ DATE _____

Upstate Periodontics, PA

PRIVACY PRACTICES

This notice describes how health information about you may be used or disclosed by our office, and how you can get access to this information. Please review carefully. The privacy of your health information is important to us.

We are required, by 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 February 14, 2014.

This office has a formal business agreement with Google, Inc. and Curve Dental. Your health information will be stored securely by these entities, under provisions of the HIPAA. We feel that utilizing this storage increases the level of security and protection of your information in the event of natural disaster, theft, or technological failure.

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 one of our treatment coordinators at 864-654-3416, or email us at upstate.periodontics@gmail.com

REASONS FOR USE OR DISCLOSURE OF PATIENT INFORMATION

Treatment: We may use or disclose your health information to another dentist or healthcare provider providing treatment to you, or if we refer you to another health care provider.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. We may need to share part of your health information with our billing department, your insurance company, and others who are responsible for your bills, such as your spouse, as necessary for us to collect payment. For example, we may give information about a dental procedure that you have scheduled as part of our pre-estimate services.

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, and licensing or credentialing activities.

To Your Family, Friends, and Other Persons Involved in Your Care: We may share with a family member, friend or other person identified by you, your health information that is directly related to that person's involvement in your care, or to notify such individuals of your location or general condition, but only if you agree that we may do so, or, based on our professional judgment, we determine that you would not object to the disclosure.

As Required by Law: We may use and disclose relevant health information when required by federal or state law, or in response to a subpoena. You will be notified, as required by law, of any such uses or disclosures.

Contacting You: We may use and disclose your health information to contact you about appointments and other matters pertaining to your treatment. We may contact you by telephone, email, or mail.

Your Authorization: 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 uses or disclosures already made with your authorization while it was in effect.

Upstate Periodontics, PA

PATIENT RIGHTS

Right to See and Copy Your Health Information: You have the right to see or get copies of your health information, with limited exceptions. If we deny your request due to one of these exceptions, we will respond to you in writing with the reason we cannot grant your request, and describe any rights you may have to request a review of our denial. You must make a written request us to access your health information. Your written request must be signed and dated. We may charge you a fee for expenses such as copies, staff time, and postage. Instead of providing you with a copy of your health information, we may prepare a summary or an explanation of your health information for a fee, if you agree in advance to the form and fee of the summary or explanation.

Right to Request Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information, including uses or disclosures for treatment, payment, and health care operations, and to family members, friends, or others involved in your care or payment for your care. Such requests much be made in writing at our address, provided below. We are not required to agree to these additional restrictions, but if we do we will abide by our agreement, except under emergency circumstances.

Right to Request Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. For example, you can ask that we only contact you at work, or only by mail. All such requests should be made in writing at the address provided below.

Right to Request Amendment: You have the right to request that we amend your health information. You must submit a written request that is signed and dated. Your request must explain why your health information should be amended. If we deny your request, we will respond to you in writing with the reason we cannot grant your request and explain your options.

Right to Written Notice: If you receive this notice on our website or by email, 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 at 864-654-3416 and ask to speak with a Treatment Coordinator, or email us at upstate.periodontics@gmail.com.

Any requests made in writing should be sent to the following address:

Upstate Periodontics, PA
David C. Garrison, DMD
PO Box 1804
Clemson, SC 29633

If you are concerned that we may have violated your privacy rights, you may contact our office, or you may submit a written complaint to the U.S. Department of Health and Human Services.

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.

Sign_____ Date_____

UPSTATE PERIODONTICS AND IMPLANT DENTISTRY

HIPAA Correspondence Form

In compliance with the Health Insurance Portability Accountability act, Upstate Periodontics is committed to protecting your personal health information. Normal treatment operations require periodic communication with the dentists and staff of your referring office, as well as occasionally speaking with your insurance company regarding your treatment.

On the lines below, please designate the names and phone numbers of additional individuals who are authorized to communicate with Upstate Periodontics regarding your treatment. You may wish to designate your spouse, a member of your family or other caretaker. A legal guardian may designate individuals on behalf of a minor child (less than 18 years of age). Unless indicated on the lines below, we will not communicate protected health information to any individual requesting such information.

Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number

Upstate Periodontics will also communicate with you by telephone or email during the course of your treatment. Please designate the phone numbers that we may use to contact you regarding your treatment. Please circle the appropriate option below:

Home Phone: Yes No May we leave a message? Yes No

Cell Phone: Yes No May we leave a message? Yes No

Work Phone: Yes No May we leave a message? Yes No

May we contact you via email? Yes No

Patient Name (Print)

Patient Signature

Date