WELCOME TO OUR OFFICE

Thank you for choosing our office to provide you with your dental health care. We want to welcome you into our dental family and look forward to many quality years together.

Dr. Duke was born and raised here in Americus, Georgia. He acquired this practice from Dr. William Kimble in 2000 after graduating from the Medical College of Georgia now named GRU or Georgia Regents University. Dr. Duke is married to the former April Burch and they have four children: Karson, Nathan, Lauren and Maison. Dr. Duke is very community minded. He is a member and Deacon of First Baptist Church of Americus, the American Dental Association, coaches recreational ball for Sumter County and serves the Sumter County YDC. As you can see, Dr. Duke is a family man as well as a community minded man who is committed to the health care of others.

To help make your first visit to our office an enjoyable one, we are enclosing a new patient packet. This will help get you back to see the doctor in a timely manner. You will also find an appointment card enclosed for your convenience. We know how valuable your time is and ask that you fill out the paperwork and arrive promptly for your visit. We strive to run our practice in a very timely manner and appreciate your cooperation in making this happen. Also enclosed is a copy of our office policies. This will help all of us work together and understand the guidelines that our office is built upon.

We encourage you to ask questions about your treatment to ensure your total understanding and involvement with our office in your dental health care. Dr. Duke wants your smile to be the greatest. In return, the best complement our patients can give us is to recommend us to their families and friends.

We look forward to seeing you soon.

Gina Whitney Debby Sarah Kristi Roy Jean

Ray M. Duke, Jr., D.M.D., PC

Medical History

Patient Name: Birth Date:

Address:

Phone: Home Cell Work

Can we confirm by texting cell, e-mail, or both? Yes No

Although dental personnel primarily treat the area in and around your mouth, your mouth is a 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?	Yes No	If yes
Have you ever been hospitalized or had a major operation?	Yes No	If yes
If you have had a joint replacement provide name and number of surgeon?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Are you taking any medications, pills, or drugs?	Yes No	If yes
Are you on a special diet?	Yes No	
Do you use tobacco?	Yes No	
Do you take an Antibiotic pre-med prior to dental treatment?	Yes No	

Do you use controlled substances? Yes No If yes

Women: Are you...

Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you ALLERGIC to any of the following?

Aspirin Penicillin Codeine Acrylic

Latex Sulfa Drugs Local Anesthetics

Other? If yes

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

AIDS/HIV Positive	Yes No	Cortisone Medicine	Yes No	Hemophilia	Yes No	Radiation Treatments	Yes No
Alzheimer's Disease	Yes No	Diabetes	Yes No	Anaphylaxis	Yes No	Drug Addiction	Yes No
Hepatitis A, B or C	Yes No	Anemia	Yes No	Herpes	Yes No	Rheumatic Fever	Yes No
Angina	Yes No	Emphysema	Yes No	High Blood Pressure	Yes No	Arthritis/Gout	Yes No
Epilepsy or Seizures	Yes No	High Cholesterol	Yes No	Scarlet Fever	Yes No	Artificial Heart Valve	Yes No
Excessive Bleeding	Yes No	Hives or Rash	Yes No	Shingles	Yes No	Artificial Hip/Knee	Yes No
Excessive Thirst	Yes No	Hypoglycemia	Yes No	Sickle Cell Disease	Yes No	Asthma	Yes No
Fainting Spells/Dizziness	Yes No	Sinus Trouble	Yes No	Blood Disease	Yes No	Frequent Cough	Yes No
Kidney Problems	Yes No	Blood Transfusion	Yes No	Leukemia	Yes No	Stomach/Intestinal Disease	Yes No
Breathing Problems	Yes No	Frequent Headaches	Yes No	Liver Disease	Yes No	Stroke	Yes No
Genital Herpes	Yes No	Low Blood Pressure	Yes No	Cancer	Yes No	Lung Disease	Yes No
Thyroid Disease	Yes No	Chemotherapy	Yes No	Hay Fever	Yes No	Tonsillitis	Yes No
Heart Attack/Failure	Yes No	Osteoporosis	Yes No	Tuberculosis	Yes No	Cold Sores/Fever Blisters	Yes No
Heart Murmur	Yes No	Pain in Jaw Joints	Yes No	Tumors or Growths	Yes No	Congenital Heart Disorder	Yes No
Heart Pacemaker	Yes No	Parathyroid Disease	Yes No	Ulcers	Yes No	Convulsions	Yes No
Psychiatric Care	Yes No						

Have you ever had any serious illness not listed Yes No If yes

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:

X Date:

RAY M. DUKE, JR, DMD, PC

626 East Forsyth Street, Americus, Georgia 31709

Patient Registration

Patient Information:

First Name:_____ Last Name:_____ Preferred Name:_____

Street Address:_____ City/State/Zip_____

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

Email Address:_____ May we text you? ( )YES ( )NO

Preferred Contact (please check): ( ) Home ( ) Work ( ) Cell ( ) Email

Sex (circle): Male Female Marital Status (circle) if adult: Single Married Divorced Widowed

Date of Birth:_____ Social Security Number:_____

Preferred Pharmacy:_____ ER Contact: Name:_____ Phone:_____

Phone:_____ Relationship to Patient:_____

Place of Employment:_____

Responsible Party: or SAME AS ABOVE (circle if same as above)

First Name:_____ Last Name:_____ Preferred Name:_____

Street Address:_____ City/State/Zip_____

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

Email Address:_____ May we text you? ( )YES ( )NO

Preferred Contact (please check): ( ) Home ( ) Work ( ) Cell ( ) Email

Sex (circle): Male Female Marital Status (circle)if adult: Single Married Divorced Widowed

Date of Birth:_____ Social Security Number:_____

Place of Employment:_____

Primary Insurance Information:

Name of Insured_____ Relationship to Insured: Self Spouse Child Other

Insured SSN:_____ Insured DOB:_____

Employer:_____ Insured Company:_____

Address:_____ Address:_____

City/State/Zip:_____ City/State/Zip:_____

Secondary Insurance Information:

Name of Insured_____ Relationship to Insured: Self Spouse Child Other

Insured SSN:_____ Insured DOB:_____

Employer:_____ Insured Company:_____

Address:_____ Address:_____

City/State/Zip:_____ City/State/Zip:_____

Whom may we thank for referring you or how did you hear about us?_____

RAY M. DUKE, JR, DMD PC

626 East Forsyth Street, Americus, Georgia 31709

ACKNOWLEDGEMENT OF RECEIPT OF

NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of this office's NOTICE OF PRIVACY PRACTICES.

_____

Please Print Name

_____

Signature

_____

Date

FOR OFFICE USE ONLY

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

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

_____

_____

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 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 _____, 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 make the new Notice available 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.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician 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.

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, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, 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.

To Your Family and Friends: 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 a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, 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 incapacity or 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.

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.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

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 of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as email, 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. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, a fee may apply 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 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. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation 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: If you receive this Notice on our Web site or by electronic mail (e-mail), 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.

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 Officer: Jean P. Dunn - Office Manager

Telephone: 229-924-4054 Fax: 229-924-2290

Ray M. Duke, Jr. DMD, PC
626 E Forsyth Street
Americus, GA 31709

RAY M. DUKE, JR, DMD, PC

GENERAL CONSENT FORM

CONSENT TO TREATMENT

I do hereby authorize and request the performance of dental services and the use of whatever procedures Dr. Duke May deem necessary for treatment. I understand that Dr. Duke and his staff will use clinical and patient management techniques that are reasonable, necessary, and advisable. I also authorize the administration of anesthetics or analgesics that may be deemed appropriate by Dr. Duke. I understand that the purpose for using local anesthetics may be therapeutic, diagnostic, or for the treatment of facial pain. I understand that potential complications include, but are not limited to pain, swelling, bruising, temporary limited opening, and local infection. I understand that in occasional cases the anesthesia may be prolonged and in very rare cases permanent.

I understand that I am responsible for obtaining any current x-rays that may have been taken at a previous office. If I do not obtain them, I permit the retaking of any necessary x-rays at my expense.

I understand that any treatment plans presented, along with the fees outlined, could change depending on the time elapsed since the initial examination and extent of dental pathology. Occasionally, once the treatment plan has been started, complications may arise that dictate additional procedures or treatment. Dr. Duke or his staff will always advise me of any changes.

In the event that Dr. Duke or a staff member is exposed to my blood or other bodily fluids, I agree to have my blood drawn and tested for Hepatitis B virus (HBV), Hepatitis C virus (HCV), and the human immunodeficiency virus (HIV). I understand that this testing would be done in a confidential manner, and would be made available only to the person who was exposed, and the person would be advised of his/her rights regarding protected health information.

Patient/Guardian signature Date

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT

Ray M. Duke, Jr. DMD, PC
Welcome To Our Practice

We are committed to helping you keep your beautiful smile and to creating a long lasting positive relationship with you and your entire family. It is our goal to provide the highest quality of dental care to each patient. Our greatest compliment is when you recommend us to your family and friends. We appreciate the opportunity of serving you and your entire family.

OFFICE HOURS AND APPOINTMENTS

Our office hours are Monday - Thursday 8:30 am until 5:30 pm.

Patients are seen by appointment only due to forty percent of our patients being school age, you will alternate morning and afternoon appointments to enable everyone the opportunity to only miss one class per year out of school. Two weeks before your six months checkup, you will be mailed a post card to remind you. At that time if your appointment is inconvenient, please call our office to reschedule as there is a $30 failed appointment fee that will be required before rescheduling. If you have text, you will receive a text one week prior of your appointment after scheduling to remind you of your appointment, receive text one day prior to your appointment and/or receive a phone call the day before your appointment. If you are a cash basis, insurance basis or Medicaid patient and fail to keep your appointment without notifying us 24 hours in advance, you will be charged the $30 fee and it must be paid before rescheduling the failed appointment. If you have Wellcare, PeachState or Amerigroup, per their regulations on the third failed appointment, you will be dismissed from the practice. No-Shows are unacceptable as failure to keep an appointment not only compromises your health but inconveniences others. If you cannot keep an appointment, please call a minimum of 24 hours in advance of your appointment to reschedule.

With today's technology, may we suggest that you put your appointment in your phone to remind you of your appointment or maybe you have some other technology that will remind you along with our 3 contacts.

We pride ourselves on seeing you in a timely manner. Only under emergency situations will you experience any wait time and you will be notified immediately upon sign in as you may prefer to reschedule. We ask that you give us the same respect by being on time. Anyone that is 10 minutes late will be asked to reschedule as this is the only way we can stay on time for all patients including you.

If you do not update your phone numbers/address and we are unable to confirm your appointment, we will cancel your appointment without notice.

Insurance

We file insurance as a courtesy to you. If you have any questions regarding your coverage, please call the 800 number on your insurance card. You will want to ask questions regarding your deductible, calendar year maximum, whether you have a waiting period for major dental work (if your insurance is new or less than a year old), preventive coverage, basic and major coverage. If more than one insurance company is involved, we will file both primary and secondary insurances. It is the responsibility of the subscriber to inform our office of any insurance changes during treatment. If at any time insurance benefits change during treatment, the remaining balance, if any, becomes the responsibility of the patient. Any unpaid balance is your responsibility, whether insurance related or not. This office is not responsible for benefits you feel should have been paid, changes in coverage, etc. You are 100% responsible for 100% of the treatment fee and any additional charges incurred. You will be required to pay your deductible and any percentage balance AT THE TIME TREATMENT OCCURS as we do not

bill accounts due to the high cost of collection. All accounts must remain current. Any un-expected balance not covered by insurance is also your responsibility. Also, we will do one pre-authorization per treatment needed at no charge. If you let that pre-authorization expire without proceeding with work, each additional pre-authorization for the same treatment will have a processing fee of $30.00.

Payment/Returned Check Fees/Collections

PAYMENT IS EXPECTED AT THE TIME TREATMENT IS RENDERED. We have two outside payment plans.

One is administered through Care Credit. You may apply with them by phone 800-365-8295 or online by visiting www.carecredit.com. They will check your credit and if approved depending on the amount needed, you will be offered either 6 or 12 months at no interest or 13 months and above with interest.
The other is through I Care Financial. **No credit check** is required, there is a 15% processing fee, a 30% down payment is required and you will have to have a debit card so that monthly payments will be processed through our office.

There will be a $35 insufficient fund fee charged to any account for any returned check and your returned check is turned over to Quick Recovery.

If your insurance fails to pay, you have a returned check or a balance on your account for any reason that would entail collection; there is a 36% collection fee which will be added to the balance of your account. If your account is turned over to the Magistrate Court, all court costs will be included in the collection procedure.

Parent/Guardian on Site

Patients under the age of 18 (that did not drive themselves to their appointment) must have a parent and/or guardian on site with them. Please do not leave during your child's appointment under any circumstances. Due to our office being on a busy highway, we request that you wait in our waiting room to ensure the safety of your young child/children in leaving our office as well as any emergency that may arise. If a parent drops a minor child off, we will reschedule the child's appointment for a later date when a parent or guardian can be present. We do not allow parents to accompany their child into the exam rooms. Your child's treatment will be discussed with you by the doctor, assistant or hygienist after the appointment. We have found that children will work with us better when you are not present. However, if you child is frightened and will not cooperate, we will not force any treatment on your child. We will immediately come get you and refer to a pediatric dentist until they are more comfortable.

By signing this statement, I declare that I have read and understand the Office Policies for Ray M. Duke, Jr., DMD, PC.

_____ _____

Patient/Guardian Date

OFFICE COPY