

For Office Use:

Account # _____ 1. _____
2. _____
3. _____



Southern Smiles Dental Associates, LLC

Larry L. Webb, D.M.D.

770-968-1720

WELCOME!

Thank You for selecting our dental healthcare team! To help us meet all your dental needs, please fill out this form completely.

PATIENT'S FULL NAME _____ **NAME CALLED** _____

Dr. Mr. Mrs. Ms. Minor (Child) (Please Check One)

Student Status: Full Time/ Part time/ None Name of School _____ City/State of School _____

Date of Birth ____/____/____ Social Security # ____ - ____ - ____ Marital Status: S M D W Sex: M F

Address _____ Home Phone (____) _____

City _____ State _____ Zip _____ Cell Phone (____) _____

PATIENT'S EMPLOYER _____ Work Phone (____) _____

Employer Address _____

City _____ State _____ Zip _____

PERSON RESPONSIBLE FOR PAYMENT: (If different from Patient)

NOTICE - By state law, the parent who brings a child to our office is the responsible party.

Name _____ Name Called _____

Relationship to Patient _____ Social Security # ____ - ____ - ____ Marital Status: S M D W Sex: M F

Address _____ Date of Birth ____/____/____

City _____ State _____ Zip _____ Home Phone (____) _____

Employer _____ Work Phone (____) _____

Employer Address _____

City _____ State _____ Zip _____

GENERAL INFORMATION:

SPOUSE'S NAME _____ Work Phone (____) _____

Spouse's Employer _____ Home Phone (____) _____

In Case of Emergency, contact _____ Home Phone (____) _____

Reason for visit _____

How did you hear about our office? Person- _____ Other- _____

PRIMARY DENTAL INSURANCE COMPANY: _____ Group # _____

Claims Address _____ Ins. Phone(____) _____

City _____ State _____ Zip _____

Employee _____ Date Of Birth ____/____/____ ID# _____

Social Security # ____ - ____ - ____ Relationship to Patient _____

SECONDARY DENTAL INSURANCE COMPANY: _____ Group # _____

Claims Address _____ Ins. Phone(____) _____

City _____ State _____ Zip _____

Employee _____ Date Of Birth ____/____/____ ID# _____

Social Security # ____ - ____ - ____ Relationship to Patient _____

PLEASE COMPLETE BOTH SIDES OF THIS FORM ➡

PRIMARY Physician _____ Phone (_____) _____
 Specialist _____ Phone (_____) _____
 Other _____ Phone (_____) _____

FOR OFFICE USE

Do you presently have OR have you ever had any of the following: PLEASE READ CAREFULLY

Yes / No	(Please check one)	Yes / No	
<input type="checkbox"/> <input type="checkbox"/>	Heart Condition	<input type="checkbox"/> <input type="checkbox"/>	Hearing Impaired
<input type="checkbox"/> <input type="checkbox"/>	Heart Murmur/Rheumatic Fever	<input type="checkbox"/> <input type="checkbox"/>	Lung Condition or Emphysema
<input type="checkbox"/> <input type="checkbox"/>	Heart Attack	<input type="checkbox"/> <input type="checkbox"/>	Asthma
<input type="checkbox"/> <input type="checkbox"/>	Irregular Heart Beat	<input type="checkbox"/> <input type="checkbox"/>	Sinus Condition
<input type="checkbox"/> <input type="checkbox"/>	Heart Pacemaker	<input type="checkbox"/> <input type="checkbox"/>	Tuberculosis
<input type="checkbox"/> <input type="checkbox"/>	Damaged or Prosthetic Heart Valves	<input type="checkbox"/> <input type="checkbox"/>	Do you use tobacco? Type _____
<input type="checkbox"/> <input type="checkbox"/>	Stroke	<input type="checkbox"/> <input type="checkbox"/>	Hepatitis or Jaundice Type _____
<input type="checkbox"/> <input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/> <input type="checkbox"/>	AIDS, ARC, or HIV
<input type="checkbox"/> <input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/> <input type="checkbox"/>	Venereal Disease/STD
<input type="checkbox"/> <input type="checkbox"/>	Chest Pain	<input type="checkbox"/> <input type="checkbox"/>	Liver Condition
<input type="checkbox"/> <input type="checkbox"/>	Anemia or Blood Disorder	<input type="checkbox"/> <input type="checkbox"/>	Kidney Condition
<input type="checkbox"/> <input type="checkbox"/>	Abnormal Bleeding/Clotting/Healing	<input type="checkbox"/> <input type="checkbox"/>	Diabetes
<input type="checkbox"/> <input type="checkbox"/>	Blood Transfusion	<input type="checkbox"/> <input type="checkbox"/>	Hyperglycemia/Hypoglycemia
<input type="checkbox"/> <input type="checkbox"/>	Anxiety/Depression/Other	<input type="checkbox"/> <input type="checkbox"/>	Thyroid Condition
<input type="checkbox"/> <input type="checkbox"/>	Alzheimer's Disease	<input type="checkbox"/> <input type="checkbox"/>	Cancer - Type _____
<input type="checkbox"/> <input type="checkbox"/>	Drug or Alcohol Addiction	<input type="checkbox"/> <input type="checkbox"/>	Radiation Treatment
<input type="checkbox"/> <input type="checkbox"/>	Convulsions/Fainting/Seizures	<input type="checkbox"/> <input type="checkbox"/>	Arthritis or Rheumatoid
<input type="checkbox"/> <input type="checkbox"/>	Head/Neck/Jaw Injury	<input type="checkbox"/> <input type="checkbox"/>	Joint Replacement/Prosthesis
<input type="checkbox"/> <input type="checkbox"/>	Glaucoma/Blindness	<input type="checkbox"/> <input type="checkbox"/>	Stomach Ulcers/GI Condition/Reflux
<input type="checkbox"/> <input type="checkbox"/>	Cold Sores/Fever Blisters/RAU	<input type="checkbox"/> <input type="checkbox"/>	Osteoporosis/Bisphosphonate

REACTION or ALLERGY TO:

Yes / No (Please check one)	Yes / No
<input type="checkbox"/> <input type="checkbox"/> Codiene	<input type="checkbox"/> <input type="checkbox"/> Latex
<input type="checkbox"/> <input type="checkbox"/> Penicillin	<input type="checkbox"/> <input type="checkbox"/> Bleach
<input type="checkbox"/> <input type="checkbox"/> Novocaine/Anesthetic	<input type="checkbox"/> <input type="checkbox"/> Iodine

WOMEN: Are you currently

Yes / No
<input type="checkbox"/> <input type="checkbox"/> On Birth Control
<input type="checkbox"/> <input type="checkbox"/> Pregnant-Due Date _____
<input type="checkbox"/> <input type="checkbox"/> Breast Feeding

Other (please list) _____

Please List All Medications You Are Taking:

Medication	For Office use:	Medication	For office use:

Please list all medical or dental information which may affect your treatment: _____

- The above information is accurate to the best of my knowledge.
- I understand that all fees are to be paid at time of service, unless prior arrangements have been made.
- I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me (or my child) during the period of such dental care to third party payors and/or other health practitioners.
- I authorize the Insurance Company to pay Southern Smiles Dental Associates, LLC, directly for any benefits due to me for the treatment rendered.
- I permit a copy of these authorizations to be used in place of the originals.
- I understand that professional services are rendered and charged to the patient; therefore, I am responsible for my account, NOT the Insurance Company.
- In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to affect collection of this account or future outstanding accounts.

Signature of Patient, Parent, and/or Responsible Party _____

Date _____

PLEASE COMPLETE BOTH SIDES OF THIS FORM 

SOUTHERN SMILES DENTAL ASSOCIATES, LLC
LARRY L. WEBB, D.M.D.
ACKNOWLEDGEMENT OF PRIVACY PRACTICES

**** You may refuse to sign this Acknowledgement****

Patient name: _____
(please print patient's name)

Patient's Date of Birth: _____

I, _____
(please print the responsible party's name)

Have received a copy of this office's Notice of Privacy Practices

(signature of responsible party)

(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
- ___ Communication barriers prohibited obtaining acknowledgement
- ___ An emergency situation prevented us from obtaining acknowledgement
- ___ Other (please specify)

SOUTHERN SMILES DENTAL ASSOCIATES, LLC
LARRY L. WEBB, D.M.D.
NOTICE OF PRIVACY PRACTICES
UPDATED FEBRUARY 2026

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 April 14, 2003, 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 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, we will charge you \$0.20 for each page, \$50.00 per hour for staff time to locate and 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.

UPDATES FEBRUARY 2026

Part 2 is a federal law (42 U.S.C 290dd-2 and 42 CFR part 2) that protects the confidentiality of patient records for people receiving services for substance use disorders (SUDs). Part 2 confidentiality rules describe when and how SUD patient records may be used and disclosed. These records are called **Part 2 records**.

Part 2 rules apply to any federally assisted program that provides SUD diagnosis, treatment, or referral for treatment.

These programs are called **Part 2 programs**. Some Part 2 requirements also apply to people and organizations who receive Part 2 records, such as other health care providers, Qualified Service Organizations (QSOs), HIPAA covered entities and business associates, intermediaries, and investigative agencies. Confidentiality protections are important because fear of discrimination or legal trouble can deter people from seeking SUD treatment. Part 2 rules establish:

Limitations on when SUD patient records can be shared - In general, Part 2 programs cannot share any information that would identify someone as having, or having had, a substance use disorder unless Part 2 specifically permits it. With limited exceptions, such as for emergency medical treatment, records may only be shared if the patient gives written consent or there is a court order and subpoena (or similar legal mandate).

Single consent and redisclosure - Patients can provide a single consent for all future uses and disclosures of Part 2 records for treatment, payment, and health care operations. This is called a "TPO consent." When an entity that is subject to HIPAA, such as a covered health care provider or a patient's health plan, receives a Part 2 record with the TPO consent, that entity can share the record again without consent in all the ways that HIPAA allows, except for using the information in legal proceedings against the patient.

Prohibitions on the use of SUD patient records against a patient - Part 2 prohibits SUD patient records from being used or disclosed in legal proceedings against patients without their consent or a court order and subpoena (or a similar legal mandate). It also establishes requirements for court orders that permit use and disclosure under limited circumstances.

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: Linda Smith

Telephone: 770-968-1720

Fax: 770-968-1625

Address: 6612 Exchange Place, Morrow, GA 30260