PATIENT INFORMATION

PATIENT INFORMATION

Last Name	First Name	Middle Initial	Preferred Name
Social Security Number	Date of Birth	Cell Phone #	Home Phone #
Preferred Contact Method ☐ Text Message ☐ Phone Call to Cell ☐ Phone Call to Home			
Email Address			
Street Address	City	State	Zip Code
☐ Male ☐ Female	☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow ☐ Child (under 12)		
Is the patient a minor? ☐ Yes ☐ No	Name of Responsible Party	Relationship to Patient	

PRIMARY INSURANCE

Holder: _____

Insurance Co: _____

Group #: _____

Member id: _____

Phone: _____

SECONDARY INSURANCE (if applicable)

Holder: _____

Insurance Co: _____

Group #: _____

Member id: _____

Phone: _____

EMPLOYER

Name: _____

Address: _____

City, State Zip: _____

Occupation: _____

Phone: _____

EMERGENCY CONTACT

Name: _____

Relationship: _____

Phone 1: _____

Phone 2: _____

May we share personal medical information? ☐ Yes ☐ No

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the provider or clinic. I authorize my provider to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of medical care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPAA NOTICE that is available to you in the back of this packet.

_____ _____ _____

Patient / Guardian Signature *(If guardian, write name please)* Date

PATIENT MEDICAL HISTORY

PATIENT NAME: _____ **DOB:** _____ **Date:** _____

Do you have or ever had any of the issues listed below:

Yes	No		Yes	No		Yes	No	
☐	☐	AIDS/HIV Positive	☐	☐	Glaucoma	☐	☐	Psychiatric Care
☐	☐	Alzheimer's Disease	☐	☐	Heart Attack/Failure	☐	☐	Radiation Treatments
☐	☐	Anaphylaxis	☐	☐	Heart Murmur	☐	☐	Renal Dialysis
☐	☐	Anemia	☐	☐	Heart Pacemaker	☐	☐	Respiratory Disease
☐	☐	Angina	☐	☐	Heart Trouble/ Disease	☐	☐	Rheumatic Fever
☐	☐	Arthritis/Gout	☐	☐	Hemophilia	☐	☐	Rheumatism
☐	☐	Artificial Heart Valve	☐	☐	Hepatitis A	☐	☐	Scarlet Fever
☐	☐	Artificial Joint	☐	☐	Hepatitis B or C	☐	☐	Shortness of Breath
☐	☐	Asthma	☐	☐	Herpes	☐	☐	Sickle Cell Disease
☐	☐	Cancer	☐	☐	High Blood Pressure	☐	☐	Sinus Trouble
☐	☐	Chemical Dependency	☐	☐	Hypoglycemia	☐	☐	Special Diet / Weight Loss
☐	☐	Chemotherapy	☐	☐	Kidney Problems	☐	☐	Stroke
☐	☐	Cold Sores/Fever Blisters	☐	☐	Liver Disease/Jaundice	☐	☐	Swelling of Limbs
☐	☐	Congenital Heart Disorder	☐	☐	Low Blood Pressure	☐	☐	Temporal Arteritis
☐	☐	Cortisone Medicine	☐	☐	Lung Disease	☐	☐	Thyroid Disease
☐	☐	Diabetes	☐	☐	Migraines	☐	☐	Tonsillitis
☐	☐	Emphysema	☐	☐	Mitral Valve Prolapse	☐	☐	Tuberculosis
☐	☐	Epilepsy/Seizures/Convulsions	☐	☐	Neurological Disease	☐	☐	Tumors or Growths
☐	☐	Excessive Bleeding	☐	☐	Osteoporosis/Osteopenia	☐	☐	Ulcers
☐	☐	Fainting Spells/Dizziness	☐	☐	Pain in Jaw Joints	☐	☐	Venereal Disease
☐	☐	Gastrointestinal Disease	☐	☐	Prostate Disease	☐	☐	Pregnant/Nursing

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Local Anesthetics
☐ Latex ☐ Sulfa Drugs ☐ Metal ☐ Other: _____

ADDITIONAL QUESTIONS

Yes	No		All Current Medications
☐	☐	Do you drink? # per day_____	_____
☐	☐	Do you smoke? # per day_____	_____
☐	☐	Do you vape? ☐ Cannabis ☐ Nicotine	_____
☐	☐	Do you use any edible cannabis or CBD products?	_____
☐	☐	Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates?	_____ _____
☐	☐	Are you taking any medications, pills, or drugs?	_____
☐	☐	Have you ever taken an antibiotic prior to dental treatment?	_____
☐	☐	Are you satisfied with your teeth's appearance?	_____
☐	☐	Would you like to keep your teeth all your life?	_____

Patient / Guardian Signature: _____ **Date:** _____

PATIENT MEDICAL HISTORY

DENTAL HISTORY

Yes	No		Yes	No		Yes	No	
☐	☐	Bad Breath	☐	☐	Food collection in teeth	☐	☐	Mouth pain
☐	☐	Bleeding Gums	☐	☐	Foreign objects in mouth	☐	☐	Orthodontics
☐	☐	Blisters (mouth or lips)	☐	☐	Grinding teeth	☐	☐	Pain around ear
☐	☐	Burning Sensation	☐	☐	Gums swollen/tender	☐	☐	Periodontal treatment
☐	☐	Chewing on one side	☐	☐	Jaw pain/tiredness	☐	☐	Sensitivity to cold
☐	☐	Clicking or Popping Jaw	☐	☐	Lip or cheek biting	☐	☐	Sensitivity to heat
☐	☐	Dry Mouth	☐	☐	Loose teeth / broken fillings	☐	☐	Sensitivity to sweets
☐	☐	Fingernail biting	☐	☐	Mouth breathing	☐	☐	Other

_____ Date of last dental visit?

_____ Date of last full mouth x-rays?

_____ Date of last dental cleaning?

_____ How often do you have dental examinations?

_____ How often do you brush/floss?

_____ What other dental aids do you use?

ADDITIONAL QUESTIONS

Previous hospitalizations / surgeries

Current Physician's Name

Previous Dentist/Office name

What is the reason for your visit today?

Do you have any dental problems now? If yes, please describe

Do you feel nervous about having dental treatment? if yes, what is your biggest concern?

Have you ever had an upsetting dental experience? If yes, please describe

How did you hear about our office?

Patient / Guardian Name: _____

Patient / Guardian Signature: _____ **Date:** _____

FINANCIAL AND APPOINTMENT POLICIES

PATIENT NAME: _____ **DOB** _____

Initial all policies that have been read and understood

Financial Policy

____ Payment is expected at the time of service. We accept cash, check, credit cards, debit cards, health savings account cards, Sunbit, and CareCredit. **There will be a $35.00 service charge for any returned checks**. We do not accept temporary or new account checks.

____ Past due accounts will be turned over to a collection agency after we have tried to resolve your balance three times. Any fees incurred due to this will be added to the outstanding balance. This may include late fees, collection agency fees, court fees, etc.

____ We accept all dental insurances as long as they offer in and out-of-network benefits. We file your dental insurance claims as a curtesy for you at no charge. It is the patient's responsibility to provide us with current and accurate insurance information prior to the date the services are rendered. If we are unable to verify your dental insurance benefits prior to the date of service, you will be expected to pay out of pocket for the dental visit at that time. Once the correct dental insurance has been put on file and we are able to file a claim, if you are owed a refund for any out-of-pocket expenses, we will do so accordingly.

____ ***Verification of eligibility and benefits payable by your insurance company does not constitute a guarantee of claim payment. Final determination of benefits payable will be made at the time a claim is submitted, processed, and paid/unpaid by your insurance company.***

____ Not all services are covered by your insurance company. In the event that your insurance carrier determines a service is "not covered," you will be responsible for the complete charge. If your insurance provides coverage for alternate services, downgrades any service, etc. you will also be responsible for whatever portion is not covered by the insurance company. We only file a pre-determination estimate to your insurance company at YOUR REQUEST ONLY. Please be aware that some insurance companies may not honor a pre-treatment/determination or they may alter it. In all cases, this may delay important dental care that is viable to your dental health. Insurance limitations and regulations vary with all insurance plans. We do not base your treatment plan on what your insurance plan does or does not cover. It is ultimately YOUR RESPONSIBILITY to be aware of your dental plan coverage, regulations, and limitations to avoid confusion and any surprises.

Appointment Policy

____ Due to a high number of patients requiring dental care, certain appointment times might not be readily available. Because of this, **we enforce a missed appointment policy to ensure that all patients receive care as soon as possible. Patients who are 10 minutes late to an appointment may have to be rescheduled. After 2 missed appointments without 48 hours prior notice, a patient may be subject to being scheduled on the day of only. If you have 3 broken appointments within a year, you will be dismissed from the practice.**

____ Certain procedures and appointments 2 hours or longer may be subject to a pre-payment to ensure your scheduled time.

I do hereby consent and acknowledge my agreement to the terms set forth in the Financial and Appointment Policies and any subsequent changes. I understand that this consent shall remain in force from this point forward.

PATIENT/GUARDIAN NAME _____ **DATE** _____

PATIENT/GUARDIAN SIGNATURE _____

HIPPA PRIVACY NOTICE

THIS NOTE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

1. **PURPOSE** ABC Family Dentistry and its staff follow the privacy practices described in this Notice and in the Corporation's Policies and Procedures. ABC Family Dentistry keeps your information in records that will be maintained and protected in a confidential manner, as required by law. Please note that in order to provide you with the best possible care and treatment, all staff involved in the health care operations of ABC Family Dentistry may have access to your records.

2. **HOW YOUR INFORMATION IS USED FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS**: We will always limit the use(s), disclosure(s) and request(s) of your protected health to that which is determined to be the minimum necessary to accomplish the intended purpose. ABC Family Dentistry follows rules of regulatory agencies for the efficient and effective utilization of care. Examples of these regulatory agencies include the State of TN Dept. of Health and the Office of Medicaid.

3. **HOW YOUR PROTECTED HEALTH INFORMATION IS USED AND STORED:** Your paper dental record will be stored in a locked area when not in use and retained by ABC Family Dentistry for a minimum of seven years after your last clinical contract with us. Records for minors will be maintained until the minor attains the age seven years beyond the age of majority. After that time has elapsed, the record will be shredded or otherwise destroyed in a way that protects your privacy, except where law requires it to be kept for a longer period of time. If ABC Family Dentistry obtains electronic medical records, your clinical record will be stored on a database that is secured with physical and technical safeguards and only accessed by personnel with proper security training and clearance. In addition to those items listed in #2(TPO), and until records are destroyed, they may be used for the following purposes unless you ask for restrictions on a specific use or disclosure (instructions listed in #5):

a. Appointment reminders
b. Notification when an appointment is canceled or rescheduled by ABC Family Dentistry
c. As may be required by law

4. **YOUR AUTHORIZATION IS REQUIRED FOR OTHER DISCLOSURES:** Except as described previously, we will not use or disclose information from your record unless you authorize ABC Family Dentistry to do so. You may revoke your permission in writing, which will be effective only after the date of your written revocation.

5. **YOU HAVE RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION:** You have the following rights regarding your health information.

a. Right to request restriction. You may request limitations on the information we may disclose, but we are not required to agree to your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

b. Right to confidential communications. You may request communications in a certain way or at a certain location, but you must specify how or where you wish to be contacted.

c. Right to inspect and copy. You have the right to inspect and copy your information regarding decisions about your care. However, we may charge a fee for copying, mailing, and supplies.

d. Right to request clarification of the record. If you believe that the information, we have about you is incorrect or incomplete, you may ask to add clarifying information. ABC Family Dentistry is not required to accept the information you propose.

e. Right to accounting of disclosures. You may request a list of the disclosures of your health record that have been made to persons or entities other than for treatment, payment or health care operations in the last six (6) years, but not prior to November, 2008.

f. Right to a copy of this Notice. You may request a copy of this Notice at any time.

6. **REQUIREMENTS REGARDING THIS NOTICE** ABC Family Dentistry is required to provide you with this Notice that governs our privacy practices. ABC Family Dentistry may change its policies or procedures in regard to privacy practices. If and when changes occur, the changes will be effective for information we have about you may ask for and receive a copy of the Privacy Notice that is in effect at that time. ABC Family Dentistry will have this Notice posted.

7. **COMPLAINTS:** If you believe your privacy rights have been violated, you may file a complaint with ABC Family Dentistry. You will not be penalized or retaliated against in any way for making a complaint. If you have a complaint, if you have any questions about this notice, if you wish to request an additional copy of this notice, or if you wish to request restrictions on uses and disclosure for health care treatment or operations, please contact us at 423-639-2176.

I have read and understand the Privacy Notice of ABC Family Dentistry.

PATIENT/GAURDIAN SIGNATURE _____ **DATE:** _____