Patient Information

Welcome to Art of Dentistry! We will always do our best to earn the trust that you have placed in us. Please fill out these forms.

Personal Information

Patient's Full Name: ____ Date of Birth: _________________________

Preferred name: ____ Social Security #: ______________________

☐ Female ☐ Male Marital Status: _________________________________ Driver's Lic #: _________________________

Complete Address: ____

E-mail: ____ Cell Phone: ____

Home Phone: ____ Work Phone: ___________________________ Ext__________

Parent/Guardian

Is patient a minor *(<u>under</u> 18)*? ☐ Yes ☐ No If Yes, fill out the following information for the parent or guardian:

Full Name: ____ Relationship to Patient: _________________ Phone #: ___________________

Emergency Contact

Complete the following information about the patient's emergency contact:

Full Name: ____ Relationship to Patient: _________________ Phone #: ___________________

Communication Preferences

Detail below the communication preferences for the patient (or guardian if patient is a minor):

Please mark your preferred method/s of communication:
☐ Home Phone ☐ Cell Phone ☐ Text Message ☐ Email

We may send appointment confirmations and reminders via automated text message or email:
Can you receive text messages? ☐ Yes ☐ No
Can you receive emails? ☐ Yes ☐ No

Can we leave a voicemail on your . . .
home phone? ☐ Yes ☐ No
cell phone? ☐ Yes ☐ No

Media Release

As a patient of Art of Dentistry, PLLC, I understand that my photographs and radiographic images will be used for inclusion in my dental records and if required by law enforcement.
In addition, I hereby consent that photographs, video pictures, and/or radiographic images can be taken of me and used by Art of Dentistry, PLLC.

For any purpose of illustration, teaching, publication in dental journals, or for any other dental purpose deemed appropriate. ☐ Yes ☐ No

Use on social media sites to to demonstrate final outcomes. ☐ Yes ☐ No

Publicity or ad campaigns. ☐ Yes ☐ No

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 or Guardian

_______________________________________ Date

_______________________________________ Print Name

_______________________________________ Relationship to Patient

Patient Name: ____________________

Date of Birth: ____________________

Date: ____________________

MEDICAL HISTORY

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: ____________
Have you ever had a serious head or neck injury?	☐ Yes ☐ No	If Yes: ____________
Are you taking any medications, pills, or drugs?	☐ Yes ☐ No	If Yes: ____________
Do you take, or have you taken, Phen-Fen or Redux?	☐ Yes ☐ No	If Yes: ____________
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	☐ Yes ☐ No	If Yes: ____________
Are you on a special diet?	☐ Yes ☐ No	If Yes: ____________
Do you use tobacco?	☐ Yes ☐ No	If Yes: ____________

Women: Are you… *(mark what applies)*
☐ Pregnant/ Trying to get pregnant? ☐Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following? *(mark what applies)*

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

Do you have any other allergy? ☐ Yes ☐ No If Yes: ____________
Do you use controlled substances? ☐ Yes ☐ No If Yes: ____________

Do you have, or have you had, any of the following? Check any that apply

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

Other serious illness not listed above: ____________

Medical History Comments: ____________

____

____________ Signature of Patient or Guardian ____________ Date

____________ Print Name ____________ Relationship to Patient

HIPAA Consent

THIS NOTICE DESCRIBES TO WHOM MEDICAL INFORMATION ABOUT YOU MAY BE DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides privacy protections to your medical records. Our benefits office (or other third party designated by our office) may sometimes need to disclose medical information or payment information protected by HIPAA in relation to our group health plans to your family members or close friends involved in your health care. For example, your spouse may need to contact us if you are in the hospital to determine whether a particular procedure is covered under our group health plan or may need assistance filing a claim for medical services. Under HIPAA, unless you specifically object we are allowed to use our professional judgment in deciding whether to discuss you medical and payment information with you family members or close friends. However, we would like to provide you with the opportunity to tell us with whom we may discuss your medical or payment information under our group health plans.

☐ You may communicate with the following individuals relating to my medical or payment information:

____ ____

____ ____

____ ____

☐ Please do not discuss my medical or payment information with the following individuals:

____ ____

____ ____

____ ____

☐ Please do not discuss my medical or payment information with anyone.

____ ____

Signature of Patient or Guardian | Date

____ ____

Print Name | Relationship to Patient

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ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

I, ____, hereby acknowledge that I have been given the opportunity to review a copy of **Art of Dentistry's** *HIPAA Notice of Privacy Practices*.
I understand that **Art of Dentistry's** *HIPAA Notice of Privacy Practices* may change periodically and that I am entitled to receive a copy of **Art of Dentistry's** revised *HIPAA Notice of Privacy Practices* upon request.

I understand that, if I have questions about **Art of Dentistry's** *HIPAA Notice of Privacy Practices*, I may contact **Zonia Lopez at 423-362-7962**.

I understand that it is my right to refuse to sign this Acknowledgement should I so choose, and that **Art of Dentistry** will not refuse treatment to me if I refuse to sign this Acknowledgement.
I further understand that I may contact the Secretary of the U.S. Department of Health and Human Services should I have concerns regarding **Art of Dentistry's** privacy policies and procedures.

____ ____

Signature of Patient or Guardian | Date

____ ____

Print Name | Relationship to Patient

Financial Policy

It is our goal to keep prices as low as possible. If you have insurance, we will file it for you as a courtesy. If you do not have insurance, we accept cash and all major credit/debit cards. We will accept checks only from established patients.

Regarding Insurance:
Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We accept assignment of insurance benefits after you furnish us with your full insurance information and this is verified by your insurance carrier. Your deductible and patient portion are due at the time of service. Some of the services provided may be a non-covered service and not considered necessary by your dental carrier. You are responsible for payment of any insurance company's arbitrary determination of usual and customary rates. If the patient is a minor, the adult accompanying a minor patient is responsible for payment in full.

Assignment of Insurance Benefits:
I hereby authorize payment directly to **Art of Dentistry** and its dental providers for the dental service benefits otherwise payable to me.

I understand that, although **Art of Dentistry** will do all that is in their power to present to me estimates that are as accurate as possible, any quote given to me, in person, in writing, over the phone, or in any form of communication used by **Art of Dentistry, PLLC** will only be an estimate based on the information provided to them by my insurance carrier.

I understand that if performed dental services are not under contract with my insurance carrier or I have met my contract limitations, I am responsible for payment of the full balance due.

Missed Appointments:
Your time is valuable. That is why we strive to see you in a timely manner. The time of your dental provider, as well as other patients' time, is also valuable. In order to respect this, we kindly ask that you give us a **24-hour advance notice** for any cancelled appointment. Once two scheduled appointments have been missed without the requested advance notification, we reserve the right to allow only same-day appointments. We also reserve the right to deny any future scheduling of appointments due to repeatedly missed, cancelled, or late appointments. In the latter case, you would be notified of such action and given 30 days to find another provider.

Unpaid Balances:
If your account becomes past due, we will take necessary steps to collect this debt. I understand that any attorney fees, court costs, and collection fees become my responsibility and will be added to my account, should it become necessary. Returned checks will be subject to a $25.00 fee per occurrence. Finance charges of 1.5% per month may be imposed on the unpaid balance after your account has gone 30 days past due.

Credit History:
If your account were to become past due, we have the option to check your credit history and to report your account history to any credit reporting agency such as a credit bureau.

ACKNOWLEDGEMENT OF RECEIPT
I acknowledge that I have read in its entirety and agree to the above Financial Policy.

______________________________	______________________________
Signature of Patient or Guardian	Date
______________________________	______________________________
Print Name	Relationship to Patient