# Ashland City Dental

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Ashland City, TN 37015
615-235-5144 info@ashlandcitydental.com

## PATIENT REGISTRATION

**Welcome to our office. Please complete these forms to your best ability and if you have any questions, we will be glad to help you.**

### Patient Contact Information

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

*Preferred name if different from above: _____ Date of Birth: _____

SSN#_____ Gender: M/F Marital Status: Single Married Widowed Divorced

Preferred contact: Text / Email/ Phone call Cell phone: _____

Work phone: _____ Email: _____

### Address and Patient Information

*Would you like to use this address and responsible party for the entire family? Y/ N

Street Address: _____ Apt #_____

City: _____ State: _____ Zip Code: _____

Responsible party for account: _____ DOB: _____

How did you hear about us? _____

### Insurance Information

***(If your insurance has already been verified, you may skip this section)***

Primary Insurance: Your relationship to subscriber: Self / Spouse / Child

Subscribers Name: _____ DOB: _____

Insurance Company: _____ Phone: _____

Subscriber ID #_____ Subscriber SSN#: _____

Employer/Policy Name: _____ Group number: _____

Secondary Insurance (if applicable):

Subscribers Name: _____ DOB: _____

Insurance Company: _____ Phone: _____

SSN/ID#_____ Group Number: _____

# Medical History

**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 medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.**

First and Last name: _____ DOB: _____
Emergency Contact: _____ Phone: _____
Are you under a physician's care now? **Y N** For: _____
PCP Name/City and St: _____

## *New Patients *

Name of former dentist: _____ City/State: _____
Date of last cleaning and exam: _____
Do you have any xrays taken within the last 1-3 years at your previous dentist? **Y N Not Sure**
*If **yes**, please provide phone number to contact them: _____

Reason for today's visit: _____ Are you in pain? **Y N**
Dental concerns: _____

For the following questions about the patient's health, circle all that apply or circle **IDK** if you DONT KNOW the answer to the question.

We care about your safety and the safety of our staff. Do you have any of the following conditions?

Active Tuberculosis **Y N IDK**
Persistent cough greater than a 3-week duration? **Y N IDK**
Cough that produces blood. **Y N IDK**
Been exposed to anyone with tuberculosis? **Y N IDK**

*If you answered **YES** to any of the **4 items above**, please stop and return this form to one of our Patient Coordinators. *

Have you had an orthopedic total joint replacement (e.g., hip, knee, elbow, finger)? **Y N IDK**

If yes, date of operation and have you had any complications?
_____
_____

Are you taking, or scheduled to begin taking, either Alendronate (Fosamax) or risedronate (Actonel)? **Y N IDK**

Have you ever been hospitalized or had a major operation? **Y N IDK**
_____
_____

Are you on a special diet? **Y N IDK**
_____

Have you ever had a serious head or neck injury? **Y N IDK**

_____
_____

Do you or have you taken Phen-Fen or Redux? **Y N IDK**

Since 2001, were you treated or are you presently scheduled to begin treatment with intravenous bisphosphonates (Aredia or Zometa) for bone pain, hypercalcemia, or skeletal complications resulting from Paget's disease, multiple myeloma, or metastatic cancer? **Y N IDK**

If yes, date treatment began:
_____

Do you use controlled substances (e.g., drug whose use is regulated by the gov't)? **Y N IDK**

Do you use tobacco (e.g., smoking, snuff, chew, bidis)? **Y N IDK**

If yes, how interested are you in stopping? (Circle one):

**Very / Somewhat / Not Interested**

Do you drink alcohol? **Y N IDK**

If yes, how much alcohol did you drink in the last 24 hours? _____

How much do you typically drink in a week? _____

**WOMEN ONLY:**

Are you pregnant? **Y N**

If **yes**, do you have an OB dental clearance? **Y N**

If **yes**, please list OB name and phone number:

_____

If **yes** how many weeks? _____

Trying to get pregnant? **Y N** Nursing? **Y N**

Taking birth control or hormonal replacement? **Y N**

**Are you allergic to any of the following? Check all that apply:**

- ☐ Acrylic
- ☐ Aspirin
- ☐ Codeine or other narcotics
- ☐ Ibuprofen
- ☐ Latex
- ☐ Local Anesthetics
- ☐ Metal
- ☐ Penicillin or other antibiotics
- ☐ Sulfa
- ☐ Other: _____

**Please list all current medications:**

_____
_____
_____
_____

**Do you have any of the following medical conditions? Check all that apply:**

- ☐ AIDS/HIV Positive
- ☐ Alzheimer's disease
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Breathing Problems
- ☐ Cancer
- ☐ Chest pains
- ☐ Cold Sores/Fever Blisters
- ☐ Congenital Heart Disorder
- ☐ Convulsions
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Easily Winded
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Excessive Thirst
- ☐ Excessive bleeding
- ☐ Fainting Spells
- ☐ Frequent Cough
- ☐ Frequent Diarrhea
- ☐ Frequent Headaches
- ☐ Genital Herpes
- ☐ Glaucoma
- ☐ Hay fever
- ☐ Heart Attack/Failure
- ☐ Heart Pacemaker
- ☐ Heart Trouble/Disease
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Hypoglycemia
- ☐ Irregular heartbeat
- ☐ Kidney Disease
- ☐ Leukemia
- ☐ Low Blood Pressure
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Pain in Jaw Joints
- ☐ Parathyroid Disease
- ☐ Psychiatric Treatment
- ☐ Sinus Trouble
- ☐ Renal Dialysis
- ☐ Radiation Treatment
- ☐ Recent Weight Loss
- ☐ Rheumatism
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Sickle Cell Disease
- ☐ Spina Bifida
- ☐ Stomach/Intestinal Disease
- ☐ Stroke
- ☐ Swelling of limbs
- ☐ Thyroid Disease
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Yellow Jaundice

**Comments/Other:**

_____
_____

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 the patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

**Signature:** _____ **Date**: _____

# Office Policies and Financial Agreement

It is our desire to provide the highest quality dental care to everyone. The following is a statement of Ashland City Dental's Office/ Financial Policies. We ask that you please read, agree to, and sign before any treatment is rendered.

## Regarding Insurance

Our goal is to maximize your insurance benefits. It is important to understand that the insurance contract is between the insurance company and you, the insured. Dental insurance was not designed to pay all dental care. Treatment recommended by Ashland City Dental is never based on what your insurance company will pay. Due to pending claims and patient privacy issues, we do not always know how much an insurance company has already paid to another office or specialist, and the balance remaining on a yearly maximum. Insurance coverage is subject to limitations, exclusions, waiting periods, frequency, age restrictions, deductible and maximums which are your responsibility.

Please be prepared to show your insurance card and driver license at the time of your visit. It is the patient's/guarantor's responsibility to provide any new information regarding insurance. Our office will gladly submit your insurance claim to your insurance carrier, as a courtesy to you. At the time of treatment, the patient/guarantor is responsible for the estimated portion the insurance does not cover. If for some unforeseen reason your insurance carrier has denied or not made payment within 60 days, the patient/guarantor is responsible for the balance in full. I authorize Ashland City Dental to release information as may be required to insurance companies for processing my and /or my dependent(s) claims.

_____(Initial)

## Payment Options

Cash, Check, MasterCard, Visa, Discover, or American Express. With prior approval, we are pleased to offer a choice of referred interest or Extended Payment Plans to qualified applicants through CareCredit. If you would like to make extended payments for services provided at our office, please ask any of our administrative team for assistance in filling out an application form.

_____(Initial)

## Additional Charges

Interest will be added to any account with an outstanding balance over 60 days past due at a rate of 21% APR, or a flat rate of $5.00 a month, whichever is greater.

_____(Initial)

A returned check fee of $35 will be applied to account for returned “bad” checks. _____(Initial)

If the account is turned over to collections, a charge of $50.00 will be added to the account to cover costs involved. _____ (Initial)

## Cancellation Policy

If you are unable to keep an appointment, we ask that you kindly provide us with a minimum of two-business days' notice. Failure to do so may result in a $50.00 short notice charge. Our office does not accept cancellation or changes in appointments after hours by voicemail. You **must** call during our normal business hours. This courtesy on your part will make it possible to give your appointment to another patient who needs to see the dentist or hygienist. Multiple failed appointments may result in being dismissed from the dental practice.

## Billing

We offer the convenient option of having your statements emailed to you and pay you bill online. If you prefer your statements mailed that is still an option, please choose your preference below:

*If you would like to receive your **statements via email** initial here: _____

*If you prefer to receive your **statements via mail** initial here: _____

**Office Hours**

Monday 10am-7pm

Tuesday 10am-7pm

Wednesday 8am-5pm

Thursday 8am-5pm

Friday 8am-1pm

I have read, understand, and agree to the above Office Policies and Financial Agreements.

_____ _____

**Patient Signature** **Date**

_____

**(Parent/Guarantor signature if patient is a MINOR)**

# Authorization Form for Use or Disclosure of Patient Information

Patient name: _____DOB: _____

I hereby authorize the use of the patient information as described below. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA Privacy Regulations. The specific description of the patient information to be used or disclosed: Patient's treatment and/or account information.

The following person(s) may receive this patient information:

_____

_____

I authorize Ashland City Dental to release my information to refer me to another Doctor/Specialist office for treatment diagnosed by Dr. James Fleenor.

I authorize the following person(s) to make or use this disclosure: Ashland City Dental Initial: ____

I understand that I may revoke this authorization at any time, and that my revocation is not effective unless it is in writing and received by Ashland City Dental. If I revoke this authorization, my revocation will not affect any actions taken by the dental practice before receiving my written revocation. I understand that I may refuse to sign this authorization, and that my refusal to sign in no way affects my treatment, payment, or eligibility for benefits.

Signature of patient or patient's guardian/representative:

_____ Date: _____

If guardian or representative:

Print name: _____

Relationship to patient: _____

**AGREEMENT TO RECEIVE ELECTRONIC COMMUNICATIONS**

Patient name: _____ Date of Birth: _____

I agree that the dental practice may communicate with me electronically at the email address below and text message any cell number I have provided or will provide in the future.

**I am aware that there is some level of risk that the third parties might be able to read Unencrypted emails/texts.**

I am responsible for providing the dental practice any updates to my email address and cell number. I can withdraw my consent to electronic communications by calling (615-235-5144)

**Please check all that apply:**

____ I give Ashland City Dental permission to **text** me regarding my appointment times, confirmations, rescheduling or any account related communications at the number provided.

____ I give Ashland City Dental permission to **email** me regarding my appointment times, confirmations, rescheduling or any account related communications at the email address provided.

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***ONLY INITIAL THE FOLLOWING IF YOU ARE DECLINING THESE COMMUNICATION METHODS***

____ I **DO NOT** give Ashland City Dental permission to **text** me regarding my appointment times, confirmations, rescheduling or any account related communications at the number provided.

____ I **DO NOT** give Ashland City Dental permission to **email** me regarding my appointment times, confirmations, rescheduling or any account related communications at the email address provided.

Alternate Communications Request (Please tell us the way you would like us to contact you, and/or the address you would like us to use, if you are not wanting text or email communications).

_____

Signature of Patient: _____Date: _____

**For Personal Representatives of the Patient**

Print name of Personal Representative: _____

Relationship to the Patient: _____

## Acknowledgement of Receipt of Notice of Privacy Practices

*You May Refuse to Sign This Acknowledgement*

I have received a copy of this office's Notice of Privacy Practices.

Print Name:_____

Signature:_____

Date:_____

## Acklowledgement of Receipt of HIPAA Policies and Procedures

I have received and reviewed a copy of our dental practice's privacy, security and breach notification policies and procedures.

I understand that I should ask our dental practice's Privacy Official if I have any questions about these policies and procedures.

Print Name:_____

Signature:_____

Date:_____

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### 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 the acklowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)_____