HERMITAGE COSMETIC & IMPLANT DENTISTRY

Patient Information

ID

Chart ID

First Name Last Name Middle Initial

Patient is ☐ Policy Holder ☐ Responsible Party Preferred Name

Responsible Party (if someone other than the patient)

First Name Last Name Middle Initial

Address Address 2

City State Zip Pager

Home Phone Mobile Phone Work Phone Ext

Birth Date Soc. Sec. Driver License

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

PATIENT INFORMATION

Address Address 2

City State Zip Pager #

Home Phone Mobile Phone Work Phone Ext

Sex ☐ Male ☐ Female Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date Soc. Sec. Driver License

E-mail ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status ☐ Full Time ☐ Part Time ☐ Retired Student Status ☐ Full Time ☐ Part Time

Medicaid ID Employer ID Carrier ID

Pref. Dentist Pref. Pharmacy Pref. Hyg.

Section 3

Occupation Employer Who referred you?

PRIMARY INSURANCE INFORMATION

Name of Insured Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec. Insured Birth Date

Employer

Address

Address 2

City, State, Zip

Company Phone Number

Insurance Company

Address

Address 2

City, State, Zip

Rem. Deduct

Rem. Benefits

SECONDARY INSURANCE INFORMATION

Name of Insured Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec. Insured Birth Date

Employer

Address

Address 2

City, State, Zip

Company Phone Number

Insurance Company

Address

Address 2

City, State, Zip

Rem. Deduct

Rem. Benefits

HERMITAGE COSMETIC & IMPLANT DENTISTRY

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 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, please explain	
Have you ever been hospitalized or had a major operation?	☐ Yes ☐ No	If yes, please explain	
Have you ever had a serious head or neck injury?	☐ Yes ☐ No	If yes, please explain	
Are you taking any medications, pills or drugs?	☐ Yes ☐ No	If yes, please explain	
Do you take, or have you taken, Phen-Fen or Redux?	☐ Yes ☐ No	If yes, what?	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	☐ Yes ☐ No	If yes, what?	
Are you on a special diet?	☐ Yes ☐ No	If yes, what?	
Do you use tobacco?	☐ Yes ☐ No	If yes, what?	
Do you use controlled substances?	☐ Yes ☐ No	If yes, what?	

Are you a woman who is... ☐ Pregnant/Trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Other
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics ☐ No Known Allergies

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

☐ 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	

Have you ever had any serious illness not listed above? ☐ 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

Date

Consent / Authorization / Acknowledgment

1. **I authorize Dr. Whitefield and Whitefield Dental, hereafter referred to as "practice," to take necessary radiographs, study models, photos and other diagnostic aids as needed to make a thorough diagnosis.**

2. **I authorize this practice to perform all recommended treatment and agreed upon treatment. I also authorize the use of anesthetics, sedatives and other medication (as needed) and am fully aware that using anesthetic agents involves certain risks.**

HIPAA: Consent for Use and Disclosure of Health Information:

(Notice of privacy practices: You have the right to read this practice's Notice of Privacy Practices before you decide to sign this Consent. Our Notice of Privacy Practices provides a description of our treatment payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. Please read this Notice prior to signing this Consent. This practice reserves the right to change the privacy practices as described in our Notice of Privacy Practices. If changes are made, a revised Notices of Privacy Practices containing the modifications will be issued. These changes may apply to any of your protected health information that we maintain on file. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice at any time by contacting us at 615-889-5545, 4251 Lebanon Pike, Hermitage, TN 37076.

You have the right to revoke this Consent for use and Disclosure of Health Information at any time by giving us written notice of your revocation submitted to the Contact Person listed above. This revoke will not affect previous consent. We reserve the right to provide further treatment on your behalf or that of your dependents if this Consent is revoked.

3. **I have had the opportunity to review and obtain a copy of this practice's Notice of Privacy Practices. I hereby authorize, as indicated by my signature below, to use and disclose my protected health information to carry out treatment, payment activities and health care operations.**

Signatures below indicate that I have read this entire document and fully understand the contents of this Consent/Authorization/Acknowledgment. I have been provided with the opportunity to ask questions and obtain further clarification.

Signature of Patient, Parent or Guardian

Date

Select One: ○ Adult Patient ○ Guardian ○ Personal Representative

If signature provided represents the patient's guardian or "personal representative" please complete the following:

Patient Name (please print)

Date

Financial Policy

Thank you for choosing our office as your dental health care provider. We are committed to providing you with the highest quality lifetime dental care, so that you may fully attain optimum oral health. Please understand that payment of your bill is considered part of your treatment.

Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, Discover, American Express, and HSA. Outside financing is available upon request and approval.

- **Please check if you would like more information about financing options.**
- **Does your insurance have any waiting periods?** ☐ **Yes** ☐ **No** ☐ **I don't know**

Please note: Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance, you will be responsible for any collection and or legal charges incurred. A $30 charge will be billed to the patient for any no show or broken appointments with less than 24 hours notice for an office visit.

Do you have insurance?

- As a courtesy to you, we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you. However, it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible.
- All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer and your insurance company. Our office is not a party to that contract.
- Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payments regardless of any insurance company's arbitrary determination of usual and customary rates.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.
- We ask that you pay the deductible and co-payment, which is the estimated amount not covered by your insurance company, by cash, by check, MasterCard, Visa or Discover at the time we provide the service to you.
- Insurance payments are ordinarily received within 30–60 days from the time of filing. If your insurance company has not made payment within 60 days, we ask that you contact your insurance company to be sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into dispute with your insurance company over any claim.

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our financial policy.

I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office.

Signature of Patient, Parent or Guardian

Date

HERMITAGE COSMETIC & IMPLANT DENTISTRY

Dental History

Please check any of the following problems that apply to you.

- ☐ Sensitivity (hot, cold, sweet)

Where? ☐ UR ☐ UL ☐ LR ☐ LL

- ☐ Headaches, earaches, neck pain
- ☐ Jaw joint pain
- ☐ Teeth or fillings breaking
- ☐ Grinding or clenching teeth
- ☐ Bleeding, swollen or irritated gums
- ☐ Loose, chipped or shifting teeth
- ☐ Bad breath or bad taste in your mouth

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

- ☐ Dentures
- ☐ Partial Dentures
- ☐ Braces
- ☐ Periodontal (gum) treatments

Please share the following dates:

Your last cleaning ____/____

Your last oral cancer screening ____/____

Your last complete X-Rays ____/____

Name of Previous Dentist

City

State

Phone Number

What is the most important thing to you about your future smile and dental health?

If you could whiten your teeth for a cost anyone could afford, would you do it? ☐ Yes ☐ No

Do you smoke or use chewing tobacco? ☐ Yes ☐ No

How much? For how long?

If you could change your smile, you would:

- ☐ Make my teeth brighter
- ☐ Make my teeth straighter
- ☐ Close spaces
- ☐ Replace black metal fillings with natural, tooth-colored fillings
- ☐ Repair chipped teeth
- ☐ Replace missing teeth
- ☐ Replace old crowns that don't match
- ☐ Have a smile makeover

On a scale of 1–10, with 10 being the highest rating:

How important is your dental health to you?

1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ○

Where would you rate your current dental health?

1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ○

Where do you want your dental health to be?

1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ○

Why did you leave your previous dentist?

What is most important to you about your dental visit today?

Signature of Patient, Parent or Guardian

Date of Birth