GREENEVILLE DENTAL ASSOCIATES, P.C.

PATIENT INFORMATION

NAME: _____ PREFERRED NAME/NICKNAME: _____

BIRTH DATE: _____ SS#: _____ ☐ MALE ☐ FEMALE

ADDRESS: _____CITY:_____STATE:_____ZIP:_____

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

EMAIL: _____ MAY WE CONTACT YOU BY TEXT? Y / N

CHECK APPROPRIATE BOX: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED ☐ MINOR

EMPLOYER/SCHOOL: _____ OCCUPATION: _____

SPOUSES NAME: _____ PHONE: _____

EMERGENCY CONTACT: _____ RELATIONSHIP TO PATIENT: _____

EMERGENCY CONTACT PHONE: _____

If someone referred you, please let us know who to thank! How did you hear about us? _____

_____

RESPONSIBLE PARTY INFORMATION

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT? _____

RELATIONSHIP TO PATIENT: ☐ SELF ☐ PARENT ☐ SPOUSE ☐ OTHER _____

ADDRESS: _____ EMAIL: _____

PHONE: _____ ★ **SIGNATURE** OF RESPONSIBLE PARTY: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

YOU MAY REFUSE TO SIGN ACKNOWLEDGEMENT

THE NOTICE OF PRIVACY POLICIES IS LOCATED IN THE LOBBY. COPIES ARE AVAILABLE BY REQUEST.

I authorize this office to leave messages on my answering machine or with a family member. I authorize this office the use of mail reminders. I authorize family members to drop off and pick up things on my behalf. I authorize the release of information (including x-rays) to other doctors/dentist by my request or on behalf of myself. It is understood that if I bring a friend or family member into the facility or ask you to call them, that I agree that you may share my personal information with them. I understand that written notification is required if I request that you treat my information in a manner not listed above or in your privacy policy.

★ **SIGNATURE**: _____ **DATE**: _____

FOR OFFICE USE ONLY

☐ Patient Refused to Sign ☐ Communications barriers prohibited obtaining the acknowledgement. ☐ Other: _____

DENTAL INSURANCE INFORMATION ☐ **Check box if NO dental insurance**

PLEASE PRESENT YOUR CARD TO THE FRONT DESK **(AND)** FILL THIS AREA OUT COMPLETELY

We cannot file Medicare, Medicaid, TennCare or Dental embedded Medical plans

PRIMARY INSURANCE POLICY (Please confirm with your insurance company that this is your primary policy)

NAME OF POLICY HOLDER (THIS WILL NOT ALWAYS BE THE PATIENT): _____

RELATIONSHIP OF POLICY HOLDER TO PATIENT: _____

BIRTHDATE OF INSURED: _____ SS# OF INSURED: _____

EMPLOYED BY: _____ WORK PHONE: _____

INSURANCE COMPANY: _____ (Please present card to be scanned)

IF YOU HAVE SECONDARY INSURANCE, PLEASE CONFIRM WITH YOUR INSURANCE COMPANIES WHICH IS PRIMARY AND WHICH IS SECONDARY. FAILURE TO DO SO WILL DELAY CLAIMS, RESULTING IN OUT OF POCKET EXPENSES

SECONDARY INSURANCE POLICY (Please confirm with your insurance company that this is your secondary policy)

NAME OF SECONDARY POLICY HOLDER: _____ RELATIONSHIP: _____

BIRTHDATE: _____ SS#:_____

EMPLOYED BY: _____ WORK PHONE: _____

INSURANCE COMPANY: _____ (Please present card to be scanned)

INSURANCE POLICY

As your dental care provider, our relationship is with you, the patient, and not your insurance company. Your insurance policy is a contract between you, and your insurance company. As a courtesy to our patients, we will complete insurance forms and submit claims for services provided on your behalf; however, **patients are directly responsible for all incurred charges** – including the ones their insurance does not cover.

As a courtesy to our patients, we provide a recommended treatment plan. This plan includes the **estimated** out-of-pocket expenses for the patient and is not a guarantee of insurance coverage. **The estimated out-of-pocket expense is collected on the day services are rendered.**

Just as each patient is different, each patients' dental insurance plans can also be different. For this reason, you may receive less of a benefit than we estimate for you. You are responsible for knowing what your insurance does and does not cover, and **you are responsible for paying for services your insurance carrier does not cover.**

By signing below, you agree that you have read this section and authorize our office to accept an assignment of benefits from your insurance company.

SIGNATURE: _____ **DATE**: _____

FINANCIAL POLICY

PATIENTS WITHOUT DENTAL INSURANCE

Cost of treatment is due the day service is rendered.

PATIENTS WITH DENTAL INSURANCE

1. Patient is responsible for providing our office with correct and updated insurance information. If we are not given the correct insurance information and are unable to process your claims after 30 days, you will become responsible for the full cost of treatment.
2. **Patient is responsible for knowing their insurance benefits.**
3. Work completed at another office or with a specialist will effect available benefits. Reduced benefits will also impact our estimates. Check with your insurance company to verify frequency limitations and exclusions.
4. **Estimated patient portion is due the day service is rendered.** When a patient chooses to utilize insurance to help pay, we can only **estimate** the balance due to us.
5. All dental insurance plans are not the same or cover the same dental services. If your insurance does not cover a service, **you will be responsible for the non-covered charge.**

ALL PATIENTS

1. For your convenience, we accept cash, check, MasterCard, Visa, Discover, American Express and Care Credit.
2. Our approved payment plan option is Care Credit. Please ask us about Care Credit for more information.
3. Any outstanding balance over 60 days will be charged a yearly 18% APR finance charge. A billing fee of $1.00 will be assessed for each statement sent past 30 days.
4. A fee of $50 is charged for patients who miss or cancel more than 2 times in a 12 month period without a 24 (business) hour notice.
5. There will be a $30 fee charged on all returned checks.

By signing below you agree that you have read this section and accept full financial responsibility for all charges and fees incurred related to any and all services provided. In the event of default of payment on this account or any future accounts you may have, you agree to pay any interest accrued and any legal or court related costs and expenses, including reasonable attorney fees, incurred by Provider related to Provider's exercise of collections rights or other legal remedies.

SIGNATURE: _____ DATE: _____

You may also pre-authorize us to charge your credit card for balances on your account not covered by your insurance company: I authorize Greeneville Dental Associates, P.C. to keep my signature on file and charge my account for balance of charges not paid by insurance within 45 days and not to exceed $_____ for:

☐ All visits this year ☐ recurring charges (ongoing treatments) of $_____ every _____ from _____ to_____

Cardholder name: _____ Billing address: _____

Billing Zip: _____ Card Type: MC ___ Visa ___ Discover ___ AM Express ___ Care Credit ___ Card Exp. Date _____

Card # _____ CVV code: _____

Cardholder Signature: _____ Date: _____

CONSENT

MINOR/CHILD CONSENT (parent or legal guardian MUST be present at child's first appointment!)

I, _____, the legal parent/guardian of _____,

Request and authorize the dental staff to perform necessary dental services for my child, including but not limited to x-rays, local anesthetics and treatment advised by the doctors. If a legal guardian is not present for the visit, I authorize the dentist to make decisions on my behalf. By way of example, but not limited to: changes in the treatment plan, the use of nitrous oxide and/or the type of restoration. (Please discuss preferences beforehand if you are planning on being absent for the visit).

SIGNATURE: _____ DATE: _____

CONSENT TO RELEASE INFORMATION

If you are of age and wish to allow us to speak with another person (ex: spouse, parent, grandparent, child, friend…) on your behalf please complete the section below.

I, _____ request and authorize Greeneville Dental Associates, P.C. to release/discuss information about my health care and accounts to:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

THIS AUTHORIZATION EXPIRES ON _____ OR _____ DAYS AFTER THE DATE IT IS SIGNED; OR WHEN THE FOLLOWING EVENT OCCURS _____. Permission may be revoked or amended at any time by written request.

SIGNATURE of patient or patient's authorized representative: _____

Relationship if signed by parent, legal guardian, etc.: _____

DATE of signature: _____

MEDICAL HISTORY

MEDICATIONS

Please list all current medications: (you may alternately provide us with a list and we will scan it for you).

_____

_____

Preferred Pharmacy: _____ Pharmacy phone: (____) _____

ALLERGIES

Do you have any Allergies to: ☐ Penicillin ☐ Latex ☐ Acrylic ☐ Local Anesthetics

☐ Food ☐ Aspirin ☐ Codeine ☐ Metals (Earrings)

Please list any other Allergies: _____

Are you now under the care of a physician? ☐ Yes ☐ No

If yes, please explain: _____

Name of physician: _____ Phone: _____

- Have you been advised by your physician to take any type of pre-medication before dental treatment due to a pre-existing medical condition? ☐ Yes ☐ No

- Women: Are you pregnant? (No Nitrous) ☐ Yes ☐ No Due date: _____

  Trying to get pregnant? ☐ Yes ☐ No

Do you have, or have you had, any of the following? Please indicate the year if it was in the past.

*** May need Pre-Med (N) May not use N2O**

☐ AIDS/ HIV Positive	☐ Alcoholism	☐ Alzheimer's Disease
☐ Anaphylaxis	☐ Anemia N	☐ Arthritis/ Gout
☐ Artificial Heart Valve *	☐ Artificial Joint	☐ Asthma- Do you take Theophylline- No E-mycin (N)
☐ Breast Implants	☐ Bronchiectasis (N)	☐ Cancer/Cancer Treatment (Radiation/Chemotherapy)
☐ Cardiac Stent (past 12 months)	☐ Chronic Bronchitis- Do you take Theophylline- No E-mycin (N)	
☐ Chronic Obstructive Pulmonary Disease (COPD) (N)		☐ Claustrophobia (N)
☐ Cold Sores/Fever Blisters	☐ Congenital Heart Disorder *	☐ Congestive Heart Failure (N)
☐ Diabetes	☐ Drug Addiction	☐ Emphysema (N)
☐ Endocarditis in Past *	☐ Epilepsy or Seizures	☐ Fainting Spells/Dizziness
☐ Fibromyalgia	☐ Glaucoma	☐ Heart Attack/Failure
☐ Heart Trouble/Disease	☐ Hemophilia (Bleeding Disorders)	☐ Hepatitis A, B or C (which one) _____ (N)
☐ Herpes	☐ HPV	☐ Immune Diseases (N)
☐ Inflammatory Bowel Disease (Crohn's or Ulcerative Colitis)		☐ Joint Replacement (past 2 years or complications) *
☐ Kidney Disease (Dialysis)	☐ Lasix Eye Surgery (Past 2 months) (N)	☐ Liver Disease (Cirrhosis)
☐ Lupus	☐ Macrocytic Anemia (N)	☐ Middle Ear Infection (N)
☐ Organ Transplant	☐ Osteoporosis	☐ Pacemaker
☐ Psychiatric Care	☐ Respiratory Diseases (N)	☐ Rheumatoid Arthritis
☐ Seizures-Do you take Tegretol (Carbamazinepine)-No E-mycin		☐ Shingles
☐ Sickle Cell Disease	☐ Sjogren's Syndrome	☐ Stroke
☐ Tuberculosis (TB) (N)	☐ Trigeminal Neuralgia-Do you take Tegretol (Carbamazepine)- No E-mycin	

Are you taking or have you ever taken any of the following? Please list medication if applicable.

☐ Monoamine Oxidase Inhibitors (No EPI) ☐ Tricyclic Antidepressants (No EPI) ☐ Phen-Fen or Redux * ☐ Illegal Substances
☐ Controlled Substances ☐ Cigarettes ☐ Triazolam ☐ Steroids ☐ Chewing Tobacco

Please list drug and approximate dates if taking or did take any of the above: _____

_____

Bisophosphonates (bone strengthening drugs): (for example)

☐ Zometa (Zoledronic Acid) ☐ Aredia (Pamidronate) ☐ Fosamax (Alendronate) ☐ Actonel (Risedronate)
☐ Didronel (Etidronate) ☐ Reclast (Zoledronic Acid) ☐ Skelid (Tiludronate) ☐ Boniva (Ibandronate)
☐ Ostac (Clodronate) ☐ Aclasta ☐ Atlevia ☐ Binosto
☐ Other: _____

Blood Thinners / Antiplatelet Drugs: (for example)

☐ Aspirin ☐ Ticlopidine ☐ Plavix (Clopidogrel) ☐ Effient
☐ Aggrenox ☐ Pletal (Cilostazol) ☐ Ticlid (Ticlopidine HCl) ☐ Tricagelor (Brillanta)
☐ Dipyridamote (Persantine) ☐ Other: _____

Anticoagulants: (for example)

☐ Heparin ☐ Warfarin (Coumadin) ☐ Pradaxa (Dabigatran Etexilate)
☐ Eliquis (Apixaban) ☐ Phenindione ☐ Xarelto (Rivaroxaban)
☐ Other: _____

Beta Blockers: (for example)

☐ Propranolol (Inderal) ☐ Alprenolol (Gubernal) ☐ Acebutolol (Sectral) ☐ Betaxolol (Kerlone)
☐ Bisoprolol (Zebeta) ☐ Atenolol (Tenormin) ☐ Bisoprolol / HCTZ (Ziac) ☐ Corey (Carvedilol)
☐ Normodyne/Trandate (Labetolol hydrochloride) ☐ Metaprolol (Lopressor / Toprol XL)
☐ Sotalol (Betapace) ☐ Other: _____

Do you have any health problems that need further clarification? ☐ Yes ☐ No

If yes, please explain: _____

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 Greeneville Dental Associates, P.C. of any changes in medical status.

★ **Signature of Patient or Guardian: _____Date: _____**