****

**PATIENT INFORMATION**

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PREFERRED NAME/NICKNAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

BIRTH DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  MALE  FEMALE

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CITY:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_STATE:\_\_\_\_\_\_ZIP:\_\_\_\_\_\_\_\_\_

HOME PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CELL PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WORK PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMAIL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CHECK APPROPRIATE BOX:  SINGLE  MARRIED  DIVORCED  SEPARATED  WIDOWED  MINOR

EMPLOYER/SCHOOL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_ OCCUPATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMERGENCY CONTACT PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SIGNATURE** OF RESPONSIBLE PARTY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DENTAL INSURANCE INFORMATION**

PLEASE PRESENT YOUR CARD TO THE FRONT DESK

**\*We cannot file Medicare, Medicaid, TennCare or Blue Advantage\***

**Check box if NO dental insurance**

**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. Any outstanding balance over 60 days will be charged a yearly 18% APR finance charge. A billing fee of $2.00 will be assessed for each statement sent past 30 days.
3. A fee of $50 is charged on accounts who miss or cancel Hygiene appointments without a 24 hour notice.
4. A fee of $75 is charged on accounts who miss or cancel appointments with the Doctor without a 24 hour notice.
5. A deposit of $50 will be asked of accounts who miss multiple appointments. Habitual broken appointments will result in dismissal from the practice.
6. Accounts who are turned over to collections are dismissed from the practice.
7. 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ALL PATIENTS: 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Relationship if signed by parent, legal guardian, etc.: \_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY**

**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 (other than primary care)? 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.**

**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: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 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 HCI)  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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**