AFFORDABLE DENTAL

1833 Memorial Drive
Clarksville, TN 37043
Phone: 931-645-8575
Fax: 931-645-8120

PATIENT INFORMATION

First Name______________________________ Middle Initial___________ Last________________________________

Preferred Name_________________________ Birthdate______________________ SS#_______-_______-_______

Address____ Apartment #___________________

City______________________________________ State_________ Zip___________ Male_______/Female_______

____Single ____Married ____Widowed ____Separated ____Divorced ____Minor ____Partnered for (_____) Yrs

Home#______________________ Cell#__________________________ Email_______________________________

Employer____________________________________ Employer Phone #____________________________________

Emergency Contact______________________________________ Phone#___________________________________

Preferred Pharmacy_____________________________________ Phone #___________________________________

If Patient is a minor: Mother's Name _____________________________ Father's Name_______________________

Referred by: Friend_______________ Social Media______________ Insurance_____________ Other___________

INSURANCE INFORMATION

Primary Insured_______________________________________ Relation to Patient___________________________

Birthdate___________________ SS#_______-_______-_______ Insurance Company_________________________

Subscriber ID______________________ Phone#_____________________________ Group#___________________

Employer Name___________________________ Phone#________________________ Is there a second ins?_____

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DENTAL HISTORY

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

_____ Sensitivity (hot, cold, sweet) UR UL LR LL
_____ Headaches, earaches, neck pain
_____ Jaw joint pain
_____ Teeth or fillings breaking
_____ Grinding or clenching teeth
_____ Loose, tipped or shifting teeth
_____ Bad breath

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

_____ Dentures
_____ Partial Dentures
_____ Braces
_____ Periodontal (gum) treatments

If I could change my smile, I would:

_____ Make my teeth whiter
_____ Make my teeth straighter
_____ Close Spaces
_____ Replace black metal fillings with tooth colored restorations
_____ Repair chipped tooth
_____ Replace missing tooth
_____ Replace old crowns that do not match
_____ Have a smile makeover

On a scale of 1-10, 10 being the highest

How important is your dental health?
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

Please share the following dates:

Last cleaning & x-rays:______________ Last oral cancer screening:________________
Have you had your wisdom teeth REMOVED:_______________
Name of previous dentist:_______________________________________ Phone:___________________________
Why did you leave your previous dentist:____
What is the most important thing to you about your Future smile & dental health:_________________________
____

_____ ***I authorize payment of insurance benefits to Affordable Dental Inc. and authorize the release of my personal health/benefit information from my insurance company to Affordable Dental Inc.***

____ ___________________________
Signature of Patient/Parent or Guardian Date

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

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.

Question	Answer	
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	
Do you use tobacco?	○ Yes ○ No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

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

Other?	☐	If yes
Do you use controlled substances?	○ Yes ○ No	If yes

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

Condition	Answer	Condition	Answer	Condition	Answer	Condition	Answer
AIDS/HIV Positive	○ Yes ○ No	Cortisone Medicine	○ Yes ○ No	Hemophilia	○ Yes ○ No	Radiation Treatments	○ Yes ○ No
Alzheimer's Disease	○ Yes ○ No	Diabetes	○ Yes ○ No	Hepatitis A	○ Yes ○ No	Recent Weight Loss	○ Yes ○ No
Anaphylaxis	○ Yes ○ No	Drug Addiction	○ Yes ○ No	Hepatitis B or C	○ Yes ○ No	Renal Dialysis	○ Yes ○ No
Anemia	○ Yes ○ No	Easily Winded	○ Yes ○ No	Herpes	○ Yes ○ No	Rheumatic Fever	○ Yes ○ No
Angina	○ Yes ○ No	Emphysema	○ Yes ○ No	High Blood Pressure	○ Yes ○ No	Rheumatism	○ Yes ○ No
Arthritis/Gout	○ Yes ○ No	Epilepsy or Seizures	○ Yes ○ No	High Cholesterol	○ Yes ○ No	Scarlet Fever	○ Yes ○ No
Artificial Heart Valve	○ Yes ○ No	Excessive Bleeding	○ Yes ○ No	Hives or Rash	○ Yes ○ No	Shingles	○ Yes ○ No
Artificial Joint	○ Yes ○ No	Excessive Thirst	○ Yes ○ No	Hypoglycemia	○ Yes ○ No	Sickle Cell Disease	○ Yes ○ No
Asthma	○ Yes ○ No	Fainting Spells/Dizziness	○ Yes ○ No	Irregular Heartbeat	○ Yes ○ No	Sinus Trouble	○ Yes ○ No
Blood Disease	○ Yes ○ No	Frequent Cough	○ Yes ○ No	Kidney Problems	○ Yes ○ No	Spina Bifida	○ Yes ○ No
Blood Transfusion	○ Yes ○ No	Frequent Diarrhea	○ Yes ○ No	Leukemia	○ Yes ○ No	Stomach/Intestinal Disease	○ Yes ○ No
Breathing Problems	○ Yes ○ No	Frequent Headaches	○ Yes ○ No	Liver Disease	○ Yes ○ No	Stroke	○ Yes ○ No
Bruise Easily	○ Yes ○ No	Genital Herpes	○ Yes ○ No	Low Blood Pressure	○ Yes ○ No	Swelling of Limbs	○ Yes ○ No
Cancer	○ Yes ○ No	Glaucoma	○ Yes ○ No	Lung Disease	○ Yes ○ No	Thyroid Disease	○ Yes ○ No
Chemotherapy	○ Yes ○ No	Hay Fever	○ Yes ○ No	Mitral Valve Prolapse	○ Yes ○ No	Tonsillitis	○ Yes ○ No
Chest Pains	○ Yes ○ No	Heart Attack/Failure	○ Yes ○ No	Osteoporosis	○ Yes ○ No	Tuberculosis	○ Yes ○ No
Cold Sores/Fever Blisters	○ Yes ○ No	Heart Murmur	○ Yes ○ No	Pain in Jaw Joints	○ Yes ○ No	Tumors or Growths	○ Yes ○ No
Congenital Heart Disorder	○ Yes ○ No	Heart Pacemaker	○ Yes ○ No	Parathyroid Disease	○ Yes ○ No	Ulcers	○ Yes ○ No
Convulsions	○ Yes ○ No	Heart Trouble/Disease	○ Yes ○ No	Psychiatric Care	○ Yes ○ No	Venereal Disease	○ Yes ○ No
						Yellow Jaundice	○ Yes ○ No

Have you ever had any serious illness not listed	○ 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:

X______________________________ Date:__________

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Acknowledgement of Receipt of Notice/Guarantee of Payment

I give Affordable Dental, Inc. my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.

I have been informed that I may review Affordable Dental, Inc.'s Notice of Privacy Practices (for a more complete description of the uses and disclosures) before signing this consent.

I understand that Affordable Dental, Inc. has the right to change their privacy practices and that I may obtain any revised notices at the practice/clinic.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that Affordable Dental, Inc. is not required to agree to the request. If Affordable Dental, Inc. agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time by written request with the exception of information that was previously used or disclosed.

I understand that my estimated co-pay(s)/deductible are due in full at each appointment.

I understand that if I am not prepared to pay my estimated portion in full at the time services are rendered, I will need to reschedule my appointment.

I understand that the amount expected from my insurance, as well as myself, is an estimate. I understand that I am responsible for any amount not covered by my insurance company.

I understand that the benefit information obtained by this office from my insurance company is an estimate and NOT a guarantee of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance if applicable.

I authorize the use of my signature on all insurance submissions.

In the case of defaulted payment, I promise to pay any legal interest on the balance due together with any collection costs, court cost, and reasonable attorney fees incurred to effect collection on the account.

____ _____________________

Signature of patient, guardian or personal representative Date

____

Signature of patient, guardian or personal representative

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MISSED APPOINTMENT POLICY

We want to take this opportunity to thank you for allowing us to be your preferred dental office. We know that you have many choices and are grateful you chose us!

Effective Immediately:

1. All missed appointments will be subject to a $25 fee. Appointments must be rescheduled/cancelled at least **48** hours prior to the original appointment time to allow our office time to fill the space. This helps us keep our costs lower and keep space for emergency patients. We understand that life happens, schedules change and we strive to give you plenty of notice of upcoming appointments in case there are any changes you may need to make.
2. ***Any patient who is more than 10 minutes late will be asked to reschedule their appointment.*** Our last appointments for the day begin at 3:00 PM. Therefore, all 3:00 PM appointments must be on time otherwise the appointment will have to be rescheduled.
3. After ***3*** missed appointments (appointments that are not rescheduled/cancelled with advance notice) patients may be subject to dismissal. Families who have scheduled bulk appointments must adhere to the cancellation policy or only ***one*** appointment will be scheduled in any given day going forward.
4. Any unconfirmed appointments are subject to possible rescheduling in the event of emergency patients. Please make every effort to confirm appointments by calling the office at 931-647-8575
5. ***Any Tenncare Patient that does not give a 48 Hour notice of cancellation will be reported to their insurance company possibly leading in termination of dental insurance.***

Scheduling is a very important part of our daily practice. We strive to appreciate and respect the time our patients take to be in our office and try to keep to the schedule as much as possible. We are simply asking that our schedule be respected as well. We look forward to serving you throughout the years to come. Please feel free to contact the office if you have any questions.

______________________________________ ________________________

Signature of Patient/Parent or Guardian Date

We appreciate the opportunity to serve you and look forward to seeing your bright smile for many years to come!

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Notice of Privacy Practices

The privacy of your health information is extremely important to us. We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you notice about our privacy practices, our legal duties and your rights concerning your health information.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

USES AND DOSCLOSURES OF HEATLH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations i.e.:

Treatment: We may use or disclose your health information to a physician or other healthcare providers.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operation: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating the practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it at any time in writing. Your revocation will not affect any use or disclosures permitted while the previous authorization was in effect. Unless you give us a written authorization, we cannot disclose your health information for any reason except those described in this notice.

To Your Family & Friends: We must disclose your health information to you, as described in the Patient Rights section of this notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree we may do so.

Persons Involved In Care: We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgement disclosing only health information that is directly relevant to the person's involvement I your healthcare. We will also use our professional judgement and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written permission.

Required By Law: We may use or disclose your health information when we are required by law to do so.

Abuse Or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to the military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, post cards, or letters).

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PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies a format other than photocopies. We will use the format that you request unless we cannot practicably do so. You must make the request for this information in writing. You will be charged a reasonable cost-based fee for expenses such as copies and staff time. Requested copies will be charged at $0.10 per page and $10 per hour for staff time (total will be determined at time of service) to copy your health information and postage if you want the copies mailed.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities. If you request this information more than once in a 12 month period, you may be charged a reasonable fee for them.

Restriction: You may request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these restrictions.

Amendment: You have the right to request that we amend your health information. Such requests must be in writing and must explain why information should be amended. Under certain circumstances this request may be denied.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us at 931-645-8575.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information, you may complain to use using the contact information listed in this notice. You may also submit a written complaint to the O.S. Department of Health and Human Services. We support your right to the privacy of your health information. We will not retaliate in anyway if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

U.S. Department of Health and Human Services
Attn: Roosevelt Freeman, Regional Manager, Office for Civil Rights
Sam Nunn Atlanta Federal Center, Ste 16T70
61 Forsyth Street S.W.
Atlanta, GA 30303—8909

____ ____________________

Signature of Patient/Parent or Guardian Date

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HIPAA AUTHORIZATION

This document is written to allow a patient to choose who Affordable Dental Inc. may discuss their treatment history, treatment options, financials and appointments with if the patient is 18 years of age and over. This authorization ensures compliance with all HIPAA and OSHA guidelines.

Affordable Dental Inc. has the permission to discuss any treatment history, treatment options, financial obligations and appointments with the parties listed at the end of the document.

At any time the patient has the right to revoke these permissions in writing.

Patient's Signature:_______________________________________ Date:________________

List of person(s) allowed to receive information:

____

____

____

Staff Witness ____ Date:___________________