Patient Information

Welcome to Art of Dentistry! We will always do our best to earn the trust that you have placed in us. Please fill out these forms.

Personal Information

Patient's Full Name: ______________________ Preferred name: ______________________

( ) Male ( ) Female ( ) Single ( ) Married

Date of Birth: ______________________

Please check the best number to reach you at:

Address: ______________________ Cell Phone: ______________________ ☐

City/State/Zip: ______________________ Home Phone: ______________________ ☐

Social Security #:______________________ Work Phone: ______________________ Ext______ ☐

Spouse's Name: ______________________ I can receive text messages ☐ Yes ☐ No

E-mail: ______________________ I can receive emails ☐ Yes ☐ No

Emergency Contact ______________________ Emergency Phone # ______________________

How did you hear about us, or whom may we thank for referring you? ______________________

What is the name of your previous dentist? ______________________

If the patient is a minor, fill out the following information for the parent or guardian:

Name: ______________________ Relationship to Patient: ______________________

Address: ______________________ Home Phone #: ______________________

City/State/Zip: ______________________ Cell Phone #: ______________________

E-mail: ______________________ I can receive texts ☐ Yes ☐ No

I can receive emails ☐ Yes ☐ No

Insurance Information for Policy Holder

Name of Policy Holder: ______________________ Policy Holder's Date of Birth: ______________________

Social Security #: ______________________ Member ID: ______________________

Name of Insurance Co: ______________________ Group #: ______________ Effective Date: __________

Name of Employer: ______________________ Plan Name or #: ______________________

If you have additional Insurance please complete the following information for the Policy Holder:

Name of Policy Holder: ______________________ Policy Holder's Date of Birth: ______________________

Social Security #: ______________________ Member ID: ______________________

Name of Insurance Co: ______________________ Group #: ______________ Effective Date: __________

Name of Employer: ______________________ Plan Name or #: ______________________

Employment/Student Information

Occupation: ______________________ Business Phone: ______________________

Employer Name: ______________________ Work Address: ______________________

If Student, Grade & School Name: ______________________ City/State/Zip: ______________________

____

______________________ ______________________

Patient's (Guardian's) Signature Date

Patient Name: ______________________________

Date of Birth: ______________________________

Date: ______________________________

MEDICAL HISTORY

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 If Yes: ______________________________

Do you use tobacco? ☐ Yes ☐ No If Yes: ______________________________

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? ☐ Yes ☐ No If Yes: ______________________________

Do you use controlled substances? ☐ Yes ☐ No If Yes: ______________________________

Do you have, or have you had, any of the following? Check any that apply

AIDS/HIV Positive	☐	Cortisone Medicine	☐	Hemophilia	☐	Radiation Treatments	☐
Alzheimer's Disease	☐	Diabetes	☐	Hepatitis A	☐	Recent Weight Loss	☐
Anaphylaxis	☐	Drug Addiction	☐	Hepatitis B or C	☐	Renal Dialysis	☐
Anemia	☐	Easily Winded	☐	Herpes	☐	Rheumatic Fever	☐
Angina	☐	Emphysema	☐	High Blood Pressure	☐	Rheumatism	☐
Arthritis/Gout	☐	Epilepsy or Seizures	☐	High Cholesterol	☐	Scarlet Fever	☐
Artificial Heart Valve	☐	Excessive Bleeding	☐	Hives or Rash	☐	Shingles	☐
Artificial Joint	☐	Excessive Thirst	☐	Hypoglycemia	☐	Sickle Cell Disease	☐
Asthma	☐	Fainting Spells/Dizziness	☐	Irregular Heartbeat	☐	Sinus Trouble	☐
Blood Disease	☐	Frequent Cough	☐	Kidney Problems	☐	Spina Bifida	☐
Blood Transfusion	☐	Frequent Diarrhea	☐	Leukemia	☐	Stomach/Intestinal Disease	☐
Breathing Problems	☐	Frequent Headaches	☐	Liver Disease	☐	Stroke	☐
Bruise Easily	☐	Genital Herpes	☐	Low Blood Pressure	☐	Swelling of Limbs	☐
Cancer	☐	Glaucoma	☐	Lung Disease	☐	Thyroid Disease	☐
Chemotherapy	☐	Hay Fever	☐	Mitral Valve Prolapse	☐	Tonsillitis	☐
Chest Pains	☐	Heart Attack/Failure	☐	Osteoporosis	☐	Tuberculosis	☐
Cold Sores/ Fever Blisters	☐	Heart Murmur	☐	Pain in Jaw Joints	☐	Tumors or Growths	☐
Congenital Heart Disorder	☐	Heart Pacemaker	☐	Parathyroid Disease	☐	Ulcers	☐
Convulsions	☐	Heart Trouble/Disease	☐	Psychiatric Care	☐	Venereal Disease	☐
						Yellow Jaundice	☐

Other serious illness not listed above: ____

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 Date

Financial Policy

It is our goal to keep prices as low as possible. If you have insurance, we will file it for you. If you do not have insurance, we accept cash and all major credit/debit cards. We will accept checks only from established patients.

Regarding Insurance:
Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We accept assignment of insurance benefits after you furnish us with your full insurance information and this is verified by your insurance carrier. Your deductible and patient portion are due at the time of service. Some of the services provided may be a non-covered service and not considered necessary by your dental carrier. You are responsible for payment of any insurance company's arbitrary determination of usual and customary rates. If the patient is a minor, the adult accompanying a minor patient is responsible for payment in full.

Assignment of Insurance Benefits:
I hereby authorize payment directly to Art of Dentistry and its dental providers for the dental service benefits otherwise payable to me. PLEASE INITIAL ___________________________

I understand that, although Art of Dentistry will do all that is in their power to present to me estimates that are as accurate as possible, any quote given to me, in person, in writing, over the phone, or in any form of communication used by Art of Dentistry will only be an estimate based on the information provided to them by my insurance carrier.

PLEASE INITIAL ___________________________

I understand that if performed dental services are not under contract with my insurance carrier or I have met my contract limitations, I am responsible for payment of the full balance due.

PLEASE INITIAL ___________________________

Missed Appointments:
We ask that you give us 24 hours advance notice for any cancelled appointment. Once two scheduled appointments have been missed without the request advance notification, we will require you to pay for the appointment in advance before we can schedule you another appointment. We reserve the right to deny any future scheduling of appointments due to repeatedly missed, cancelled, or late appointments.

PLEASE INITIAL ___________________________

Unpaid Balances:
If your account becomes past due, we will take necessary steps to collect this debt. I understand that any attorney fees, court costs, and collection fees become my responsibility and will be added to my account, should it become necessary. Returned checks will be subject to a $25.00 fee per occurrence. Finance charges of 1.5% per month will be imposed on the unpaid balance after your account has gone 30 days past due.

PLEASE INITIAL ___________________________

Credit History:
If your account were to become past due, we have the option to check your credit history and to report your account history to any credit reporting agency such as a credit bureau.

PLEASE INITIAL ___________________________

I have read the Financial Policy and I understand and agree to this policy.

_____________________________ _____________________

Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

Art of Dentistry
5913 Main St., Suite 101
Ooltewah, TN 37363

Acknowledgement

I, ____________________________________, hereby acknowledge that I have been given the opportunity to review a copy of **Art of Dentistry's** *HIPAA Notice of Privacy Practices*.

I understand that **Art of Dentistry's** *HIPAA Notice of Privacy Practices* may change periodically and that I am entitled to receive a copy of **Art of Dentistry's** revised *HIPAA Notice of Privacy Practices* upon request.

I understand that, if I have questions about **Art of Dentistry's** *HIPAA Notice of Privacy Practices*, I may contact **Heidi Lopez at 423-362-1962**.

I understand that it is my right to refuse to sign this Acknowledgement should I so choose, and that **Art of Dentistry** will not refuse treatment to me if I refuse to sign this Acknowledgement.

I further understand that I may contact the Secretary of the U.S. Department of Health and Human Services should I have concerns regarding **Art of Dentistry's** privacy policies and procedures.

________________________________	________________________________
Patient Signature	Date
________________________________	________________________________
Signature of Guardian (if patient underage)	Print Name of Guardian
	________________________________
	Relationship to Patient

FOR OFFICE USE ONLY

Art of Dentistry made a good-faith effort to obtain Acknowledgement, from the patient noted above, of receipt of its *HIPAA Notice of Privacy Practices*. In spite of these efforts, **Art of Dentistry** was unable to obtain a signed Acknowledgement for the following reason(s):

- o Refusal to sign Acknowledgement on ____________________________, 20______.
- o Communications barriers prohibited us from obtaining a signed Acknowledgement.
- o An emergency situation prohibited us from obtaining a signed Acknowledgement.
- o Other (Describe):____

Date Received	By	Patient ID

Media Release Form

I, ____, hereby consent that photographs and/or video pictures can be taken of me and used by Art of Dentistry or any authorized agent of Art of Dentistry for the following purposes:

- For inclusion in my dental records. ☐ Yes ☐ No
- For any purpose of illustration, teaching, publication in dental journals, or for any other dental purpose deemed appropriate by my dentist. ☐ Yes ☐ No
- Use on social media sites to demonstrate final outcomes. ☐ Yes ☐ No
- Law enforcement requests. ☐ Yes ☐ No
- Publicity or ad campaigns. ☐ Yes ☐ No

Signature ____________________________________ Date _______________________________