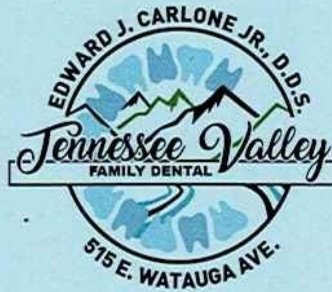

Patient Registration:

Patient Information:

First Name:______________________ Last:______________________ MI:___
Email Address:______________________ Preferred Name:______________________
Birth Date:______________________ SS#:______________________
Male ☐ Female ☐
Address:____ Apt #:________
City:______________________ State:__________ Zip:______________
Home #:______________ Cell #:______________ Work #:______________
Referred By: ____
Marital Status: Married Single Widowed Divorced
Emergency Contact:______________________ Phone #:______________

Responsible Party:

(If the patient is younger than 18 years old)
First Name:______________________ Last:______________________ MI:___
Birth Date:______________________ SS#:______________________
Address:____ Apt #:________
City:______________________ State:__________ Zip:______________
Home #:______________ Cell #:______________ Work #:______________

Dental Insurance Information:

As a courtesy to our insured patients, we will submit claims to your insurance company. We will help you to receive your maximum allowable benefits, but we can NOT guarantee payment from them. In order to do this we need your insurance card and/or insurance policy with you on your first visit of every calendar year. (Your insurance year may not run January-December)
If your insurance has not paid within 60 days, you may need to contact your insurance company or employer. The insured and/or employer through whom the policy was purchased, has a better ability to deal with the insurance company, as they are the client of the insurance company.

Policy Holder: ______________________ Insurance Company: ______________________
Policy Holder DOB: ______________ Policy Holder SS#: ______________________
Group #: ______________________ Member ID #: ______________________
Employer: ____

Authorization/Release Information:

Information release: I have reviewed the treatment plan and I authorize the release of any information relating to this claim including x-rays, study models, photographs.
I hereby authorize release of any information to the insurance company.

X____
Signature of patient or parent if minor   Date

Tennessee Valley Family Dental
Medical History

Patient Name:________________ **Birth Date:**________ **Today's Date:**________

Previous Dentist:________________ **Date Last Visited:**________

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 taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?
○Yes ○No If Yes:________________

Have you ever been told to pre-medicate for dental work? ○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 ○Codeine ○Penicillin ○Acrylic
○Metal ○Sulfa Drugs ○Latex ○Local Anesthetics
○Other: ________________

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

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
AIDS/HIV Positive	○Yes	○No	Hives or Rash	○Yes	○No	Cancer	○Yes	○No
Alzheimer's Disease	○Yes	○No	Hypoglycemia	○Yes	○No	Chemotherapy	○Yes	○No
Anaphylaxis	○Yes	○No	Kidney Problems	○Yes	○No	Chest Pains	○Yes	○No
Anemia	○Yes	○No	Stomach/Acid Reflux	○Yes	○No	Congenital Heart Disorder	○Yes	○No
Angina	○Yes	○No	Stroke	○Yes	○No	Mental Illness	○Yes	○No
Epilepsy or Seizures	○Yes	○No	Swelling of Limbs	○Yes	○No	Radiation Treatments	○Yes	○No
Excessive Bleeding	○Yes	○No	Thyroid Disease	○Yes	○No	Recent Weight Loss	○Yes	○No
Excessive Thirst	○Yes	○No	Tonsillitis	○Yes	○No	Rheumatic Fever	○Yes	○No
Fainting Spells/Dizziness	○Yes	○No	Tuberculosis	○Yes	○No	Arthritis	○Yes	○No
Frequent Cough	○Yes	○No	Tumors or Growths	○Yes	○No	Artificial Heart Valve	○Yes	○No
Leukemia	○Yes	○No	Ulcers	○Yes	○No	Artificial Joint	○Yes	○No
Liver Disease	○Yes	○No	Hemophilia	○Yes	○No	Asthma	○Yes	○No
Low Blood Pressure	○Yes	○No	Hepatitis A	○Yes	○No	Blood Disease	○Yes	○No
Mitral Valve Prolapse	○Yes	○No	Hepatitis B or C	○Yes	○No	Frequent Headaches	○Yes	○No
Osteoporosis	○Yes	○No	Cold Sores	○Yes	○No	Glaucoma	○Yes	○No
Pain In Jaw Joints	○Yes	○No	High Blood Pressure	○Yes	○No	Heart Attack/Failure	○Yes	○No
Cortisone Medicine	○Yes	○No	Scarlet Fever	○Yes	○No	Heart Murmur	○Yes	○No
Diabetes	○Yes	○No	Shingles	○Yes	○No	Heart Pacemaker	○Yes	○No
Drug Addiction	○Yes	○No	Sinus Trouble	○Yes	○No	Heart Trouble/Disease	○Yes	○No
Emphysema/COPD	○Yes	○No	Blood Transfusion	○Yes	○No	Use of Tobacco Products	○Yes	○No
High Cholesterol	○Yes	○No	Blood Thinners	○Yes	○No			

Have you ever had any serious illness Not listed above? ○Yes ○No
If Yes: ________________

Medication List:

____

____

____

____

X ________________

Signature of patient or parent if minor Date

Financial Responsibility:

Fees for professional services are charged directly to the patient and the patient is personally responsible for payment. We will prepare necessary forms to assist in obtaining your insurance benefits. We do not render our services on the basis that insurance companies will pay our fees. I understand that I am responsible for all charges that may be incurred.

I understand that if I fail to keep this account current, the office may be unable to provide additional dental services or I may need to prepay for additional services. If I default on payment, I agree to pay all fees associated with collection of the outstanding balance, including but not limited to, attorney fees and court costs.

In order to serve you better and keep the cost of dental care down, we try to maintain an efficient appointment system. However, our cost of providing care increases greatly when people fail to keep scheduled appointments or cancel at the last minute. We require at least a 24 hour notice for any canceled appointments. It is our policy to charge a missed appointment fee of $60 after the second missed or canceled appointment. Multiple broken appointments without a cancellation notice can result in a dismissal from the office.

X ____

Signature of patient or parent if minor Date

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) required the Secretary of the U.S. Department of Health and Human Services (HHS) to develop regulations protecting the privacy and security of certain health information. To fulfill this requirement, HHS published what is commonly known as the HIPAA Privacy Rule and the HIPAA Security Rule. The Privacy Rule, or Standards for Privacy of Individually Identifiable Health Information, establishes national standards for the protection of certain health information. The Security Standards for the Protection of Electronic Protected Health Information (the Security Rule) establish a national set of security standards for protecting certain health information that is held or transferred in electronic form.

ACKNOWLEDGMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of this Dental Practice's HIPAA Notice of Privacy Practices.

______________________________ ______________________________

Patient Name (Please Print) Patient Signature Date

OR

____

Signature of Personal Representative

Authority of Personal Representative: □Parent □Guardian □Power of Attorney □Other

____

Persons authorized to access information for this patient