Southeastern Dental

MADISON OFFICE
117 Gallatin Pike N, Madison, TN 37115
Phone: (615) 868-6177 Fax: (615) 868-8863

MT. JULIET OFFICE
631 S. Mt. Juliet Rd, Mt. Juliet, TN 37122
Phone: (615) 754-6677 Fax: (615) 773-5002

PATIENT INFORMATION

Name: _____ Preferred Name: _____ Gender: M ☐ F ☐

Address: _____ City/State/Zip: _____

Home phone: (____) _____ Work phone: (____) _____ Cell phone: (____) _____

Email: _____ Best time to reach you: _____

Preferred contact method: Email ☐ Text message ☐ Phone call ☐ Other ☐ _____

DOB: _____ Age: _____ SSN#: _____

Employer: _____ Occupation: _____

Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐

Spouse's name: _____ Preferred name: _____

Work phone: (____) _____ Cell phone: (____) _____ Email: _____

DOB: _____ Age: _____ SSN#: _____

Spouse's occupation: _____ Employer: _____

Who may we thank for referring you? _____

RESPONSIBLE PARTY

(If someone other than the patient is responsible for the account)

Relationship to Patient: Self ☐ Spouse ☐ Parent ☐ Other ☐ _____

Name: _____ Phone: (____) _____

Address: _____ City/State/Zip: _____

Employer: _____ Work phone: (____) _____ SSN#: _____

INSURANCE INFORMATION

Name of insured: _____ DOB: _____ SSN#: _____

Relationship to Patient: Self ☐ Spouse ☐ Child ☐ Other ☐ _____

Insurance company: _____ Grp #: _____ ID#: _____

Insurance Company Address: _____ Ins Co. Phone: (____) _____

Do You Have HealthSpring Insurance? _____

Is there secondary insurance coverage? Y ☐ N ☐

Name of insured: _____ DOB: _____ SSN#: _____

Relationship to Patient: Self ☐ Spouse ☐ Child ☐ Other ☐ _____

Insurance company: _____ Grp #: _____ ID#: _____

Insurance Company Address: _____ Ins Co. Phone: (____) _____

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MEDICAL HISTORY

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.

Are you under a physician's care now? Y ☐ N ☐
If yes, please explain: _____

Have you ever been hospitalized or had a major operation? Y ☐ N ☐
If yes, please explain: _____

Have you ever had a serious head or neck injury? Y ☐ N ☐
If yes, please explain: _____

Are you taking any medications, pills, or drugs? Y ☐ N ☐
If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? Y ☐ N ☐
If yes, please explain: _____

Are you on a special diet? Y ☐ N ☐
If yes, please explain: _____

Do you use tobacco? Y ☐ N ☐
If yes, please explain: _____

Do you use controlled substances? Y ☐ N ☐
If yes, please explain: _____

Women:

Are you Pregnant/Trying to get pregnant? Y ☐ N ☐
Taking oral contraceptives? Y ☐ N ☐
Nursing? Y ☐ N ☐

Are you allergic to any of the following?

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

Other ☐ If yes, please explain: _____

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

Y ☐ N ☐ AIDS/HIV	Y ☐ N ☐ Asthma	Y ☐ N ☐ Cold Sores/Fever Blisters
Y ☐ N ☐ Alzheimer's Disease	Y ☐ N ☐ Blood Disease	Y ☐ N ☐ Congenital Heart Disorder
Y ☐ N ☐ Anaphylaxis	Y ☐ N ☐ Blood Transfusion	Y ☐ N ☐ Convulsions
Y ☐ N ☐ Anemia	Y ☐ N ☐ Breathing Problem	Y ☐ N ☐ Cortisone Medicine
Y ☐ N ☐ Angina	Y ☐ N ☐ Bruise Easily	Y ☐ N ☐ Diabetes
Y ☐ N ☐ Arthritis/Gout	Y ☐ N ☐ Cancer	Y ☐ N ☐ Drug Addiction
Y ☐ N ☐ Artificial Heart Valve	Y ☐ N ☐ Chemotherapy	
Y ☐ N ☐ Artificial Joint	Y ☐ N ☐ Chest Pains	

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

Y ☐ N ☐ Easily Winded
Y ☐ N ☐ Emphysema
Y ☐ N ☐ Epilepsy or Seizures
Y ☐ N ☐ Excessive Bleeding
Y ☐ N ☐ Excessive Thirst
Y ☐ N ☐ Fainting Spells/ Dizziness
Y ☐ N ☐ Frequent Cough
Y ☐ N ☐ Frequent Diarrhea
Y ☐ N ☐ Frequent Headaches
Y ☐ N ☐ Genital Herpes
Y ☐ N ☐ Glaucoma
Y ☐ N ☐ Hay Fever
Y ☐ N ☐ Heart Attack/Failure
Y ☐ N ☐ Heart Murmur
Y ☐ N ☐ Heart Pace Maker
Y ☐ N ☐ Heart Trouble/Disease
Y ☐ N ☐ Hemophilia
Y ☐ N ☐ Hepatitis A
Y ☐ N ☐ Hepatitis B or C
Y ☐ N ☐ Herpes
Y ☐ N ☐ High Blood Pressure
Y ☐ N ☐ Hives or Rash
Y ☐ N ☐ Hypoglycemia
Y ☐ N ☐ Irregular Heartbeat
Y ☐ N ☐ Kidney Problems
Y ☐ N ☐ Leukemia
Y ☐ N ☐ Liver Disease
Y ☐ N ☐ Low Blood Pressure
Y ☐ N ☐ Lung Disease
Y ☐ N ☐ Mitral Valve Prolapse
Y ☐ N ☐ Pain in Jaw Joints
Y ☐ N ☐ Parathyroid Disease
Y ☐ N ☐ Psychiatric Care
Y ☐ N ☐ Radiation Treatments
Y ☐ N ☐ Recent Weight Loss
Y ☐ N ☐ Renal Dialysis
Y ☐ N ☐ Rheumatic Fever
Y ☐ N ☐ Rheumatism
Y ☐ N ☐ Scarlet Fever
Y ☐ N ☐ Shingles
Y ☐ N ☐ Sickle Cell Disease
Y ☐ N ☐ Sinus Trouble
Y ☐ N ☐ Spina Bifida
Y ☐ N ☐ Stomach/Intestinal Disease
Y ☐ N ☐ Stroke
Y ☐ N ☐ Swelling of Limbs
Y ☐ N ☐ Thyroid Disease
Y ☐ N ☐ Tonsillitis
Y ☐ N ☐ Tuberculosis
Y ☐ N ☐ Tumors or Growths
Y ☐ N ☐ Ulcers
Y ☐ N ☐ Venereal Disease
Y ☐ N ☐ Yellow Jaundice

Have you ever had any serious illness not listed above? Y ☐ N ☐
If yes, please explain:_____

Other comments: _____

_____

_____

Please list any medications you are currently taking. Please include non-prescription medications:

_____ _____ _____

Please list any known allergies: _____ or ☐ NONE KNOWN

Signature needed

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 _____ DATE _____

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THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney).

"Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.
We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we usually will not ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance;
- and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors;
- for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office;
- or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death;
- or to funeral directors to aid in burial;
- or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials;
- for lawful national intelligence activities; for military purposes;
- or for the evaluation and health of members of the foreign service; disclosures of de-identified information; disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else.

Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours. If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it.

Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can: ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want.

- To ask for a restriction, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this Notice.
- To ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- To ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- To ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any

rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

- Get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

- Get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I received a copy of Southeastern Dental Group's Notice of Privacy Practices.

Patient name _____

Signature _____ Date _____

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FINANCIAL POLICY

In our continue commitment to provide the highest quality dental care available to all our patients and to have those services comfortably affordable, we are pleased to offer you these options for payment.

Please check one of the following:

- ☐ VISA
- ☐ MasterCard
- ☐ Discover
- ☐ American Express
- ☐ Personal Check
  returned checks will have a $25.00 return check fee
- ☐ Cash

We are pleased offer a third party extended payment financing through Care Credit.
Please ask a member of the staff for details and credit applications.

We are committed to support you in understanding your dental health, so that you will always be able to make the best choices.

We will, as a courtesy, process your insurance claims in our office, which will relieve you of this time consuming and sometimes - complicated task. We will always recommend treatment based upon your dental needs, not based on insurance coverage, which can be inadequate with some dental plans.

I agree that I am fully responsible for the total payment of all procedures performed in this office - this includes any treatment that is not benefit of any dental insurance that I may have. I understand that all services are due and payable at the time services are rendered, regardless of whether or not my insurance benefits have been received. One and one-half percent (1.5%) per month interest (18% per year) will be charged on accounts 60 days from treatment date.

I understand and agree that if the amount for which I am responsible becomes delinquent, I will pay all cost associated with the collection process. This includes but not limited to collection fees, attorney fees, court filing fees, and any other cost as allowed by law.

MISSED APPOINTMENTS

Appointment times are reserved especially for you. If you arrive late, the Doctor may request that you re-schedule the appointment and you may be charged a fee $40. If for any reason you should need to change your appointment, there will be no charge, provided you give us 48-hour notice. Please help us serve you better by keeping your scheduled appointments. We are here to assist you in any way possible. Please make your questions and concerns known to our team. Our goal is to ensure that you have an outstanding experience.

Financial Coordinator _____

Signature _____ Date _____