Welcome!

Please take a few minutes to answer the following questions
so we can better assist you with your dental needs.

Patient Information

Date _____ Soc. Sec. # _____ Birthdate _____

Name _____ Home Phone _____
Last Name First Name Initial

Address _____ Cell Phone _____

City _____ State _____ Zip _____ E-mail _____

Sex: ☐ M ☐ F ☐ Minor ☐ Single ☐ Married ☐ Long Term Partner ☐ Divorced ☐ Widowed ☐ Separated

Employer _____ Business Phone _____

Business Address _____ Occupation _____

Who should we thank for referring you? _____

In case of emergency, who should we contact? _____ Phone _____

Primary Insurance

Person Responsible for Account _____
Last Name First Name Initial

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Responsible Party Employed By _____ Business Phone _____

Business Address _____ Occupation _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

Additional Insurance

Insured Name _____
Last Name First Name Initial

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Insured Employed By _____ Business Phone _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

Dental History

Former Dentist _____ Date of Last X-Rays _____

City, State _____ How Often Do You Floss? _____

Date of Last Dental Visit _____ How Often Do You Brush? _____

Please check all that apply:

- Bad Breath ☐
- Bleeding Gums ☐
- Blisters on Lips or Mouth ☐
- Finger Nail Biting ☐
- Grinding Teeth ☐
- Lip or Cheek Biting ☐
- Loose Teeth or Broken Fillings ☐
- Orthodontic Treatment ☐
- Pain Around Ear ☐
- Periodontal Treatment ☐
- Sensitivity to Cold ☐
- Sensitivity to Heat ☐
- Sensitivity to Sweets ☐
- Sensitivity When Biting ☐
- Frequent Headaches ☐
- Jaw, Head or Neck Injuries ☐
- Jaw Difficulty: Clicking and/or Pain ☐
- Tooth Pain ☐

Medical History

Physicianís Name _____ Date of Last Visit _____

	Yes	No
1. Are you currently under medical treatment?	☐	☐
2. Have you ever had any serious illnesses or operations?	☐	☐
3. Are you currently taking any medication?	☐	☐
Please describe: _____		
4. Do you smoke?	☐	☐
5. Do you use alcohol, cocaine or other drugs?	☐	☐
6. Do you wear contact lenses?	☐	☐

7. Have you had any allergic reactions to the following:

	Yes	No
Local Anesthetics (eg. novocaine)	☐	☐
Penicillin or other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates (sleeping pills)	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Other	☐	☐

8. (Women Only) Are You:

Pregnant?	☐	☐
Nursing?	☐	☐
Taking birth control pills?	☐	☐

Please check all that apply:

- AIDS ☐
- Anemia ☐
- Arthritis, Rheumatism ☐
- Artificial Heart Valves ☐
- Artificial Joints ☐
- Asthma ☐
- Back Problems ☐
- Bleeding abnormally, with extractions or surgery ☐
- Blood Disease ☐
- Cancer ☐
- Chemical Dependency ☐
- Chemotherapy ☐
- Chronic Fatigue Syndrome ☐
- Circulatory Problems ☐
- Congenital Heart Lesions ☐
- Cortisone Treatments ☐
- Cough - persistent or bloody ☐
- Diabetes ☐
- Emphysema ☐
- Epilepsy ☐
- Fainting or Dizziness ☐
- Glaucoma ☐
- Headaches ☐
- Heart Murmur ☐
- Heart Problems ☐
- Hepatitis-Type _____ ☐
- Herpes ☐
- High Blood Pressure ☐
- HIV Positive ☐
- Jaundice ☐
- Jaw Pain ☐
- Kidney Disease ☐
- Latex Sensitivity ☐
- Liver Disease ☐
- Low Blood Pressure ☐
- Mitral Valve Prolapse ☐
- Nervous Problems ☐
- Pacemaker ☐
- Psychiatric Care ☐
- Radiation Treatment ☐
- Respiratory Disease ☐
- Rheumatic Fever ☐
- Scarlet Fever ☐
- Shortness of Breath ☐
- Sinus Trouble ☐
- Skin Rash ☐
- Stroke ☐
- Swelling of Feet/Ankles ☐
- Swollen Neck Glands ☐
- Thyroid Problems ☐
- Tonsillitis ☐
- Tuberculosis ☐
- Tumor or growth on head/neck ☐
- Ulcer ☐
- Venereal Disease ☐

Assignment and Release

I hereby authorize payment directly to _____ for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ Date _____

Gray Station Dental
Richard Turner DMD
100 Chapel Street
Gray, TN 37615

HIPAA Notice

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

> Treatment (including direct or indirect treatment by other healthcare Providers involved in my treatment);
> Obtaining payment from third party payers (e.g. my insurance company);
> The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices,* which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

We value and respect the privacy of our patients, our guests, and our staff. **Videoing, recording, and photographing of treatment or recommendation of treatment are strictly prohibited.** Please do not take, shear, or post pictures, recordings, or videos of GSD staff/providers without their permission. You must ask their permission first before taking the picture, making the recording, or publishing it, such as on Facebook or Instagram, etc. You are not allowed to take pictures of other patients and guests without their permission. Our other patients and guests have also an interest in privacy. It is not appropriate to record or take pictures of other patients, including in group treatment settings, without their permission. We have the right to ask you to stop using your mobile devices and/or recording in violation of our policy. If you refuse, we may stop your treatment and ask you to leave. If you are a guest, we may ask you to leave regardless of whether the patient is still being treated. Privacy is everyone's responsibility, and we appreciate your cooperation and support.

Please list authorized persons with whom we may discuss your Protected Health Information (PHI) in addition to custodial parents and legal guardians.

_____ _____

_____ _____

_____ _____

Signature of Patient/legally authorized representative Date

_____

Print Name

Office Financial/Cancellation Policy

We share your concerns regarding the increasing cost of health care. We believe that you, our patients, expect and deserve the highest quality care we can provide at a reasonable cost. Our providers treat patients based on the "NEED" of treatment not based on what insurance will cover. With this in mind, we would like to share some information with you about our financial policy. We want you to feel comfortable with us regarding your financial and insurance matters and thus prevent any misunderstandings. We hope you will consult with us if you have any questions regarding our services, financial or cancellation policies.

We ask that you realize that we do not work for an insurance company. Rather we work 100% for our patients. We feel that insurance can be a great benefit for many patients and want you to know we will do everything in our power to ensure you get every benefit allotted in your insurance contract. However, the treatment we recommend and the fees we charge will always be based on your individual needs, not based on what your insurance will or will not cover.

Patients with insurance: At the time of treatment, patients are requested to pay all fees toward the charges not covered by insurance. This amount will be based upon benefit information obtained from your insurance company, including but not limited to your deductible or non-covered charges. We deal with many different insurance companies and plans. It is the patient's responsibility to know their insurance plan. We will be happy to request a pre-authorization from your insurance company for any procedure over $300 **at the patient's request**.

Patients without insurance: Patients without insurance are required to pay all fees at the time of service. We do not offer payment plans.

Payment Options: Visa, MasterCard, Discover, American Express and Care Credit are accepted. Cash and Check are accepted as well. *Returned checks for any reason are subject to a **$40.00 fee** that will be added to your account*

Account Balance: Balances due in full within **30 days** of treatment regardless of insurance coverage or estimated payment. In the event that payment for our services is not made within 60 days of the service date, an interest charge of 1.5% per month will be added to the account (18% per annum). Therefore, patients with insurance whose claims have not been paid within 30 days should contact their insurance company to determine the reason for the delay of payment. Delinquent accounts will be reviewed for collections if not paid in full within **90 days**.

Cancellations: Keep in mind that our time is valuable as we do not overbook our patients. It is our office policy to reschedule you if you are later than **15 minutes** to your appointment. We also require a notice of **24 hours** on all appointment **cancellations** as well as **confirmations**. We try our very best to get a hold of you to confirm each appointment via text, email, and phone calls. If your appointment is not confirmed within **24 hours** of the scheduled time, it will be automatically **canceled**. Cancellations without adequate notice will be subjected to a **$50.00 fee** on the third offense.

_____ _____

Signature of Patient/Legal Guardian Date

Gray Station Dental
Richard Turner DMD
100 Chapel Street
Gray, TN 37615

I, _____, consent to be a patient of the above-named Dental Providers office and agree to a radiographic and clinical examination. I also understand and consent to the following:

During the course of treatment, I may undergo procedures in all phases of dentistry including periodontics (gum treatment and surgery), oral surgery, endodontics (root canals), fixed and removable prosthodontics (crowns, bridges and dentures), implant dentistry, restorative dentistry, temporomandibular disorder treatment, oral pathology, pediatric dentistry, and radiography.

I will provide a thorough and complete medical history, supply a full list of my medications with dosages, and consent to my dentist communicating with my other medical practitioners to inquire about any aspect of my health history.

No guarantees can be made about treatment outcomes, restoration longevity, or prognoses. I understand that any branch of medicine, including dentistry, can involve unanticipated results.

I will pay in full any cost of treatment or insurance copayments according to the office's financial policy. I understand that even if an insurance pre-estimate is given or a procedure has been preapproved, I am responsible for any costs that my insurance does not cover.

My treatment plan may change at any time, and I will do my best to approach my dental care with optimism and open communication with my dentist, hygienist, and dental office staff.

I am welcome to ask questions about any aspects of my dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspects of my treatment that I am unsure about.

_____ _____

Patient or Guardian Name Date

_____ _____

Witness Date