901 DENTAL™

MEDICAL HISTORY

PATIENT LAST NAME _____ **FIRST** _____ **MIDDLE** _____

DENTAL HISTORY Reason for today's visit _____

Are you happy with your smile? Yes □ No □ If No, what would you change? _____

Former dentist _____ Date of last dental visit/x-rays _____

Please check if you have/had:	Yes	No		Yes	No		Yes	No
Bad breath	□	□	Head, neck, jaw pain, or aches	□	□	Orthodontic treatment	□	□
Blisters on lips or mouth	□	□	Lip or cheek biting	□	□	Nitrous oxide	□	□
Burning sensation on tongue	□	□	Loose teeth or broken fillings	□	□	Periodontal treatment	□	□
Chew on one side of mouth	□	□	Mouth breathing	□	□	Sensitivity (cold, heat, sweets)	□	□
Tobacco use	□	□	Gums swollen, tender, bleeding	□	□	Do you snore?	□	□
Clench or grind your teeth	□	□	Dry mouth	□	□	Been tested for sleep apnea?	□	□

Have you ever had an allergic reaction to novocaine, local, or general anesthetics? **Yes** □ **No** □ If yes, please explain _____

Have you ever had trouble with/from prior dental treatment? **Yes** □ **No** □ If yes, please explain _____

MEDICAL HISTORY Physician's name _____ Date of last visit _____

Have you ever had any serious illnesses or operations? **Yes** □ **No** □ If yes, please explain _____

Have you ever taken bisphosphonates for osteoporosis/brittle bones (IV or oral)? **Yes** □ **No** □ If yes, please list kind/dates _____

Have you ever had **head or neck** radiation therapy? **Yes** □ **No** □

Are you taking any blood thinners? **Yes** □ **No** □ If Yes, which one(s)? _____

(Women) Are you pregnant? Yes □ No □ Due Date? _____ Nursing? Yes □ No □ Taking birth control? Yes □ No □

Are you allergic to: **Penicillin** □ **Clindamycin** □ **Sulfa drugs** □ **Codeine** □ **Latex** □ **Other Allergy?** _____

List all medications you are taking _____

_____

Please check if you have/had:	Yes	No		Yes	No		Yes	No
Allergies, hay fever, sinusitis	□	□	Heart murmur	□	□	Stroke	□	□
Anemia	□	□	Heart Problems	□	□	Slow healing wounds	□	□
Arthritis, Rheumatism	□	□	Hepatitis type _____	□	□	Swelling of feet or ankles	□	□
Artificial heart valve(s)	□	□	Herpes	□	□	Thyroid problems	□	□
Artificial joint(s)	□	□	High blood pressure	□	□	Tonsillitis	□	□
Asthma	□	□	Any immune deficiency	□	□	Tuberculosis	□	□
Bleeding abnormally with surgery	□	□	Jaundice	□	□	Tumor or growth on head/neck	□	□
Blood disease, clotting disorders	□	□	Kidney disease	□	□	Venereal disease	□	□
Cancer	□	□	Low blood pressure	□	□	Autism	□	□
Chemical dependency	□	□	Mitral valve prolapse	□	□	Down Syndrome	□	□
Chemotherapy	□	□	Osteoporosis /osteopenia	□	□	Ulcers	□	□
Circulatory problems	□	□	Pacemaker	□	□	Headaches	□	□
Long term cortisone/steroid use	□	□	Respiratory disease	□	□	Skin rash	□	□
Cough, persistent or bloody	□	□	Rheumatic fever	□	□	Sickle cell anemia	□	□
Diabetes	□	□	Shortness of breath	□	□	Neurological disorder	□	□
Epilepsy	□	□	Sinus trouble	□	□	Are you under care of a physician?	□	□
Fainting	□	□	Emphysema	□	□	If Yes, for what? _____		

AUTHORIZATION AND RELEASE I have read and answered the above questions to the best of my knowledge.

Signature of Patient or Guardian _____ Date _____

901 DENTAL™

NEW PATIENT REGISTRATION

Patient's Last Name _____ First _____ Middle _____

Nickname _____ Date of Birth _____

Street Address _____ City _____ State _____ Zip Code _____

Telephone (Mobile) _____ (Work) _____ (Home) _____

Email _____

How did you hear about our practice? _____

INSURANCE INFORMATION

Primary Insurance	**Secondary Insurance**
Subscriber Name _____	Subscriber Name _____
Social Security Number _____	Social Security Number _____
Date of Birth _____	Date of Birth _____
Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other	Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other
Employer Name _____	Employer Name _____
Employer Phone _____	Employer Phone _____
Insurance Company _____	Insurance Company _____
Insurance Group _____	Insurance Group _____
Insurance Phone _____	Insurance Phone _____

Please present your insurance card to be photocopied for our records.

RESPONSIBLE PARTY (If minor or different from patient listed above)

Last Name _____ First _____ Middle Initial _____

Street Address (if different) _____ Date of Birth _____

City _____ State _____ Zip Code _____

Telephone (Mobile) _____ (Work) _____ (Home) _____

Email _____

EMERGENCY CONTACT

Full Name _____ Telephone (Mobile) _____ (Home) _____

AUTHORIZATION

I consent to the diagnostic procedures and dental treatment performed by my dentist, and to the release of information concerning my (or my child's) health care, advice, and treatment to another dentist, or for evaluating and administering any claims for insurance benefits. I consent to the direct payment of my insurance benefits to the practice and understand my insurance may pay less than the actual bill for services and that I am responsible for any services not paid or covered.

ELECTRONIC COMMUNICATIONS

I consent to receiving HIPAA-compliant electronic communications, such as email and text messages regarding treatment, payment, etc. I understand there is no obligation to receive these electronic communications.

Signature of Patient or Guardian _____ Date _____

Patient Treatment Consent/Agreement

Consent to Treatment The undersigned consents to radiographs (x-rays), laboratory procedures, anesthesia, diagnostic tests, dental treatment, or other procedures rendered to the patient. Although the undersigned may elect not to undergo certain specific procedures, without adequate diagnosis or treatment plan the practice may decline to treat the patient.

Privacy Practices 901 Dental's Notice of Privacy Practices is available to the undersigned in paper form by request. The undersigned consents to the use and disclosure of his/her health information to carry out treatment and health care operations. The undersigned authorizes representatives from 901 Dental and it's affiliates to use all or part of the patient's record, including written records, radiographs, photographs, videotapes, and laboratory reports for teaching and/or in promotional efforts so long as the patient is not identified by name in connection therewith. The undersigned has the right to revoke consent at any time by written notice.

Patient Rights and Responsibilities The undersigned hereby acknowledges that 901 Dental's Patient Rights and Responsibilities brochure is available to him/her in paper form.

Financial Agreement The undersigned agrees, whether he/she signs as agent or as patient, he/she hereby individually obligates himself/herself to pay for treatment received at 901 Dental in accordance with the regular rates and terms of the practice. Failure to pay for services in a timely manner may jeopardize the patient's access to routine dental care. In the event the patient's account is transferred to a bad debt collection agency the undersigned may be responsible for reasonable attorney's fees and collection expenses.

Minors and Dependent Adults The parent (or legal guardian) of patients under the age of 18 (or dependent adults) must be registered as the guarantor; the guarantor's name and physical address is required. Either parent may be held responsible for payment of treatment rendered to their minor child or dependent adult. 901 Dental's policy is to bill the parent/legal guardian who presented the minor/dependent adult for treatment. The same applies to minors/dependent adults of divorced parents.

Insurance 901 Dental submits to insurance as a courtesy to our patients; balances after insurance are billed to the guarantor. Ultimately, the guarantor is responsible for payment, regardless of the insurance carrier's consideration.

The undersigned authorizes 901 Dental to submit claims (on the patient's behalf) to insurance, Medicare, Medicaid, or other third party payer(s) and to disclose health information to the extent necessary to obtain payment. The undersigned also assigns benefits paid by insurance, Medicare, Medicaid, or other third party payer(s) directly to 901 Dental. In consideration of the dental services provided, the undersigned assigns to the practice any benefits to which the undersigned may be entitled to receive, including without limitation any such benefits due or claims the undersigned has under or pursuant to a benefit plan governed under ERISA, 29 USC sec. 101 et seq.

I have reviewed 901 Dental's Financial Policy as stated above and I understand and accept responsibility of cooperating with these policies. I understand that I will be responsible for financial balances resulting from treatment received that is not paid by my insurance company, Medicare, Medicaid, or any third party agency. I also understand that a cancellation fee may be charged/any deposit paid for an appointment/treatment will be forfeited should I cancel or reschedule my appointment with less than 48 business hours notice. My signature acknowledges that I understand and accept the above agreement.

_____ _____

Patient Name Date

_____

Patient or Guardian Signature

901 Dental and Your Insurance Plan: What You Need to Know

Our office works very hard to help ensure you obtain the maximum benefit of your insurance plan. Below is some information to help you understand your coverage.

DO YOU ACCEPT MY INSURANCE? HOW MUCH WILL THEY PAY?

We accept numerous different insurance plans, meaning that we work with literally hundreds of companies. Although we do maintain computerized histories of payment by any given company, they do change. Therefore, it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is ONLY AN ESTIMATE. If you would like to know your exact insurance benefit, we will be happy to file a "pre-treatment authorization" with your insurance company prior to treatment. This can significantly delay treatment, but will give you the exact out of pocket figures to expect.

I THOUGHT I PAID MY PORTION, BUT I GOT A BILL. WHY?

We base the patient portion of your bill on our most current data, but there are many factors that can affect this estimate. There may be a deductible (individual or family) or you may have received treatment in another office prior to joining the 901 Dental family, which is not calculated into our database. Sometimes you may need to see a specialist for care, which also deducts from your annual benefit. Insurance companies do not (and, in most cases, cannot) notify us of changes to your benefits, they only notify you. If any of the above situations apply to you, please let us know when we estimate your treatment plan so we can adjust accordingly.

INSURANCE DIDN'T PAY, NOW WHAT?

We bill your insurance as a courtesy. If insurance does not pay within 90 days, 901 Dental reserves the right to request payment from you in full for services rendered and let you collect the insurance funds that are due. This is rare, but it is important that you recognize that the insurance policy you have is a legal contract between YOU and your insurance company. Our office is not (and cannot) be a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.

FINANCIAL OPTIONS

901 Dental does request payment in full for your portion at the time of service. We accept MasterCard, VISA, American Express, and Discover. All sales are final. If you are in need of an extended finance option, we also work with Care Credit, a healthcare financing credit card designed to meet your treatment plan needs. We also accept the More Mastercard and have other financing options available. Just ask one of our front office staff members for an application.

We welcome you to our family and look forward to helping you get the healthy, beautiful smile you've always wanted. Please let us know if there is anything we can do to make your visits here more pleasant.

I have read, understand, and accept the terms of the above outlined policies for insurance handling and financial commitments that I may incur as a result of treatment at 901 Dental.

_____ _____

Signature Date

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You May Refuse To Sign This Acknowledgement

I have received a copy of this office's Notice of Privacy Practices.

Please Print Name

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice Of Privacy Practices, but acknowledgement could not be obtained because:

□ Individual refused to sign

□ Communication barriers prohibited obtaining the acknowledgement

□ An emergency situation prevented us from obtaining acknowledgement

□ Other (Please specify)

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

With your written permission, we may discuss your health information with a person(s) you designate. Your authorization allows dental providers and staff members at 901 Dental to discuss your health history, dental treatment, finances, and appointments (including scheduling) with a designated adult, such as a family member, friend, or dental or medical practitioner outside the practice. Please consider listing your emergency contact.

Patient Name: _____ Birthdate: _____

This patient is an: Adult Minor Child Dependent Adult

Address _____

_____

☐ YES, I specifically authorize 901 Dental to disclose my Protected Health Information (PHI) to the following individual(s):

1. _____
   Name Phone # Relationship to Patient

2. _____
   Name Phone # Relationship to Patient

3. _____
   Name Phone # Relationship to Patient

4. _____
   Name Phone # Relationship to Patient

☐ NO, I do not want my Protected Health Information shared with any individuals.

This authorization is valid unless otherwise revoked. I may cancel this consent at any time by sending a written notice to 901 Dental, 9775 Hwy 64, Suite 101, Arlington, TN, 38002. I understand that any discussion of information which was made before I cancelled my consent does not mean that my rights to confidentiality were breached.

Patient or Guardian Signature: _____

APPOINTMENT CANCELLATION POLICY

- In our dental practice, we respect the importance of your time and we work very hard to schedule appointments that accommodate the scheduling needs of all our patients. We want you to know that we make every effort to see you at your scheduled appointment time.

- For each appointment, **the staff sets up a treatment room with a block of time that is reserved specifically for you. Before each appointment the doctor spends time reviewing your information and planning your care.** We feel that a successful outcome to treatment is the result of combined efforts of both you and this office.

- Because we take such efforts to prepare for your scheduled appointment, **we greatly appreciate that you notify us at least 48 BUSINESS HOURS prior to your scheduled appointment time if you must CANCEL or RESCHEDULE your appointment.** Please initial _____

- Broken appointments and missed appointments at short-notice create scheduling difficulties for the office as well as our other patients.

- **To help you, our office can send you several reminders prior to your appointment:**
    1. 1-week confirmation email
    2. 3-day, 1-day, and 2-hour text message reminders
    3. A personal phone call to confirm your appointment
    4. An appointment reminder card

- We kindly ask that you confirm your appointment with us either by text message response or phone call response. Please initial _____

- **If you break or miss an appointment without providing us with a 48-business hour notice, we may no longer be able to schedule you in our appointment book.** You will still always be able to be seen and treated as a patient, but may be seen on a walk-in only basis – without a reserved time slot. Please also note that a cancellation fee may be charged/any deposit paid for an appointment will be forfeited if the appointment is cancelled or rescheduled without at least 48-hours notice.

Patient or Guardian Signature: _____ Date: _____