Jackson Smiles
FAMILY DENTISTRY

276 Carriage House Drive
Jackson, TN 38305

Phone: 731-668-2900
Fax: 731-668-6902

JacksonSmilesTN.com

PATIENT INFORMATION

We are pleased to welcome you to our office. For your convenience, our forms have ACTIVE FIELDS so you can fill them out on your computer and print them out. If you have any questions, we'll be glad to help you.

PERSONAL

Patient Name_____
Last First MI (Preferred)
Birthdate_____ SS#_____ DL# _____ Gender ◯M ◯F Married ◯Y ◯N

Work Phone_____ Cell Phone_____Email_____

If patient is under 18 yrs, please also complete the following:

Guarantor *Name*_____
Last First MI (Preferred)
Birthdate_____ SS#_____ DL# _____ Gender ◯M ◯F Married ◯Y ◯N

Work Phone_____ Cell Phone_____Email_____

Student status if dependent over 19 (for ins) ◯Nonstudent ◯Fulltime ◯Part time

How did you hear about us? (Please be specific so we can thank them!)_____

_____

ADDRESS AND HOME PHONE

Check if same for entire family ☐

Address_____

Address 2_____

City_____ State_____Zip_____

Home Phone_____

INSURANCE POLICY 1

Patient relationship to subscriber ◯Self ◯Spouse ◯Child

Subscriber Name_____Sub.ID # _____Sub.DOB_____

Insurance Company _____Phone_____

Employer_____Group Name_____Group #_____

INSURANCE POLICY 2

Patient relationship to subscriber ◯Self ◯Spouse ◯Child

Subscriber Name_____Sub.ID # _____Sub.DOB_____

Insurance Company _____Phone_____

Employer_____Group Name_____Group #_____

Comments_____

Please complete reverse side.

FINANCIAL AGREEMENT

* For my convenience, this office may release my information to my insurance, and receive payment directly from them.
* If sent to collections, I agree to pay a **$30 collection fee**, all related fees and court costs.
* Every effort will be made to help me with my insurance, but if they do not pay as expected, I will still be responsible.
* Treatment plans may change, and I will be responsible for the work actually done.

Signature_____ Date_____

MEDICAL HISTORY

Name of Medical Doctor_____ City/State_____

Emergency Contact_____ Phone_____Relationship_____

List all the medications or drugs you are now taking:

[ ] None

_____

_____

_____

_____

Check medications or drugs you are allergic to:

- ☐ None
- ☐ Aspirin
- ☐ Codeine/ Other Narcotics
- ☐ Erythromycin
- ☐ Latex Rubber
- ☐ Local Anesthetics
- ☐ Metals
- ☐ Penicillin
- ☐ Sulfa Drugs
- ☐ Other _____

Check any medical conditions you may have:

- ☐ None
- ☐ AIDS/HIV
- ☐ Alcohol/Drug Abuse
- ☐ Anemia/Leukemia
- ☐ Anorexia/Bulimia
- ☐ Arthritis
- ☐ Asthma/Hay Fever
- ☐ Blood Clotting Problems
- ☐ Blood Transfusion
- ☐ Bronchitis
- ☐ Cancer/Tumor or Growth
- ☐ Cardiac Pacemaker
- ☐ Chest Pain Upon Exertion
- ☐ Damage Heart Valve
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting Spells/Seizures
- ☐ Fever Blisters/Herpes
- ☐ Frequent Headaches
- ☐ Frequently Dry Mouth/Sjogren
- ☐ Gall Bladder Trouble
- ☐ Heart Attack/Stroke
- ☐ Heart Disease/Angina
- ☐ Heart Murmur
- ☐ Hepatitis/Jaundice
- ☐ High Blood Pressure
- ☐ Hives/Skin Rash
- ☐ Joint Replacement, Date of: _____
- ☐ Kidney/Bladder Trouble
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mental Health Problems
- ☐ Mitral Valve Prolapse
- ☐ Persistent Diarrhea
- ☐ Rheumatic Fever
- ☐ Rheumatic Heart Disease
- ☐ Sexually Transmitted Disease
- ☐ Sinus Trouble
- ☐ Stomach Ulcers
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Other _____

WOMEN ONLY- Are you pregnant or do you have reason to believe you may be? __Yes __No

Tobacco use? If so, what kind and how much?_____

Unusual reaction to dental injections?_____

Reason for today's visit_____ Are you in pain? Yes No

New patients:

Name of former dentist_____ City/State_____

Date of last cleaning and exam_____

By signing below, I certify that all of the above information is true to the best of my knowledge.

_____ _____

Patient/Guardian Name (printed) Date

_____

Patient/Guardian Signature

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DENTAL HEALTH QUESTIONNAIRE

1. When was your last dental visit? _____

2. Approximately how often were your appointments with your last dentist? _____

3. Are you experiencing any dental problems? If so, are they (circle one): Mild☐ Moderate☐ Severe☐

4. How often do you brush your teeth? _____ Floss? _____ Water Jet Floss? _____

5. Do you have any loose teeth? Yes○ No○ Chipped teeth? Yes○ No○ Broken teeth? Yes○ No○

6. Are there any spaces between your teeth where food often gets stuck? Yes○ No○

7. Do you frequently get headaches or migraines? Yes○ No○

8. Do you have any jaw joint issues (such as popping) or pain? Yes○ No○

9. Do you clench and/or grind your teeth when you are awake or asleep? Yes○ No○

10. Do your teeth feel worn down? Yes○ No○

11. Do you snore at night or commonly have a hard time sleeping well? Yes○ No○

12. Do you have any sort of sleep apnea that you are aware of? Yes○ No○

13. Have you ever had periodontal (gum) treatment of any kind? Yes○ No○

14. Do your gums bleed when you brush your teeth? Yes○ No○ When you floss? Yes○ No○

15. Have you ever had orthodontic treatment such as braces or aligner therapy? Yes○ No○

16. Are you interested in short-term braces? Yes○ No○

17. Do you have wisdom teeth? Yes○ No○ If so, are they bothering you? Yes○ No○

18. Are you interested in dental implants to replace missing teeth? Yes○ No○

19. What level of dental treatment are you interested in (circle one): Emergency☐ Long-term☐

20. How do you feel about your smile? What (if any) improvements would you like to see?

21. What are your goals with our office?

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Financial Menu

Thank you for choosing Jackson Smiles Family Dentistry (hereinafter referred to as "we" or "Practice") for your dental care. Our goal is to provide for you a pleasant and relaxing environment with the finest care possible. We will strive to educate you about your diagnosis and treatment alternatives as well as your financial options. This document is designed to help you understand our office procedures and financial policies.

Payment

Payment is expected the day dental services are provided. For your convenience Master Card, Visa, Discover, debit cards, checks, and cash are accepted. We will provide a written Treatment Proposal that will detail your diagnosis, treatment alternatives, estimated insurance coverage (if applicable), and your estimated portion due to begin treatment. No procedure performed on the human body can be guaranteed, as such payment is due and fees non-refundable regardless of treatment outcome. Payment for services rendered is also required if you decide to abandon a course of treatment in favor of an alternative form of treatment.

Dental Insurance

As a courtesy to you we accept, and will file, most primary insurance plans that do not require a specific provider. Please provide us with your identification card. Dental insurance is not intended to be a "pay all" service but is intended to help reduce your "out of pocket" expenses. Please be prepared to pay your deductible and estimated co-payment in full as treatment is initiated. We do NOT accept assignment of benefits for secondary insurance. Therefore any balance remaining after your primary insurance has responded is due in full. As a courtesy of those with secondary insurance', we will prepare a claim form and submit it on your behalf when you have paid your account in full.

Insurance Payment

As a courtesy to you, we will file your primary insurance claim and are willing to wait up to 45 days from the date of service for payment. If payment has not been made, we will contact your carrier and strive to resolve any reason for delay. If unable to immediately resolve the situation a statement will be sent to you for immediate payment by the responsible party. Thereafter we will gladly assist you in attempting to obtain direct reimbursement from your carrier. WE MUST EMPHASIZE that our relationship is with you and not your carrier. Our primary concern is for your well-being and we structure our care accordingly. Insurance companies determine benefit packages and payment rates ("usual and customary" or UCR) by the plan type that is purchased by the employer/insured party-not by the level of care provided by our office. All charges including interest, accrued from the date services are rendered, are your responsibility regardless of insurance benefits, arbitrary determination of UCR payment, or lack thereof.

Appointments

We value your busy schedule and strive to see patients at their appointed time; we ask you to extend the same courtesy. Whenever possible please provide a minimum of 48 hours advance notice when requesting a scheduling change so that we can arrange care for other patients experiencing urgent dental needs. Failure to give adequate notice will result in a $45 office fee charged to your account that must be paid prior to rescheduling.

Returned Check Fee

A fee of $35 will be charged for any returned check. The entire outstanding balance and returned check fee must be paid immediately upon notification from our practice.

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Acknowledgement, Release, and Authority

I as the patient, or as the authorized guardian or responsible party for the patient named, consent to treatment as necessary or desirable, including but not limited to drugs, medicines, performance of clinical treatment, labs, imaging, or other studies that may be performed, ordered or used by Practice. I certify that I am here only for the medical and/or dental treatment requested and also certify that I am not representing any third party or other entity.

I authorize Practice to use or release any protected health information, as used in Health Insurance Portability and Accountability Act (HIPAA) and in the manner described in Notice of Privacy Practices, to third party payers or other health practitioners as reasonably necessary for my treatment proper or for reimbursement thereof, and further hold harmless Practice from any and all damages resulting from the reasonable use thereof. I also give my consent to be contacted regarding my dental health, treatment, and scheduling and account information by telephone, e-mail, text message, postcard, newsletter, and /or letter.

I authorize and request my insurance company to pay the Practice any monies due me as reimbursement for services rendered by Practice. I understand my insurance carrier may pay less than the total fee for services rendered and unconditionally agree to be responsible for and to pay all charges incurred on my behalf or on behalf of those for which I am responsible. I permit a copy of this authorization to be used in place of the original.

I agree to pay treble damages if I cash any insurance or other check that represent reimbursement to Practice for services rendered and I fail to immediately tender the monies due to Practice. **I agree and understand** in the event I do not pay Practice the balance due and my account is placed in the hands of a collection agency and/or attorney for collection proceedings, I will be legally responsible for all costs of collection, including but not limited to: collection agency fees, including those derived as a percentage of outstanding balance, court costs, litigation expenses, attorney's fees, as well as other incidental expenses incurred by Practice, and further I consent to the jurisdiction of the General Sessions Court of Madison County, Tennessee and agree that Tennessee law governs all matters arising out of this agreement.

I further understand a 1.5% finance charge per month (18 percent annually) will be added to my account for any balance over 60 days, regardless of any pending insurance claims. I agree to pay Practice a minimum fee of $45 for any appointment I schedule and fail to arrive for or cancel with less than 48 hours notice. I certify that any information I have provided today is correct to the best of my knowledge. I also understand that it is my responsibility to inform Practice or any Responsible Party of changes to the information I have provided today. If the patient is a minor, I certify I am legal guardian.

Patient Name _____ Responsible Party _____

Signed _____

Date _____

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Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed, and how you can get access to this information. Please review carefully. If you have any questions about this notice, please contact our office.

Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted by law. It also describes your rights to access and control your protected health information. We are required by Federal Law to give you this Notice and to maintain the privacy of your health information. We must also abide by the terms of this Notice while it is in effect. We reserve the right to change our privacy practices and the terms of this Notice at any time. Before we make any significant changes in our privacy practices, we will change this Notice and make the Notice available on request.

Uses and Disclosures of Protected Health Information
You will be asked to sign an Acknowledgement of Receipt of Notice of Privacy Practices. Once you have received our Notice of Privacy Practices, disclosure of your protected health information will be used for treatment, payment and health care operations. Your protected health information may also be used and disclosed by our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of our practice. Following are examples of the types of uses and disclosures of your protected health care information that our office is permitted to make:

Treatment: We will use and disclose your protected health care information to other dentists and physicians to provide, coordinate, or manage your health care. For example, your protected health care information may be provided to another dentist to whom you have been referred to ensure that the necessary information is available to diagnose or treat you. In addition, we may disclose your health information at times to a dental laboratory or specialist.

Payment: Your protected health information will be used to obtain payment for services we provide to you. This may include certain activities that your insurance plan may undertake before it approves or pays for the services we recommend.

Healthcare Operations: We may use or disclose your protected health information in order to support the business activities of our practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, credentialing activities, conducting training and conducting other business activities. For example, we may use a sign-in sheet at the front desk where you will be asked to sign your name when you arrive. We may also call you by name in the waiting room when your dentist or dental professional is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointments.

Business Associates: We will share your protected health information with third party Business Associates that perform various activities (billing or laboratory services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

Communication: We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services that we offer. We may also send you information about products or services that we believe will be beneficial to you. You may contact our office to request that these materials not be sent to you.

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Uses and Disclosures of Protected Health Information that may be made with your consent

Uses and Disclosures of Protected Health Information will be made only with your written authorization, unless permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that our practice has already taken an action as provided for in the authorization.

If you are not present or able to agree or object to the use or disclosure of the protected health information, then we may, using our professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information.

Family: Unless you object, we may disclose to a member of your family, or any other person you identify, your protected health information to the extent necessary to help with your healthcare or with payment for your healthcare. We will also use our professional judgment to make reasonable decisions in your best interest in allowing a person to pick up prescriptions, dental supplies, x-rays, or other similar forms of health information.

Uses and Disclosures of Protected Health Information that may be made without your consent

When required by law: We must make disclosures when required by the Secretary of the Department of Health and Human Services to investigate or determine compliance.

Emergencies: We may disclose your health information in an emergency treatment situation. If this happens, we will try to obtain your Acknowledgement of Receipt of Notice of Privacy Practices as soon as is reasonably practicable after the delivery of treatment. In the event of your incapacity or an emergency, we will disclose health information based on a determination using our professional judgment, disclosing only health information that is directly relevant to the person's involvement in your health care.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to the health or safety of others.

Military Activity and National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized Federal officials health information required for lawful intelligence, counterintelligence and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody, the protected health information of inmates or patients under certain circumstances.

Your Rights

You have the right to inspect and copy your protected health information: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other that photocopies. We will use the format you request unless we cannot practically do so. You must make the request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. If you prefer, we will prepare a summary of an explanation of your health information, for a fee.

You have the right to request a restriction of your protected health information: You have the right to request that we place additional restrictions on our use and disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement, except in an emergency.

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You have the right to request alternative communications from us: You have the right to request that we communicate with you about your health information by an alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

You have the right to request an amendment to your health information: You have the right to request that we amend your health information. Your request must be in writing. The request must explain why the information should be amended. We may deny your request under certain circumstances.

You have the right to receive an accounting of disclosures we have made of your health information: This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice. It excludes disclosures we may have made to you, or to a family member involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. The right to receive this information is subject to certain explanations, restrictions and limitations. If you request this accounting more than once in a 12 month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

You have the right to make a complaint about our privacy policies: If you are concerned that we have violated your privacy rights, you may file a complaint with our office using the contact information listed at the end of this Notice. You may also file a written complaint with the Department of Health and Human Services. We will provide you with their address upon request. We will not retaliate against you for making a complaint to either our office or the Department of Health and Human Services.

You may request an electronic or a paper copy of this Notice.

Privacy Practices effective February 9, 2015

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New Patient Consent – Use and Disclosure of Health Information & Standard Consent for Dental Procedures

I, _____(patient), understand that as part of my healthcare, Jackson Smiles, originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis and any plans for future care or treatment. I understand that this information serves as a:

- Basis for planning my care and treatment,
- Means of communication among the many healthcare professional who contribute to my care,
- Source of information for applying my diagnosis and treatment information to my bill,
- Means by which a third-party payer can verify that services billed were actually provided, and
- Tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. I understand that the following privileges and rights to:

- Review the notice prior to signing this consent,
- Object to the use of my health information for directory purposes, and
- Request restriction as to how my health information may be used or disclosed to carry out treatment, payment or healthcare options.

I understand that Jackson Smiles is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance therein. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Jackson Smiles reserves the right to change their notice and practices prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Jackson Smiles change their notice, they will send a copy of any revised notice to the address I have provided.

I understand that as part of ensuring the security of my medical records, my picture may be taken upon registration to confirm my identification on all future visits to Jackson Smiles.

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosure via fax. By signing below, I fully understand and accept the terms of this consent.

Patient Name Printed _____

Patient Signature _____ Date _____

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Patient HIPAA Consent Form

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 at 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 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 these restrictions.

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.

Patient Name Printed _____

Signature _____ Date _____

Relationship to Patient _____