Welcome

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us.

DATE:

PATIENT INFORMATION

Name: **Birth date:** **SS#**

Address: **City:** **State:** **Zip:**

Email: **Cell Phone:** **Home Phone:**

Sex: ☐ **M** ☐ **F** ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Partnered ☐ Minor

Who may we thank for referring you?

Employer/School: Employer/School Phone:

Employer/School address: City: State: Zip:

Spouse/Parent's Name: Employer: Phone:

Person to contact in case of emergency (and phone number)**:**

RESPONSIBLE PARTY

Person responsible for this account: **Relation to patient:**

Address: **City:** **State:** **Zip:**

Birth date: **Best phone:** **Work phone:** ext

Employer: **Current patient in our office?** ☐ **Yes** ☐ **No**

INSURANCE INFORMATION

Name of policy holder: **Relation to patient:**

Insured home address: **City:** **State:**

Birth date: **SS#** **Zip Code:**

Best Phone: **Employer:** Date Employed:

Insurance Company: **Group #** **ID#**

Deductible Amount: Annual Maximum:

ADDITIONAL INSURANCE

Name of policy holder: **Relation to patient:**

Insured home address: **City:** **State:**

Birth date: **SS#** **Zip Code:**

Best Phone: **Employer:** Date Employed:

Insurance Company: **Group#** **ID#**

Deductible Amount: Annual Maximum:

DENTAL HISTORY

Reason for today's visit: Date of last dental care:

Former Dentist: Date of last dental X-rays:

Address: City: State:

Check if you have had problems with any of the following:

☐ Bad breath ☐ Grinding teeth ☐ Bleeding gums ☐ Food collection between the teeth

☐ Clicking or popping jaw ☐ Periodontal treatment ☐ Loose teeth or broken fillings ☐ Sores/growths

☐ Sensitivity to cold ☐ Sensitivity to hot ☐ Sensitivity to sweets ☐ Sensitivity when biting

How often do you floss? How often do you brush?

MEDICAL HISTORY

Physician's name: Date of last visit:

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine), and Redux (dexfenfluramine). ☐ Yes ☐ No

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, describe:

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, approximate date:

(For women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check if you have had any of the following:

☐ Anemia	☐ Congenital Heart Lesions	☐ Hepatitis	☐ Scarlet Fever
☐ Arthritis, Rheumatism	☐ Cortisone Treatments	☐ Hernia Repair	☐ Shortness of Breath
☐ Artificial Heart Valves	☐ Cough, persistent	☐ High Blood Pressure	☐ Skin Rash
☐ Artificial Joints, Pins, etc.	☐ Cough up blood	☐ HIV/AIDS	☐ Stroke
☐ Asthma	☐ Diabetes	☐ Jaw Pain	☐ Swollen Feet/Ankles
☐ Back Problems	☐ Epilepsy	☐ Kidney Disease	☐ Thyroid Problems
☐ Bleeding Anormally	☐ Fainting	☐ Liver Disease	☐ Tobacco Habit
☐ Blood Disease	☐ Glaucoma	☐ Mitral Valve Prolapse	☐ Tonsilitis
☐ Cancer	☐ Headaches	☐ Pacemaker	☐ Tuberculosis
☐ Chemical Dependency	☐ Heart Murmur	☐ Radiation Treatment	☐ Ulcer
☐ Chemotherapy	☐ Heart Problems	☐ Respiratory Disease	☐ Venereal Disease
☐ Circulatory Problems	☐ Hemophilia	☐ Rheumatic Fever	

List all medications you are currently taking and correlating diagnosis:

Allergies:

David Roach, DDS
3824 Bedford Avenue, Nashville, TN 37215
Phone: 615-383-7801 Fax: 615-297-2834

PATIENT CONSENT FORM & FINANCIAL AGREEMENT

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s) have insurance coverage with _____ and assign directly to David Roach Family Dentistry all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. Payment of insurance-specified co-payment is due at the time of service. I am contracted with the above insurance company(ies) to pay this co-payment amount. I understand that I am financially responsible for all charges whether or not they are paid by insurance.

David Roach Family Dentistry may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that my information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physicians certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and I may contact this organization at any time at the above address to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used and disclosed to carry out treatment, payment or health care operations. I also understand you are required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you've taken action relying on this consent.

I, _____, choose the following option for my dental care and for the care of my dependents, if any.

Please check that which applies:

☐ I do not have dental insurance, and thus:

- ☐ As treatment progresses, at each appointment I elect to pay with: ☐ cash ☐ check ☐ credit card
- ☐ I prefer to secure a bank or credit union loan for the entire amount and make monthly payments to my lending institution.
- ☐ I wish to apply for your in-office finance plan. I understand that on approved credit, I may finance my entire treatment and make monthly payments.
- ☐ For treatment over $400.00, I elect to pay half on the preparation date and the balance on the second appointment.

☐ I have dental insurance through _____; I elect to pay my deductible and any uninsured portions as treatment progresses.

Patient Name: _____ **Date:** _____

Electronic Signature of Patient or Responsible Party: _____

Relationship to Patient: _____