DentalSpa Clarksville
800 Weatherly Drive Suite 103-B Clarksville, TN 37043
Phone: 931.647.8437 Fax: 931.647.8439
www.ClarksvilleDentalSpa.com

PATIENT REGISTRATION

Chart ID# ____________

Sec I

First Name____________________ Last Name _______________________ Middle Name ________________

Preferred Name ____

Street Address ____

City ____________________________________ State __________ Zip _____________________________

Mailing Address (if different from above) ____

City ____________________________________ State ___________ Zip ____________________________

Home Phone #___________________ Work # ________________Ext#_____ Cell# ___________________

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widow

Date of Birth: _____/________/_________ Age: ______ Social Security # _______- _______- ____________
Month Day Year

Emergency Contact Name and Number ____
(Must be different from the numbers above)

Email: ____________________________________ ☐ I would like to receive correspondences via e-mail.

Sec II

Current Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ COBRA Employer Name_____________________

Student Status: ☐ Full Time ☐ Part Time Name of School ____

How did you hear about us? ☐ Online directory ☐ Search Engine ☐ Social Media ☐ Phone Book ☐ TV ☐ Mag ☐ News ☐ Other

☐ Referred by a Patient __________________________ ☐ Referred by a Doctor ____________________

Do you have other family members (spouse/children) who attend this Practice? If so, who? ______________________

FOR OFFICE USE ONLY: LINKED ☐ ____

Sec III

Responsible Party (Adult Patient as listed above, Spouse, Parent or Legal Guardian responsible for this account)

What is your relationship to the patient? ____

First Name _______________________ Last Name _____________________ Middle Name ______________

Mailing Address ____

City ____ State ________ Zip ___________________________

Home Phone #___________________ Work # ______________Ext#_____ Cell# ______________________

Date of Birth ________/______/_________ Social Security # ____
Month Day Year

Sec IV

Insurance ☐ No Primary or Secondary Insurance

NOTICE: If you currently do not have insurance but may get it in the future, please be aware of our insurance office policy below. **We must have all insurance changes and updates 24 hours prior to your appointment!** Understand, we have to make lengthy calls to your insurance company *before* your appointment to obtain detailed information so we can get as accurate of an estimation as possible—ultimately to save you time and money.

Name of Primary Insurance Card Holder ________________________DOB___/____/____ SSN# _____-____-______

Name of Primary Dental Insurance Company____

Name of *Secondary* Insurance Card Holder ______________________DOB___/____/____ SSN# _____-____-______

Name of *Secondary* Dental Insurance Company ____

We file your insurance claim as a courtesy. If insurance policy changes are not provided to us 24 Hours prior to your appointment, payment will be due in full and we will in turn, file your claim to reimburse the policy holder. If your policy has been terminated or has a waiting period, you will be immediately responsible for charges incurred today. We make every effort to obtain as much policy information as possible. In addition, we are not responsible for erroneous information, status, or coverage quoted to us. As stated by your insurance company, the information given to us is an estimate (not a guarantee). Actual payment/benefit of your claim will be determined once the claim is processed by your insurance company.

For Office Use Only: ☐ Copy of Primary Card Attached ☐ Copy of Secondary Card Attached

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PATIENT MEDICAL HISTORY

Patient Full Name: ______________________ Patient Chart#: __________

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 or medications we prescribe. Thank you for answering the following questions.

Are you under a physicians care now? ◯ Yes ◯ No If Yes, Please Explain: __________
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If Yes, Please Explain: __________
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If Yes, Please Explain: __________
Are you taking any medications, pills or drugs? ◯ Yes ◯ No If Yes, Please Explain: __________
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No If Yes, Please Explain: __________
Do you take or have you taken Phen-Fen or Redux? ◯ Yes ◯ No If Yes, Please Explain: __________
Are you on a special diet? ◯ Yes ◯ No If Yes, Please Explain: __________
Do you use tobacco? ◯ Yes ◯ No If Yes, Please Explain: __________
Do you use controlled substances? ◯ Yes ◯ No If Yes, Please Explain: __________

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking Oral Contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are You allergic to any of the following? ◯ Aspirin ◯ Penicillin ◯ Codeine ◯ Local Anesthetics ◯ Acrylic ◯ Metal ◯ Latex ◯ Other If yes, please explain:
____

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

Condition	YES	NO	Condition	YES	NO	Condition	YES	NO	Condition	YES	NO
AIDS/HIV Positive	◯	◯	Cortisone Medicine	◯	◯	Hemophilla	◯	◯	Renal Dialysis	◯	◯
Alzheimer's Disease	◯	◯	Diabetes	◯	◯	Hepatitis A	◯	◯	Rheumatic Fever	◯	◯
Anaphylaxis	◯	◯	Drug Addiction	◯	◯	Hepatitis B or C	◯	◯	Rheumatism	◯	◯
Anemia	◯	◯	Easily Winded	◯	◯	Herpes	◯	◯	Scarlet Fever	◯	◯
Angina	◯	◯	Emphysema	◯	◯	High Blood Pressure	◯	◯	Shingles	◯	◯
Arthritis/Gout	◯	◯	Epilepsy or Seizures	◯	◯	Hives or Rash	◯	◯	Sickle Cell Disease	◯	◯
Artificial Heart Valve	◯	◯	Excessive Bleeding	◯	◯	Hypoglycemia	◯	◯	Sinus Trouble	◯	◯
Artificial Joint	◯	◯	Excessive Thirst	◯	◯	Irregular Heart Beat	◯	◯	Spina Bifida	◯	◯
Asthma	◯	◯	Fainting Spells/Dizziness	◯	◯	Kidney Problems	◯	◯	Stomach/Intestinal Disease	◯	◯
Blood Disease	◯	◯	Frequent Cough	◯	◯	Leukemia	◯	◯	Stroke	◯	◯
Blood Transfusion	◯	◯	Frequent Diarrhea	◯	◯	Liver Disease	◯	◯	Swelling of Limbs	◯	◯
Breathing Problem	◯	◯	Frequent Headaches	◯	◯	Low Blood Pressure	◯	◯	Thyroid Disease	◯	◯
Bruise Easily	◯	◯	Genital Herpes	◯	◯	Lung Disease	◯	◯	Tonsillitis	◯	◯
Cancer	◯	◯	Glaucoma	◯	◯	Mitral Valve Prolapse	◯	◯	Tuberculosis	◯	◯
Chemo Therapy	◯	◯	Hay Fever	◯	◯	Pain In Jaw Joints	◯	◯	Tumors or Growths	◯	◯
Chest Pains	◯	◯	Heart Attack/Failure	◯	◯	Parathyroid Disease	◯	◯	Ulcers	◯	◯
Cold Sores/Fever Blisters	◯	◯	Heart Murmur	◯	◯	Psychiatric Care	◯	◯	Venereal Disease	◯	◯
Congenital Heart Disorder	◯	◯	Heart Pace Maker	◯	◯	Radiation Treatments	◯	◯	Yellow Jaundice	◯	◯
Convulsions	◯	◯	Heart Trouble/Disease	◯	◯	Recent Weight Loss	◯	◯			

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, Please Explain: __________
____

Comments:

AUTHORIZATION & RELEASE: I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me, or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill of services. I agree to be responsible for payment of all services rendered on my behalf or my dependants. It is my responsibility to inform the dental office of any changes in my medical status.

By signing below, I acknowledge that I am over the age of 18 and/or I am the legal parent or guardian.

Signature of PATIENT, PARENT or GUARDIAN__________ **DATE**__________

Please Print Name __________

Your Privacy Is Important to Us

Acknowledgement of Receipt of Notice of Privacy Policies

I received a copy of the Notice of Privacy Practices of Clarksville Dental Spa **I hereby authorize,** as indicated by my signature below, Clarksville Dental Spa to use and to disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent form.

Print Name ______________________ Address ______________________

Signature ______________________ Date ______________________

Please check your preferred means of communication:

☐ You may contact me at my home telephone ______________________

☐ You may contact me on my mobile telephone number ______________________

☐ You may contact me on my work telephone number ______________________

☐ You may send me an email at ______________________

☐ Other ______________________

Please list authorized persons with whom we may discuss your Protected Health Information (PHI), Please notify us if you desire to remove a name from this list in the future.

1. ______________________ Date / / Relationship: ______________________
2. ______________________ Date / / Relationship: ______________________
3. ______________________ Date / / Relationship: ______________________
4. ______________________ Date / / Relationship: ______________________

*** Fore 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 the acknowledgement

☐ Other (Please Specify)

Staff Person Initials: ______________________

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FINANCIAL POLICY

Thank you for choosing our practice to provide your dental needs. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy, which we require you to read and sign prior to treatment.

Payment is due in full at the time of service. Our practice does not accept monthly payments. We accept cash, checks, and all major credit and debit cards. We have financing available from 3 months all the way up to 5 years and have options for those who may not be able to obtain financing.

TREATMENT ESTIMATES

- Fees are estimates only, and are valid for 3 months from the time treatment is presented. Treatment can be altered if your dental needs change. You will be notified of any changes. You will always be given a treatment estimate for future appointments.
- We are required by law to inform you of your dental condition. Our goal is to educate patients about the treatment they need and help them achieve optimum oral health. We recommend dental treatment based on necessity not based on what your insurance company may or may not cover. Once we provide you with this information, it is then your decision to accept or deny treatment.

INSURANCE

- Our practice collects a standard amount before procedures are performed, this amount **DOES NOT** reflect what your insurance will pay, but instead what we prefer to collect at the time of service. We may call to verify your insurance, but we do not get detailed policy information such as waiting periods, limitations, or special clauses.
- Please read your insurance policy carefully. It is your responsibility to be aware of your plan benefits as well as its limitations.
- Our office is unable to wait past 60 days for insurance claims to be paid. If your claim takes longer than 60 days to be processed, you will be asked to pay that portion and seek reimbursement from your insurance.
- If your insurance pays more than expected, you will be reimbursed immediately. If a balance remains after insurance pays, you will receive a statement and payment is due in full within 30 days.
- Usual and Customary Rates: Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible to pay the difference between our fee and what your insurance company determines to be “usual and customary” rate.

SEDATION APPOINTMENTS

Patients are required to pay their portions prior to the day of treatment. All third-party financing must be approved before date of sedation appointment.

MINOR PATIENTS

No minor will be seen in our office without a parent or guardian present. The parent accompanying the minor child is responsible for payment. In the case of divorce, regardless of decree, the parent who brings the child and has signed the financial agreements is responsible to pay for the child’s services.

MISSED APPOINTMENTS

***Effective immediately, there will be a $150 charge to return to Dr. Harrison’s services if two appointments have been broken or cancelled in less than 24 hours. There will be a $400 charge for any IV sedation or general anesthesia broken or cancelled with less than 48 hours notice, whether the appointment is rescheduled or not.

I understand this financial policy and that I am responsible to pay all fees associated with my treatment. I understand that estimates given to me are ONLY ESTIMATES and I am still responsible for any balance not covered by my insurance company.

Patient (PARENT) Signature ______________________________ Date ____________________

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Patient #: _________

Name: ______________________________ Social Security # ______________________________

Address: ______________________________ Telephone: ______________________________

______________________________ E-mail: ______________________________

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosure we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Clarksville Dental Spa
800 Weatherly Drive Suite 103-B Clarksville, TN 37043
Phone: 931.649.8437 Fax: 931.647.8439

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, ______________________________, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: ______________________________ Date: ______________________________

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: ______________________________ Relationship to Patient: ________________

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: ______________________________ Date: ______________________________

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Include completed Consent in the Patient's chart.

DentalSpa
Clarksville

Patient Consent

Clinical

1. I authorize Clarksville Dental Spa to perform all recommended treatment.

2. I authorize the Practice to take radiographs, study model, photos, and other diagnostice aids or materials (collectively, “Diagnostic Material”) as needed to make a thorough diagnosis. I authorize that such Diagnostic Material may be released to third-party payors and/or other health professionals.

3. I authorize the use of anesthetics, sedative, and other medication, as needed, and am fully aware that using anesthetic agents involves certain risks, including but not limited to redness and swelling of tissues, pain, itching, vomiting, dizziness, miscarriage, cardiac arrest, drowsiness, and/or lack of coordination.

Financial

4. I am responsible for payment for all services rendered on my behalf. I understand that payment is due when services are rendered. I am aware that a 1.5% MPR or 18% APR is automatically tabulated into my account if my balance is 30 days old or older. Should my account become delinquent, I will be responsible for all additional collection costs, including reasonable attorney fees.

5. A $50 missed appointment fee will be charged to my account for all missed appointments or last minute cancellations by me. I am aware that to hold down operating costs, 24 hours notice of cancellation is required.

Insurance

6. I authorize the Practice to release to staff, hospitals, health care service plans, insurance companies, self-insurers or their representatives, any and all information, records, and other Diagnostic Material about my medical history, services rendered, or recommended treatment.

7. I authorize the Practice to submit claims for payment for services rendered or pre-authorizations necessary to my insurance company, on my behalf and in my name listed as “signature on file” and assign to the Practice the Insurance benefits providing assignment is accepted. I am responsible for payment regardless of coverage provided.

I have read this Patient Consent and agree to all terms and conditions herein.

Patient’s Name: ______________________________ Date: ______________

Patient’s Address: ____

If patient is a child, please provide the parental or legal guardian’s consent:

Signature: ____________________ Relationship: __________ Date: ______________

NOTE (MINORS): The parent or legal guardian must complete this form for a minor, provide consent for dental treatment and accompany the child during each dental visit. If the parent or guardian consented to treatment in advance, an authorized individual named on Page 1 may bring the child. Treatment will not be provided for unattended children.