# Lynnwood Dental

## Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Gender: M F (circle one) Married: Yes No (circle one)

Social Security #: _____ Birth Date: _____

***So that we may easily contact you please include the following:***

Cell Phone #: _____ Home Phone #: _____ Email: _____

Address: _____
Street Apartment #

_____
City State Zip Code

## Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

**Have you ever had any of the following? Please check those that apply:**

- ☐ AIDS
- ☐ Anemia
- ☐ Alcohol Dependency
- ☐ Arthritis / Rheumatism
- ☐ Artificial Joints / Joint Replacement
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer Type_____
- ☐ Chemical Dependency
- ☐ Cold Sores / Fever Blisters
- ☐ Diabetes
- ☐ Dizziness / Fainting
- ☐ Epilepsy / Seizures
- ☐ Eating Disorder
- ☐ Excessive Bleeding
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Headaches

Heart Disease
- ☐ Heart Attack Date____
- ☐ Heart Murmur
- ☐ Pacemaker
- ☐ Heart Surgery
- ☐ Mitral Valve Prolapse
- ☐ Congenital Heart Defect

- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Hepatitis
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Health Care
- ☐ Nervous Disorders
- ☐ Pregnancy (Currently)
- ☐ Nursing (Currently)
- ☐ Radiation / Chemotherapy Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Sexually Transmitted Disease
- ☐ Sinus Problems
- ☐ Steroid Treatment
- ☐ Stomach Problems
- ☐ Stroke

Thyroid Disorders
- ☐ Hyperthyroid
- ☐ Hypothyroid

- ☐ Tuberculosis
- ☐ Ulcers

OTHER:
- ☐ _____
- ☐ _____

- List all current medications (including non-prescription): _____

_____

- List all allergies (ex. penicillin, codeine, latex): _____
- Have you ever had any complications following dental treatment? ☐ Yes ☐ No

  If yes, please explain: _____
- Do you use tobacco products? ☐ Yes ☐ No

  If yes, quantity, frequency: _____
- Have you ever taken medication for osteoporosis? ☐ Yes ☐ No
- Please explain any past hospitalizations or major surgeries: _____

_____
- Are you now under the care of a physician? ☐ Yes ☐ No

  If yes, please explain: _____

  Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No

  If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

## Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

## Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

## Insurance Information

**Primary**

Insurance Plan Name and Address: _____

_____

Name of Insured: _____
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's SS#: _____ Insured's Employer Name: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

**Secondary**

Insurance Plan Name and Address: _____

_____

Name of Insured: _____
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Employer Name: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

### Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

### Emergency Contact

Name: _____ Phone #: _____

Relationship: _____

Payment for services is due when services are provided unless prior arrangements have been made. We will use the information you provide to file your claim with your insurance carrier. However, you are ultimately responsible for all charges.

_____ _____ Date: _____
Printed Name Signature of patient, parent or guardian

# Lynnwood Dental

**122 Lynnwood Drive**
**Knoxville, TN 37918**
**www.LynnwoodDental.com**

## GENERAL CONSENT FOR TREATMENT

Thank you for choosing our office for your dental care. We will work with you to help you achieve excellent oral health. While recognizing the benefits of a pleasing smile and teeth that function well, you should be aware that dental treatment, like treatment of any other part of the body, has some inherent risks. These are seldom great enough to offset the benefits of treatment, but should be considered when making treatment decisions.

Benefits of dental treatment can include: relief of pain, the ability to chew properly, and the confidence and social interaction that a pleasing smile can bring. Nonetheless, there are some common risks associated with virtually any dental procedure, including:

1. **Drug or chemical reaction.** Dental materials and medications may trigger allergic or sensitivity reactions causing symptoms such as redness, swelling, itching, and/or anaphylactic shock and death.
2. **Long-term numbness (paresthesia).** Local anesthetic, or its administration, while almost always adequate to allow comfortable care, can result in transient, or in rare instances permanent, numbness.
3. **Muscle or joint tenderness**. Holding one's mouth open can result in muscle or jaw joint tenderness, or in a predisposed patient, precipitate a TMJ disorder.
4. **Sensitivity in teeth or gums, infection, or bleeding**.
5. **Swallowing or inhaling small objects**.

I have advised the office of any and all allergies I have and will inform them in the future of any changes.

**Consent for Composite Restorations on Posterior Teeth**
Tooth colored composite fillings are a modern day improvement over amalgam (mercury) fillings of the past. It is for this reason that Lynnwood Dental performs only composite fillings. Some insurance policies do not cover composite fillings on posterior teeth. These companies reimburse for what they would pay for an amalgam restoration, with the balance the responsibility of the patient. I agree to be financially responsible for all copays related to posterior composites for myself and those for whom I am financially responsible.

**Cancellation Policy**
Our office is a busy one – we have many patients, and our schedule can be quite full. As such, we request at least 24 hours notice before canceling and/or rescheduling any dental appointment. Each appointment is a valuable block of time in our schedule, and when proper notice is given, we are still able to offer your canceled appointment time to another patient. A $35.00 per hour fee will be accessed for all no-shows and late cancellations.

I have read and understand the statement on this page.

_____ _____
Patient's signature Date

_____ _____
Parent's signature (if minor patient) Date

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**Knoxville, TN 37918**
**www.LynnwoodDental.com**

## FINANCIAL STATEMENT

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. The following is a statement of our Financial Agreement, which we require you read prior to any treatment.

All patients must complete our Registration and Medical/Dental History form before seeing the providers.

* **FULL PAYMENT IS DUE AT THE TIME OF SERVICE.**
* **WE ACCEPT CASH, CHECKS, VISA/MASTERCARD, DISCOVER, AND AMEX.**

**REGARDING INSURANCE**
We will gladly estimate your deductible, your portion of treatment costs, and bill your insurance company for your treatment, all at no extra cost to you. We do require that you pay your portion of the treatment fee (Co-Pay and deductible) at the time of service. We will bill your insurance company if we are provided with your insurance information and a copy of your insurance card. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Please be sure to read and know your own insurance policy. We are more than happy to assist you in billing your primary dental benefits provider, however, **if your insurance company has not paid within 45 days, you will be responsible for the balance in full, and all insurance inquiries and follow-up become your responsibility.** ***The balance is your responsibility whether or not your insurance company deems your treatment to be a covered benefit.***

**SECONDARY INSURANCE PLANS**
We do not bill secondary insurance companies, but we will provide you with copies of the needed information so that you can forward that information to your secondary insurance company for reimbursement.

**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 for payment of any insurance company's arbitrary determination of usual and customary rates.

**PATIENTS WITHOUT INSURANCE**
Patients without dental insurance are responsible for payment in full when treatment is received unless financial arrangements have been made prior to appointment.

**FINANCIAL ARRANGEMENTS**
In the event a short-term financial arrangement is necessary, payment options will be discussed on an individual basis.

**NO-SHOW AND LATE CANCELLATIONS**
To assure that each and every patient is seen in a timely manner, it is imperative that our office receive a **24 hour** notice if you are unable to keep your appointment. A $35.00 per hour fee will be accessed for all no-shows and late cancellations.

**INTEREST, LATE FEES and COLLECTION FEES**
As stated on our Patient Registration form, we reserve the right to assess an annual 18% interest charge on all overdue accounts 60 days after original charge is made. Late fees will be assessed to payments received after the due date on statement. If payment is not made as agreed, patient shall be responsible for any reasonable attorney fees, costs of collection, and court costs incurred in efforts to enforce this agreement.`

Thank you for understanding our Financial Agreement. Please let us know if you have any questions or concerns.

I herby authorize and direct payment of dental insurance benefits to Lynnwood Dental, Sara B. Boren, DDS, PLLC.
**I UNDERSTAND AND AGREE TO THIS FINANCIAL STATEMENT.**

_____ _____

SIGNATURE DATE

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# HIPAA Privacy Rule of Patient Authorization Agreement

### Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))

I, _____, (patient's name) understand that as part of my healthcare, this facility originates a nd maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment;
- a means of communication among the health professionals who may contribute to my healthcare;
- a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party payer can verify that services billed were actually provided;
- a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I have the right to read or be provided a copy of the ***Notice of Privacy Practices*** that provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this facility's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

# Privacy Rule of Patient Consent Agreement

### Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.506(a))

I understand that:

- I have the right to review this facility's Notice of Information practices prior to signing this consent;
- This facility, reserves the right to change the notice and practices and that prior to implementation will mail a copy of any revised notice to the address I've provided if requested;
- I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that this facility is not required by law to agree to the restrictions requested.
- I may revoke this consent in writing at any time, except to the extent that this facility, has already taken action in reliance thereon.
- It is this facility's procedure to share Protected Health Information with labs, x-rays, consulting physicians, and hospitals. We will call the pharmacy of your choice regarding your prescriptions. We will only exchange minimum necessary Protected Health Information for each transaction.

Signature of Patient or Legal Representative Witness _____

Printed Name of Patient or Legal Representative Witness _____

Date:_____