

## PATIENT INFORMATION

SAL: Mr./Mrs./Ms. \_\_\_\_ Last \_\_\_\_\_ Address \_\_\_\_\_  
First : \_\_\_\_\_ MI: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_  
Nick Name: \_\_\_\_\_ Phone h. \_\_\_\_\_ w. \_\_\_\_\_  
SSN: \_\_\_\_\_ Sex: M / F Cell Phone \_\_\_\_\_  
Relation To Insured \_\_\_\_\_ E-Mail Address \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Marital Status \_\_\_\_\_

## Individual Financially Responsible for Account

The undersigned hereby authorizes the doctor to take X-rays, study models, photographs, or any other diagnostic aid deemed appropriate to make a thorough diagnosis of the patients dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated. I also understand that the use of anesthetic agents embody a certain risk. I understand that payment for dental services provided in this office for myself and my dependents is mine, due and payable at the time services are rendered. I also assign all insurance benefits to the doctor performing dental services. A fee may be charged for all appointments broken without 24hour notice.

Signature of Responsible Party \_\_\_\_\_ Date \_\_\_\_\_

SAL: Mr./Mrs./Ms. \_\_\_\_ Last \_\_\_\_\_ Address \_\_\_\_\_  
First: \_\_\_\_\_ MI: \_\_\_\_\_ Address \_\_\_\_\_  
SSN: \_\_\_\_\_ Sex: M / F City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Phone \_\_\_\_\_

### EMPLOYER

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ Zip \_\_\_\_\_  
Phone \_\_\_\_\_ Ext. \_\_\_\_\_

### INSURANCE

Insurance Carrier \_\_\_\_\_  
Policy/Group# \_\_\_\_\_ Ph# \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_  
Ins. start date \_\_\_\_\_ Type of Ins. PPO, HMO,  
SelfPay, other

### SPOUSE

SAL: Mr./Mrs./Ms. \_\_\_\_ Last \_\_\_\_\_  
First : \_\_\_\_\_ MI: \_\_\_\_\_  
SSN: \_\_\_\_\_ Sex: M / F  
Date of Birth \_\_\_\_\_

### SPOUSE EMPLOYER

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ Zip \_\_\_\_\_  
Phone \_\_\_\_\_ Ext. \_\_\_\_\_

### SPOUSE(OTHER INSURANCE)

Insurance Carrier \_\_\_\_\_  
Policy/Group# \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_  
Ins. start date \_\_\_\_\_ Type of Ins. PPO, HMO,  
SelfPay, other

### EMERGENCY CONTACT (NOT LIVING WITH YOU)

Name \_\_\_\_\_  
Address \_\_\_\_\_  
Phone \_\_\_\_\_

### HOW DID YOU HEAR ABOUT OUR OFFICE. AND WHO MAY WE THANK FOR REFERING YOU?

Publication's  
Name \_\_\_\_\_  
Individual's Name \_\_\_\_\_

DENTAL HISTORY

Reason for Today's Visit \_\_\_\_\_

Former Dentist \_\_\_\_\_ Address \_\_\_\_\_

Date of last dental care \_\_\_\_\_ Date of last dental X-rays \_\_\_\_\_

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

- Bad breath                       Food collection between teeth     Periodontal treatment     Sensitivity to sweets
- Bleeding gums                       Grinding teeth                       Sensitivity to cold             Sensitivity when biting
- Clicking or popping jaw     Loose teeth or broken fillings     Sensitivity to hot             Sores or growths in your mouth

How often do you floss? \_\_\_\_\_ How often do you brush? \_\_\_\_\_

Are you happy with the color of your teeth? Yes No      Would a smile enhancement interest you? Yes No

MEDICAL HISTORY

Physician's Name \_\_\_\_\_ Date of Last Visit \_\_\_\_\_

Have you ever taken Phen-fen or other diet pills? Yes No If yes, drug name \_\_\_\_\_

Have you had any serious illnesses or operations? Yes No If yes Describe \_\_\_\_\_

Have you ever had a blood transfusion? Yes No If yes, give approximate dates \_\_\_\_\_

(Women) Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

Check (X) if you have or have had any of the following:

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> AIDS                    | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Hepatitis-Type _____  | <input type="checkbox"/> Rheumatic Fever            |
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Cough, Persistent    | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Scarlet Fever              |
| <input type="checkbox"/> Arthritis, Rheumatism   | <input type="checkbox"/> Cough up Blood       | <input type="checkbox"/> HIV Positive          | <input type="checkbox"/> Shortness of Breath        |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Jaw Pain              | <input type="checkbox"/> Skin Rash                  |
| <input type="checkbox"/> Artificial Joints       | <input type="checkbox"/> Epilepsy             | <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> Stroke                     |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Fainting             | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Swelling of Feet or Ankles |
| <input type="checkbox"/> Back Problems           | <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Thyroid Problems           |
| <input type="checkbox"/> Blood Disease           | <input type="checkbox"/> Headaches            | <input type="checkbox"/> Nervous Problems      | <input type="checkbox"/> Tobacco Habit              |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Heart Murmur         | <input type="checkbox"/> Pacemaker             | <input type="checkbox"/> Tonsillitis                |
| <input type="checkbox"/> Chemical Dependency     | <input type="checkbox"/> Heart Problems       | <input type="checkbox"/> Psychiatric Care      | <input type="checkbox"/> Tuberculosis               |
| <input type="checkbox"/> Chemotherapy            | Describe _____                                | <input type="checkbox"/> Radiation Treatment   | <input type="checkbox"/> Ulcer                      |
| <input type="checkbox"/> Circulatory Problems    | <input type="checkbox"/> Hemophilia           | <input type="checkbox"/> Respiratory Disease   | <input type="checkbox"/> Venereal Disease           |

MEDICATIONS

List medications you are currently taking: \_\_\_\_\_

ALLERGIES

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

AUTHORIZATION

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits.

I understand that I am financially responsible for all charges on this account. I also agree to be responsible for all court costs, reasonable attorney fees and collection agency fees in the event of default.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Payment is due in full at time of treatment unless prior arrangements have been approved

# Patient Liability

We feel it is appropriate to clarify a possible misconception you might have regarding your insurance company and the percentage your insurance company will allow.

Most insurance companies do not pay 100 percent of a dental bill. You, the patient, are responsible for the total bill. Each insurance company has different rules, regulations and coverage guarantees. Usually no two insurance companies are alike in what dental services they cover. It would be a good idea for you to investigate your policy so you will be aware of your obligation.

By understanding this concept now, you will avoid surprises later. Our policy at this office states that you are totally responsible for your bill. We will appropriately process your insurance claim for the insurance company to reimburse you.

We will assist you in every way possible to understand the terms of your insurance coverage pertaining to our dental service, however we can not accept responsibility for collecting or negotiating disputed insurance claims.

A fee may be charged for all appointments broken without 24 hour notice.

If you have any questions regarding the above, please do not hesitate to ask for our assistance in further explaining any phase of your obligation.

## Assignment of Benefits

I will be responsible for payment in full.

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Subscriber's Signature

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Date

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Patient's Signature  
(if other than insurance subscriber)

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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 IT CAREFULLY. **THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

### OUR LEGAL DUTY

Federal and state law requires us to maintain the privacy of your health information. That law also requires us to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices we describe in this notice while it is in effect. This notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such applicable law permits the changes. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice;

### USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and health care operations. For example:

**Treatment:** We may use your health information for treatment or disclose it to a dentist, physician or other health care provider providing treatment to you.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you. We may also disclose your health information to another health care provider or entity that is subject to the federal Privacy Rules for its payment activities.

**Health Care Operations:** We may use and disclose your health information for our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. We may disclose your health information to another health care provider or organization that is subject to the federal privacy rules and that has a relationship with you to support some of their health care operations. We may disclose your information to help these organizations conduct quality assessment and improvement activities, review the competence or qualifications of health care professionals, or detect or prevent health care fraud and abuse.

**On Your Authorization:** You may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any uses or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

**To Your Family and Friends:** We may disclose your health information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care. Before we disclose your health information to these people, we will provide you with an opportunity to object to our use or disclosure. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We may use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information. We may use or disclose information about you to notify or assist in notifying a person involved in your care, of your location and general condition.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters.)

**Disaster Relief:** We may use or disclose your health information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

**Public Benefit:** We may use or disclose your medical information as authorized by law for the following purposes deemed to be in the public interest or benefit: as required by law; for public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury; to report adult abuse, neglect, or domestic violence;

- to health oversight agencies;
- in response to court and administrative orders and other lawful processes;
- to law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person;
- to coroners, medical examiners, and funeral directors;
- to an organ procurement organizations;
- to avert a serious threat to health or safety;
- in connection with certain research activities;
- to the military and to federal officials for lawful intelligence, counterintelligence, and national security
- to correctional institutions regarding inmates; and
- as authorized by state worker's compensation laws.

## PATIENT RIGHTS

**Access:** 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 than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you a reasonable cost-based fee that may include labor, copying costs, and postage. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we may-but are not required to-prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this notice for more information about fees.

**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information over the last 6 years (but not before April 14, 2003). That list will not include disclosures for treatment, payment, health care operations, as authorized by you, and for certain other activities. 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. Contact us using the information listed at the end of this notice for more information about fees.

**Restriction:** You have the right to request that we place additional restrictions on our use or 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). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. Your request is not binding unless our agreement is in writing.

**Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. You must specify in your request the alternative means or location, and provide satisfactory explanation how you will handle payment under the alternative means or location you request.

**Amendment:** You have the right to request that we amend your health information. Your request must be in writing, and it must explain why we should amend the information. We may deny your request under certain circumstances.

## QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us using the information listed at the end of this notice. If you believe that:

- we may have violated your privacy rights,
- we made a decision about access to your health information incorrectly,
- our response to a request you made to amend or restrict the use or disclosure of your health information was incorrect, or
- we should communicate with you by alternative means or at alternative locations,

you may contact us using the information listed below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Provider Contact Office: William M. Smith D.D.S.,P.L.L.C.

Telephone:901-753-2273 Fax:901-7537673

Address: 1890 N. Germantown Pkwy Suite #105  
Cordova, TN 38018

*Dr. William M. Smith D.D.S., P.L.L.C.*

**SECTION A: The Patient.**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

E-mail: \_\_\_\_\_

Patient Number: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

**SECTION B: Acknowledgement of Receipt of Privacy Practices Notice.**

I, \_\_\_\_\_, acknowledge that I have received a  
Notice of Privacy Practices from the above-named practice.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

If a personal representative signs this authorization on behalf of the individual, complete the following:

Personal Representative's Name: \_\_\_\_\_

Relationship to Individual: \_\_\_\_\_

**SECTION C: Good Faith Effort to Obtain Acknowledgement of Receipt.**

Describe your good faith effort to obtain the individual's signature on this  
form: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Describe the reason why the individual would not sign this form:

**SIGNATURE:**

I attest that the above information is correct.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print name: \_\_\_\_\_ Title: \_\_\_\_\_

*Include this acknowledgement of receipt in the individual's records.*

**ACKNOWLEDGEMENT OF RECEIPT  
OF PRIVACY PRACTICES NOTICE**