Advanced Dental
HEALTH CENTER

Patient Registration

Patient Information

Patient Name _____ Legal Name _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email Address _____ Patient DOB _____ Sex: ☐ M ☐ F

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Social Security # _____

☐ Full-time student If yes, where? _____ Responsible Party: ☐ Self ☐ Other _____

Patient's Employer _____ Driver License# _____

City _____ State _____ Zip _____

Spouse's Name _____ Spouse's Cell _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone _____ Work Phone _____

What brings you in today? _____

_____

How did you hear about our practice? _____

Dental Insurance

Primary Insurance Company _____ Subscriber Name _____

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

ID# _____ Group # _____ Subscriber's DOB _____

Subscriber's Employer _____

Secondary Insurance Company _____ Subscriber Name _____

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

ID# _____ Group # _____ Subscriber's DOB _____

Subscriber's Employer _____

Assignment and Release

I certify that I and/or my dependent(s) have insurance coverage with _____ *(Insurance Company)* and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my healthcare 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 or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____

Signature of Patient, Parent or Guardian **Date**

_____ _____

Please Print Name of Patient, Parent or Guardian **Relationship** to Patient

Advanced Dental
HEALTH CENTER

Health History

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. Thank you for answering the following questions.

Are you under a physician's care now? ☐ Yes ☐ No If yes _____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes _____

Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes _____

Are you taking any medications, pills or drugs? ☐ Yes ☐ No If yes _____

Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No If yes _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ Yes ☐ No If yes _____

Are you on a special diet? ☐ Yes ☐ No If yes _____

Do you use tobacco? ☐ Yes ☐ No If yes _____

I am a woman who is... ☐ Pregnant/Trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives ☐ N/A

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Other _____

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics ☐ No Known Allergies

Do you use controlled substances? ☐ Yes ☐ No If yes _____

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

☐ AIDS/HIV Positive
☐ Alzheimer's Disease
☐ Anaphylaxis
☐ Anemia
☐ Angina
☐ Arthritis/Gout
☐ Artificial Heart Valve
☐ Artificial Joint
☐ Asthma
☐ Blood Disease
☐ Blood Transfusion
☐ Breathing Problems
☐ Bruise Easily
☐ Cancer
☐ Chemotherapy
☐ Chest Pains
☐ Cold Sores/Fever Blisters
☐ Congenital Heart Disorder
☐ Convulsions
☐ Cortisone Medicine
☐ Diabetes
☐ Drug Addiction
☐ Easily Winded
☐ Emphysema
☐ Epilepsy or Seizures
☐ Excessive Bleeding
☐ Excessive Thirst
☐ Fainting Spells/Dizziness
☐ Frequent Cough
☐ Frequent Diarrhea
☐ Frequent Headaches
☐ Genital Herpes
☐ Glaucoma
☐ Hay Fever
☐ Heart Attack/Failure
☐ Heart Murmur
☐ Heart Pacemaker
☐ Heart Trouble/Disease
☐ Hemophilia
☐ Hepatitis A
☐ Hepatitis B or C
☐ Herpes
☐ High Blood Pressure
☐ High Cholesterol
☐ Hives or Rash
☐ Hypoglycemia
☐ Irregular Heartbeat
☐ Kidney Problems
☐ Leukemia
☐ Liver Disease
☐ Low Blood Pressure
☐ Lung Disease
☐ Mitral Valve Prolapse
☐ Osteoporosis
☐ Pain in Jaw Joints
☐ Parathyroid Disease
☐ Psychiatric Care
☐ Radiation Treatments
☐ Recent Weight Loss
☐ Renal Dialysis
☐ Rheumatic Fever
☐ Rheumatism
☐ Scarlet Fever
☐ Shingles
☐ Sickle Cell Disease
☐ Sinus Trouble
☐ Spina Bifida
☐ Stomach/Intestinal Disease
☐ Stroke
☐ Swelling of Limbs
☐ Thyroid Disease
☐ Tonsillitis
☐ Tuberculosis
☐ Tumors or Growths
☐ Ulcers
☐ Venereal Disease
☐ Yellow Jaundice

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes _____

Comments _____

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

Please Print Name of Patient, Parent or Guardian

_____ _____

Signature of Patient, Parent or Guardian **Date**

P 615-460-0123 | **F** 615-460-0119 | 2405 Crestmoor Road, Nashville, TN 37215 | AdvancedDentalHealthCenter.com

Advanced Dental
HEALTH CENTER

Office Policy

We are dedicated to providing you with the very best dental care and service, as a result, your understanding of our office policy is an essential element of your care and treatment. If you have any questions, please feel free to discuss them with our office staff.

_____
Initials

Appointments

Our policy allows us to schedule appointments for our patients, with respect for your time, the next patient's time, and the doctor and hygienist's time. If a change needs to be made to your appointment, we ask you to call with 48 hours notice in order to reschedule another appointment in advance. We also request that you be on time for your visits. If you are more than 10 minutes late, you may have to reschedule your appointment.

_____
Initials

Group or Individual Dental Insurance

Treatment recommendations are based on your health not on your insurance or lack thereof. If you have dental insurance it is your responsibility to KNOW YOUR BENEFITS AND LIMITATIONS and to provide us with complete and accurate information to file your claims. Your insurance is an agreement between you and your insurance company, not between your insurance company and our office. We cannot be certain of what your insurance covers. The amount they pay varies from one policy to another. As a courtesy to you, our office will call to verify benefits; however, the benefits quoted to us by your insurance company are not a guarantee of payment. **It is to be understood and agreed that any services rendered are charges to you directly and you are personally responsible for payment of any non-covered services, downgrades, deductibles, or co-payments.** As a convenience to you, we will file your insurance, and you will be billed for any balance that remains after insurance has paid. If we have not received payment on a claim after 60 days, the entire balance of that claim is due immediately from the patient. If your insurance company later pays, we will refund your payment.

Secondary insurance claims will be filed as a courtesy. Benefits will not be verified. The portion owed for each visit will reflect the primary insurance only. Additional discounts are not applicable for in-network insurance plans and coupons.

_____
Initials

Financial

Payment is due when services are rendered. For your convenience, we accept cash, checks and credit cards. **For major procedures we collect 50% of your estimated patient portion to reserve an appointment time with Dr. Cummings, then the remaining balance when services are rendered.** Payment plan options are available through CareCredit and LendingClub. Any account over 90 days old will be assessed a finance charge of 1.5% of the unpaid balance. **You, the patient, agree to pay for reasonable attorney's fees, court costs, and costs of collection on overdue accounts. There will also be a $35 charge for any returned check.**

I have read and understand Advanced Dental Health Center's Office Policy and I agree to be bound by its terms. I am aware that I will be charged for missed appointments, and I agree to these terms.

_____ _____
Signature of Patient, Parent or Guardian **Date**

_____ _____
Please Print Name of Patient, Parent or Guardian **Staff** signature

Advanced Dental
HEALTH CENTER

Acknowledgment of Privacy Practices

I, _____, have reviewed and/or received a copy of this office's Notice of Privacy Practices
(please print name)

_____ _____
Signature of Patient, Parent or Guardian **Date**

OFFICE USE ONLY BELOW THIS LINE

We attempted to obtain written acknowledgement of reciept of our Notice of Privacy Practices, but acknowledgement could not be obtained for the following reason:

- ☐ Communication Barrier
- ☐ Other (Please Specify)

Advanced Dental
HEALTH CENTER

Authorization for Disclosure of My Healthcare Information

Patient Name _____ Date of Birth _____
(please print)

Advanced Dental Health Center may disclose the following healthcare information:

(check all that apply)

- ☐ All healthcare information in my dental record (X-Rays, bills, etc.)
- ☐ Healthcare information in my dental record relating to the following treatment or condition:

  _____

  Date of Service _____

Advanced Dental Health Center may disclose this healthcare information to the following individual(s):

(spouse, family member, etc.)

Name _____ Relationship to Patient _____

Name _____ Relationship to Patient _____

Name _____ Relationship to Patient _____

Name _____ Relationship to Patient _____

☐ **I DO NOT wish to have my healthcare information disclosed to anyone.**

_____ _____
Signature of Patient, Parent or Guardian **Date**

_____ _____
Please Print Name of Patient, Parent or Guardian **Relationship** to Patient