WELCOME TO SURRATT FAMILY DENTAL

PATIENT INFORMATION

Name: _____ Who may we thank for referring you?: _____

Gender: M ▢ F ▢ Address: _____ City/State/Zip: _____

Home phone: (____) _____ Work phone: (____) _____ Cell phone: (____) _____

Email: _____ Best time to reach you: _____

Birthdate: _____ Age: _____ SSN#: _____

Patient or Parent/Guardian's Employer: _____ Occupation: _____

If student, name of school/college:_____ City: _____ State: _____Full-Time ▢ Part-Time ▢

Minor ▢ Single ▢ Married ▢ Divorced ▢ Widowed ▢ Separated ▢

Spouse or Parent/Guardian's Name: _____ Employer: _____

Work phone: (____) _____ Cell phone: (____)_____ Email: _____

RESPONSIBLE PARTY

(If someone other than the patient is responsible for the account)

Name of Person Responsible for Patient:_____ Phone: (____) _____

Relationship to Patient: _____ Is this person currently a patient in our office? Y ▢ N ▢

Address: _____ City/State/Zip: _____ Birthdate: _____

Email: _____ Driver's License #: _____ SSN#: _____

Financial Institution: _____ Employer: _____ Work phone: (____) _____

We offer various options of payment. Please check the option you prefer. Payment in full at each appointment:

Cash ☐ Check ☐ Credit Card ☐ MasterCard ☐ VISA ☐ I wish to discuss the office's payment policy ☐

INSURANCE INFORMATION

Name of insured: _____ Birthdate: _____ SSN#: _____

Relationship to Patient _____ Name of Employer: _____

Address of Employer: _____ City/State/Zip: _____ Work Phone: (____) _____

Insurance company: _____ Grp #: _____ ID#: _____

Insurance Company Address: _____ Ins Co. Phone: (____) _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit: _____

Union of Local #: _____ Is there secondary insurance coverage? Y ▢ N ▢

Name of insured: _____ DOB: _____ SSN#: _____

Relationship to Patient: Self ▢ Spouse ▢ Child ▢ Other ▢ _____

Insurance company: _____ Grp #: _____ ID#: _____

Insurance Company Address: _____ Ins Co. Phone: (____) _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit: _____

WELCOME TO SURRATT FAMILY DENTAL

MEDICAL HISTORY

Physician _____ Office Phone: (____) _____ Date of Last Exam: _____

Are you under a medical treatment care now? Y ☐ N ☐
If yes, please explain: _____

Have you ever been hospitalized or had a surgical operation or serious illness within the last five years? Y ☐ N ☐
If yes, please explain: _____

Are you taking any medication(s), including non-prescription medicine? Y ☐ N ☐
If yes, what medication(s) are you taking?: _____

Do you take, or have you taken, Phen-Fen or Redux? Y ☐ N ☐

Do you take, or have you taken, Fosmax, Bondhus, Actonel or any cancer medications constrining bisphosphonates? Y ☐ N ☐
If yes, what medication(s) are you taking?: _____

Do you take, or have you taken, Viagra, Revatio, Cialis or Levitra in the last 24-hours? Y ☐ N ☐
If yes, please explain: _____

Do you use tobacco? Y ☐ N ☐
Do you use controlled substances? Y ☐ N ☐
Are you wearing contact lenses? Y ☐ N ☐

Are you allergic or have had any reactions to any of the following?

Aspirin ☐ Penicillin ☐ Metal(s) ☐ Latex Rubber ☐ Local Anesthetics ☐ Sulfa Drugs ☐ Barbiturates ☐

Sedatives ☐ Iodine ☐ Other ☐ If other, please explain: _____

Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? If yes, please explain: _____

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

Y ☐ N ☐ AIDS/HIV
Y ☐ N ☐ Alzheimer's Disease
Y ☐ N ☐ Anemia
Y ☐ N ☐ Angina
Y ☐ N ☐ Arthritis/Gout
Y ☐ N ☐ Asthma
Y ☐ N ☐ Cancer
Y ☐ N ☐ Chest Pains
Y ☐ N ☐ Diabetes
Y ☐ N ☐ Easily Winded
Y ☐ N ☐ Low Blood Pressure
Y ☐ N ☐ Mitral Valve Prolapse
Y ☐ N ☐ Radiation Therapy
Y ☐ N ☐ Recent Weight Loss
Y ☐ N ☐ Emphysema
Y ☐ N ☐ Epilepsy or Seizures
Y ☐ N ☐ Fainting Spells/ Dizziness
Y ☐ N ☐ Frequently Tired
Y ☐ N ☐ Glaucoma
Y ☐ N ☐ Hay Fever/Allergies
Y ☐ N ☐ Heart Attack/Failure
Y ☐ N ☐ Heart Murmur
Y ☐ N ☐ Cardiac Pacemaker
Y ☐ N ☐ Respiratory Problems
Y ☐ N ☐ Rheumatic Fever
Y ☐ N ☐ STDs
Y ☐ N ☐ Stomach/Intestinal Disease
Y ☐ N ☐ Heart Trouble/Disease
Y ☐ N ☐ Hepatitis A
Y ☐ N ☐ Hepatitis B or C
Y ☐ N ☐ High Blood Pressure
Y ☐ N ☐ Jaundice
Y ☐ N ☐ Joint Replacement or Implant
Y ☐ N ☐ Kidney Diseases
Y ☐ N ☐ Leukemia
Y ☐ N ☐ Liver Disease
Y ☐ N ☐ Stroke
Y ☐ N ☐ Thyroid Problems
Y ☐ N ☐ Tuberculosis
Y ☐ N ☐ Ulcers

WELCOME TO SURRATT FAMILY DENTAL

Have you ever had any serious illness not listed above? Y ☐ N ☐
If yes, please explain:_____

Other comments: _____

Women ONLY:

Are you pregnant or think you may be pregnant? Y ☐ N ☐
Are you taking oral contraceptives? Y ☐ N ☐
Are you nursing? Y ☐ N ☐

PATIENT DENTAL HISTORY

Name of Previous Dentist _____ Location: _____ Date of Last Exam: _____

Do your gums bleed while brushing or flossing? Y ☐ N ☐
Are your teeth sensitive to hot or cold liquids/foods? Y ☐ N ☐
Are your teeth sensitive to sweet or sour liquids/foods? Y ☐ N ☐
Do you feel pain to any of your teeth? Y ☐ N ☐
Do you have any sores or bumps in or near your mouth? Y ☐ N ☐
Have you had any head, neck, or jaw injuries? Y ☐ N ☐
Do you have frequent headaches? Y ☐ N ☐
Do you clench or grind your teeth? Y ☐ N ☐
Do you bite your lips or cheeks frequently? Y ☐ N ☐

Have you ever had any difficult extractions in the past? Y ☐ N ☐
Have you ever had any prolonged bleeding following extractions? Y ☐ N ☐
Have you had any orthodontic treatment? Y ☐ N ☐
Do you wear dentures or partials? Y ☐ N ☐
If yes, what was the date of placement?: _____
Have you ever received oral hygiene instructions regarding Y ☐ N ☐
the care of your teeth and gums? Y ☐ N ☐
Do you like your smile? Y ☐ N ☐

Have you ever experienced any of the following problems in your jaw? Y ☐ N ☐
Clicking Y ☐ N ☐
Pain (join, ear, side of face) Y ☐ N ☐
Difficulty in opening or closing Y ☐ N ☐
Difficulty in chewing Y ☐ N ☐

Signature needed

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 theird party paers others payable ot me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be resonpsible for payment of all services rendered on my behalf or my dependents.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

FINANCIAL POLICY

Welcome and thank you for choosing our office for your dental care. Your oral health is our priority. In order to dedicate our attention to providing you the highest quality of dental care, our office has the following financial policies.

DENTAL INSURANCE: As a courtesy, we file your primary dental insurance claims for services rendered in this office. Proof of insurance is necessary so that we can file your claims. We do not file secondary or medical insurance, but will be happy to give you the proper information for you to file. Due to the wide range of dental insurance companies and benefit packages, we cannot possibly know the specific details of each and every policy. We suggest that you familiarize yourself with your dental benefit package, including: deductible, co-payment and annual maximum benefits. Co-payments are expected at the time of service. Should your claim be denied or payment is less than expected, your balance is due in full.

PAYMENT: Payment is expected at the time of service. We gladly accept cash, personal checks, Visa, Master Card, Discover, American Express and Care Credit. Also, most medical spending accounts include dental services. Any special payment arrangements must be approved by our office manager. Any balance no paid within 90 days will be turned over to Nashville Adjustment Bureau as a delinquent account.

I, the undersigned, have read, understand and agree to the financial policy of Dr. Gregory Surratt.

_____ _____

Patient signature Date

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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 this infromation 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 physician certifications

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change it *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above 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 infromation is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient _____

Signature _____

Date _____