Patient Information

Today's Date:_____

Patient's Full Name:_____

Preferred Name:_____ Preferred Pronoun: He She N/A

Birthdate:_____ Age:_____ Sex: M F N/A Marital Status: M D W S

Social Security Number:_____

Address:_____ City:_____ St._____ Zip:_____

Email:_____

Home Number:_____ Work Number:_____ Cell Number:_____

Employer:_____

Whom may we thank for referring you?_____

Emergency Contact Name:_____ Number:_____

Patient relation to Emergency Contact:_____

Person Responsible for Payment

Name:_____ Birthdate:_____ SS#:_____

Relationship to Patient:_____

Address: _____ City:_____ St._____ Zip: _____

Home Number:_____ Work Number:_____ Cell Number:_____

Employer:_____

Employer's Address: _____ City:_____ St._____ Zip: _____

Dental Insurance Information:

Policy Holder:_____

DOB of Policy Holder:_____ SS# of Insured:_____

Employer:_____

Insurance Company:_____

ID#:_____ Group#:_____ Is this a DMO/HMO/DHMO: Yes No

Address: _____ City:_____ St._____ Zip: _____

Insurance Telephone Number:_____

I agree to the following statements:
BDA/OD is authorized to release information to my insurance company. I understand that a DMO, HMO, or DHMO policy will not pay BDA/OD for my visit. I give BDA/OD permission to contact me via phone and/or email with information directly related to my care and upcoming appointments.

Signature:_____ Date:_____

HEALTH HISTORY

Patient's Name:_____ Birthdate:_____

1. Date of last dental cleaning:_____
2. Medical Physician:_____ Date of last physical exam:_____
3. Are you being treated by a physician for any reason?_____
4. Have you been hospitalized during the past 2 years?_____
5. Do you have any allergies to penicillin, aspirin, codeine, sulfa drugs, anethetics, latex or other medications?_____
6. Women: Are you pregnant?_____ Are you trying to get pregnant? _____
7. Are you taking birth control pills?_____
8. Are you taking bisphosphonates (ie: fosmax) or being treated for osteoporosis?_____
9. Have you had grapefruit or grapefruit juice in the last week?_____
10. Do you currently use tobacco products?_____ Do you currently vape?_____
11. Circle any of the following that you have had or have at the present:

Alcoholism	Drug Addiction	Implant (type:_____)
Anemia	Emphysema	Jaundice
Angina Pectoris	Epilepsy	Kidney Disorders
Arthritis	Fainting/Dizzy Spells	Liver Disease
*Artifical hip/knee/joint	Glaucoma	Psychiatric Treatment
Asthma	Hay Fever	Radiation Treatment
Bleeding Disorder	Heart Disease/Attack	*Rheumatic Fever
Blood Transfusion	Heart Pace Maker	Sickle Cell Disease
Cancer (type:_____)	Heart Surgery	Sinus Problems
Chemotherapy	Herpes	Stroke
Cold Sores	Hepatitis	*Transplant:
*Congential Heart Lesion	High Blood Pressure	Tuberculosis
Diabetes	HIV positive, arc, aids	Ulcers

<u>* Antibiotic premedication may be required prior to your appointment</u>

PLEASE LIST ANY DAILY MEDICATIONS BELOW:

1 _____

2 _____

3 _____

4 _____

5 _____

Signature:_____ Date:_____

Brentwood Dental Arts

5505 Edmondson Pike Suite 201
Nashville, TN 37211
Jack Fletcher, D.D.S. & H. Douglas Holliday, D.D.S.

Thank you for choosing our office to look after your dental needs. We are committed to providing quality care and successful treatment. Please understand that payment for services rendered is a crucial part of that treatment. The following is a statement regarding our financial policy. Please read, sign, and date.

Financial Policy

Payment is due at the time of your service. For your convenience, we accept cash, checks, Visa, MasterCard, American Express, Discover, and Care Credit. Co-payment and payment for any products received is due at the time of service. If payment arrangements are necessary, a card will be put on file so that payments can be put on autopay.

Insurance Guidelines

We will file your insurance claims as a courtesy to you. However, it is ultimately your responsibility to be sure you are covered for your visit. Payment for services rendered is your responsibility, regardless of the benefits paid by your plan. If insurance has not paid within 30 days, the payment becomes your responsibility.

Interest, Collection, Copying, & Broken Appointment Fees

We reserve the right to charge finance charges of 1.5% on balances over 30 days. All fees connected with a third party including but not limited to: collection agency, attorneys, and the copying of records for use outside this practice will be applied to the account. A processing fee will be added to the account if sent to a collection agency. If an appointment is broken without the required 48 hour notice, please note that we reserve the right to charge $55.00.

Your signature indicated to our office that you have read the above statements and understand them.
Your signature also gives us the consent to use your protected information as per the Privacy Act.

Printed Name _____

Signature _____ Date _____

Notice of Privacy Practices

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights regarding the privacy of my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among multiple healthcare providers who may be involved directly or indirectly
- Obtain payment from third party payers
- Conduct normal healthcare operations
- Communicate with you through an automated system

I have received, read, and understand the Notice of Privacy Practices and give permission for Dr. Fletcher, Dr. Holliday, and Dr. Otterpohl to share my treatment plans, x-rays, and insurance information with any doctors that we mutually agree on for referrals.

Initials: _____

Authorization and consent to send unencrypted patient information by email:

Until I tell you in writing to stop, I authorize Doctors Fletcher, Holliday, and Otterpohl to transmit patient information relating to my treatment, health, or account to me or someone I designate by email or other electronic means. This correspondence does not require encryption or special security precautions. The patient information that may be emailed could include: x-rays, health history, diagnosis, treatment, and payment records. We do NOT send sensitive information such as: social security number, credit card number, mental health diagnosis, genetic information, alcohol/substance abuse, or positive HIV status unless the patient insists.

I understand that I may tell you in writing to stop emailing my patient information at any time. However, this will not affect emails that Doctors Fletcher, Holliday, or Otterpohl already sent before receiving my written instructions to stop.

Printed Name _____

Signature _____ Date _____