PATIENT REGISTRATION

ID: _____ Chart ID: _____

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder Preferred Name: _____

☐ Responsible Party

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: ____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

◯ Responsible Party is also a Policy Holder for Patient ◯ Primary Insurance Policy Holder ◯ Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City: _____ State / Zip: _____ _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ◯ Male ◯ Female Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowed

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2 Section 3

Employment Status: ◯ Full Time ◯ Part Time ◯ Retired

Student Status: ◯ Full Time ◯ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

Additional Comments:

Referred by:

Previous Dentist

Emergency Contact

Emergency Contact #

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: .00 Rem. Deduct: _____.00

FINANCIAL POLICY AGREEMENT

Thank you for choosing T.J. Fowler, D.D.S. Restorative and Cosmetic Dental Solutions as your dental care provider. We are committed to providing you with excellent, quality, and affordable dental care. We have prepared this letter to help you better understand the complexities of dental insurance; we realize how confusing it can be. Your clear understanding of our "Financial Policy and Guidelines" is important to your professional relationship. Please read it carefully, ask us any questions you may have, and sign below.

1. **Insurance**. To begin, we would like to highlight a misconception. *Dental insurance was not designed to pay for all dental care*. Instead, it is a *supplement*. All dental contracts have limits and/or various degrees of co-payment. **Knowing and understanding your insurance benefits is ultimately your responsibility**. Please review your dental contract thoroughly so we may best serve you. As always, feel free to ask our office personnel for clarification on our services, billing, insurance, and your financial responsibilities.

2. **Patients with Insurance**. Our practice participates with most private insurance plans. We submit your claim if proper and complete paperwork is provided to us prior to services being rendered. **If you fail to provide us with your complete insurance information, payment in full is expected at time of service**. If you are not insured by a plan we contract with, you may still choose to be seen. As a courtesy to you, we will file a claim with your insurance carrier on your behalf with the understanding that you will be responsible to pay all remaining balance at the time of service. There are some insurances we do not accept – such as DMO's, HMO's, State Funded, Fee-for-Service, etc.

3. **Co-payments and Deductibles**. Due to federal and insurance regulations, your contract with your insurance company requires that we collect designated co-payments and deductibles at the time of services. **Please be prepared to pay these at each visit along with any outstanding balances**.

4. **Non-covered services**. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by your insurance company. The treatment recommended by our office is never based on what your insurance company will pay; your dental care should not be governed by your insurance contract. For larger, more comprehensive treatment, we will be happy to send a predetermination prior to services rendered to your insurance company for services over $300. This process can take up to 4 weeks; this will allow you to know your out-of-pocket expense.

5. **Claims submission**. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply in a timely manner with their request. Please be aware that the balance of your claim is your responsibility regardless whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not a part of that contract. We make every effort to resolve any billing problems that arise.

6. **Patients without insurance**. Payment is due in full at time of service. **A 5% discount is offered for payment made in full at time of service only**. For more comprehensive treatment for patients of record, we can provide an estimate of our fees prior to services in the office. **This is only an estimate and the actual amount may be higher or lower**. If you cannot pay in full, you must make arrangements for payment with our office personnel **PRIOR** to services. However, we require all new patients to pay their fees in full at the time of service to establish their accounts.

7. **Payment**. We accept cash, personal checks (with proper ID), *CareCredit*, Visa, MasterCard, and Discover. There is a **$35** service charge for all returned checks. Please be aware that if a balance remains unpaid, additional fees may be charged. If your account is over 90 days past due, we will refer your account to a collection agency, and you and your family members will be discharged from this practice. I RECOGNIZE AND ACCEPT RESPONSIBILITY FOR ANY BALANCE OR FEE NOT COVERED AND/OR ANY COST OF COLLECTION. Should it be necessary to enforce the provisions of this agreement through an attorney or any legal proceedings, the undersigned promises to pay all costs of collection, including reasonable attorney's fee and all court costs.

8. **Missed appointments**. Our policy is to charge a $25 fee for missed appointments not cancelled within 24 hours before scheduled appointment. These charges will be your responsibility and billed directly to you. Patients who have broken more than three appointments may be dismissed from the practice. A broken appointment hurts everyone. Please make a conscious effort to keep your schedule appointment.

Authorizations and Assignment of Benefits:
I authorize the release of any medical information necessary to process insurance claims.
I authorize my insurance benefits to be paid directly to **T.J. Fowler, D.D.S. Restorative and Cosmetic Dental Solutions**.
I have read and understand the financial policy and agree to abide by its guidelines. I understand that charges not covered by my insurance are my responsibility and must be paid within 30 days unless other provisions are in place.

_____ _____
Signature of Patient, Policy Holder, or Legal Guardian Date

PLEASE PRINT NAME:_____

T.J. Fowler, DDS

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

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, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: _____

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

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. 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.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Tatum Fowler, DDS
120 Capital Drive; Suite 102
Knoxville, TN 37922
865-692-2222

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 reserve the right to change our privacy practices and the terms of this notice at any time, provided such applicable law permits the changes.

USES AND DISCLOSURES of HEALTH INFORMATION

We use and disclose your 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 specialists for the coordination of your health care.
Payment: We may use and disclose your health information to obtain payment for services we provide you.
Health Care Operations: We may disclose your health information to another health organization that is subject to the federal privacy rules and **authorized by law** for public health research, such as infectious diseases.
To Your Family and Friends: We may disclose your health information to a family member or other person, which you determine as acceptable, to the extent necessary to help with your health care or with payment for your health care. If you are not present, or in an emergency we may disclose your medical information based on our professional judgment and our experience with common and legal practice to make reasonable decisions in your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.
Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, emails, or letters.)
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: * child abuse reporting, employers regarding work-related illness or injury * to report adult abuse, neglect, or domestic violence *as authorized by state worker's compensation laws *in response to court and other lawful processes * to the military , and national security activities *to law enforcement officials pursuant to subpoenas, concerning crime victims, suspicious deaths, and for purposes of identifying or locating a suspect or other person.

Patient Rights

Access: You have the right to look at or get copies of your health information, with limited exceptions. You must make your request in writing to obtain access to your health information, addressed to the contact person listed at the top of this form. We have the right to charge you a reasonable cost-based fee that includes labor copying costs, and postage.
Disclosure Accounting: You have the right to know who your information has been shared with over the last 6 years (but not before April 14, 2003). List will not include disclosures such as treatments, & payments that was authorized prior by you.
Restriction: You have the right to request that we place additional restrictions on our use of disclosure of your health information, but we are not required to agree to these additional restrictions. You have the right to request that we communicate with you by alternative means or location. You have the right to request that we amend your health information. All requests must be in writing.
Questions and Complaints: If you believe that we may have violated your privacy rights, or we made a decision about access to your health information incorrectly, or our response to a request you made was incorrect, you may contact us using the information listed above. You also may submit a written complaint to the U.S. Dept. of Health and Human Services. 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.

I HAVE READ AND UNDERSTAND THIS FORM. I AUTHORIZE THE DISCLOSUER OF MY HEALTH INFORMATION AS OUTLINED IN THIS FORM WHICH IS REGULATED BY THE HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 PRIVACY RULE.

Dated _____ Patient's or Guardian's Signature **X** _____