

**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

Referral Source: \_\_\_\_\_

Student Status:  Full Time  Part Time

Medicaid ID: \_\_\_\_\_ Pref. Dentist: \_\_\_\_\_

Employer ID: \_\_\_\_\_ Pref. Pharmacy: \_\_\_\_\_

Carrier ID: \_\_\_\_\_ Pref. Hyg.: \_\_\_\_\_

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

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

## Consent/Authorization/Acknowledgement

### Clinical

1. I authorize Dr. Chad O. Edwards, referred to as "practice" hereafter, to take necessary radiographs, study models, photos and other diagnostic aids as needed to make a thorough diagnosis.
2. I authorize this practice to perform all recommended treatment and agreed upon treatment. I also authorize the use of anesthetics, sedatives and other medication (as needed) and am fully aware that using anesthetic agents involves certain risks.

### Financial

3. I am responsible for payment for services rendered on my behalf and my dependents. I have been informed that payment is due when services are rendered. I am aware that a 1.5% MPR or 18% APR is automatically tabulated into my account if my balance is 30 days old or older. Should my account become delinquent, I will assume all additional collection costs and legal fees.
4. **A \$30 CHARGE WILL BE BILLED TO THE PATIENT FOR ANY NO SHOW OR BROKEN APPOINTMENTS WITH LESS THAN 24 HOUR NOTICE FOR AN OFFICE VISIT.**

### Insurance

5. Does your insurance have a any waiting periods? Yes\_\_\_\_\_ No\_\_\_\_\_ I Don't Know\_\_\_\_\_
6. I authorize this practice to release to staff, hospitals, health care service plans, insurance companies, self-insurers or their representatives, any and all information, records and radiographs about my medical history, services rendered and treatment necessary.
7. I authorize this practice to submit claims for payment for services rendered or pre-authorizations necessary to my insurance company, on behalf and in my name listed as "signature on file" and assign to this practice the insurance benefits providing assignment is accepted. I understand that I am responsible for payment regardless of the coverage provided.
8. I understand I am responsible for the deductible, co-payment and excess over maximum the day of services.

Health Insurance Portability and Accountability Act 1996:

#### **HIPAA: Acknowledgement of Receipt of Notice of Privacy Practices:**

*(You may refuse to sign this Acknowledgement)*

9. I have READ AND UNDERSTAND ALL POLICIES STATED IN THE NEW PATIENT ACKNOWLEDGEMENT AND IMPORTANT INFORMATION. x\_\_\_\_\_

### **HIPAA: Consent for Use and Disclosure of Health Information:**

*(Notice of Privacy Practices: You have the right to read this practice's Notice of Privacy Practices before you decide to sign this Consent. Our Notice of Privacy Practices provides a description of our treatment payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. Please read this Notice prior to signing this Consent. This practice reserves the right to change the privacy practices as described in our Notice of Privacy Practices. If changes are made, a revised Notice of Privacy Practices containing the modifications will be issued. These changes may apply to any of your protected health information that we maintain on file. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice at any time by contacting Kim at 615-595-8070, 3046 Columbia Ave., Ste 201, Franklin, TN You have the right to revoke this Consent for use and Disclosure of Health Information at anytime by giving us written notice of your revocation submitted to the Contact Person listed above. This revoke will not affect previous consent. We serve the right to provide further treatment in your behalf or that of your dependents if this Consent is revoked.*

10. I have had opportunity to review and obtain a copy of this practice's Notice of Privacy Practices. I \_\_\_\_\_ hereby authorize, as indicated by my signature below, to use and disclose my protected health information to carry out treatment, payment activities and health care operations.

Signatures below indicate that I have read this entire document and fully understand the contents of this Consent/Authorization/Acknowledgement. I have been provided with the opportunity to ask questions and obtain further clarification.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date of Birth

Circle One: Adult Patient / Guardian / Personal Representative

If signature provided represents the patient's guardian or "personal representative" please complete the following:

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
DOB

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

## New Patient Insurance Acknowledgement

Understanding your insurance coverage can be challenging. Our goal is to assist you in maximizing your benefits. We care for patients from many different companies. Each company pays an insurance premium for specific coverage which fits the company budget. Each plan is slightly different with lower premium plans covering fewer services and lower fees for services. We encourage you to become familiar with your policy exclusions, deductibles and required co-payments.

### **Our courtesy service to you includes:**

1. Filing your insurance within 24 hours of your visit and requesting payment of your benefit to our office.
2. When available, we electronically file your insurance for short turn around.
3. Researching your dental insurance plan to advise you of estimated benefits available to you.
4. Re-filing your insurance a second time at 30 days and a final time at 60 days.
5. Following the American Dental Association guidelines for coding procedures and filing insurance.

### **Our expectations of you as the owner of the policy:**

1. Payment of fees not covered by your insurance plan at the time the service is delivered.
2. Understanding that the insurance policy belongs to you and we have no leverage to obtain payment from your insurance carrier.
3. Taking responsibility for payment if the insurance company does not pay our office within 75 days.
4. Keeping our office informed of any changes in your insurance coverage or employment.

To assist us in obtaining your benefits, **Please sign the "assignment of benefits" below** to allow us to file your insurance claims. Also, please have your insurance card ready for us to copy for our file.

I hereby authorize Chad O. Edwards, DDS and John L. Brannen, DDS to release to my insurance company, information acquired in the course of my dental care. I hereby authorize benefits to be paid directly to Dr. Chad O. Edwards, DDS. I understand I am responsible for any unpaid balance.

\_\_\_\_\_  
Signature of Patient/Insured

\_\_\_\_\_  
Date

## Dental Health Information

Thank you for providing us with important information that will help us care for you better.

Date of Last Dental Visit: \_\_\_\_\_ Reason for today's visit: \_\_\_\_\_

- Are you having any discomfort?  Yes  No Do you have any sensitivity to hot, cold, sweets or chewing?  
If yes, please explain \_\_\_\_\_
- Does dental treatment make you nervous?  Yes  No If yes, what can we do to make you more comfortable?  
\_\_\_\_\_
- Do you use any form of tobacco?  Yes  No If yes, what type and how often? \_\_\_\_\_  
(this may include smokeless tobacco, cigarettes, cigars, etc.)
- Have you ever had an oral cancer screening during a dental visit?  Yes  No  
Have you ever had oral cancer?  Yes  No
- On average, how much caffeine do you intake daily? \_\_\_\_\_  
(this may include coffee, tea, colas, etc.)
- On average, how much water do you think you drink daily? \_\_\_\_\_
- Do you ever experience "dry mouth syndrome?"  Yes  No  I would like more information on this
- How often do you brush your teeth? \_\_\_\_\_ times per day Floss? \_\_\_\_\_  
Do you routinely brush your tongue? \_\_\_\_\_
- Have you ever had a periodontal (or gum) disease screening during a dental visit?  Yes  No
- Do you have a history of periodontal (or gum) disease in your family?  Yes  No
- Do you suffer from migraine headaches?  Yes  No If so, how often? \_\_\_\_\_
- Do you ever clench or grind your teeth?  Yes  No  Not Aware  
If so, have you ever had this addressed or treated by a dentist?  Yes  No If yes, please explain \_\_\_\_\_
- Do you think your front teeth appear shorter than they did at one time?  Yes  No
- Do you think it is important to have your teeth cleaned at least every six months?  Yes  No
- When was the last time you were seen by a dental hygienist? \_\_\_\_\_
- Do you think your dental health influences your overall health?  Yes  No  I would like more information on this.
- Do you currently use a fluoride supplement at home or have you ever used one in the past?  Yes  No
- Have you ever had any complications following dental treatment?  Yes  No If yes, please explain: \_\_\_\_\_

On a scale of 1 to 10 (with 10 being the highest rating), how would you rate your smile? 1 2 3 4 5 6 7 8 9 10

If you could change anything about your smile what would it be? Please check all that apply

- Whiter teeth  Straighter teeth  Close spaces  Replace black mercury fillings
- Repair chipped/broken teeth  Replace missing teeth  Replace old crowns (or caps) that don't match
- Repair worn teeth  Lengthen teeth  Contour (re-shape) teeth

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian \_\_\_\_\_ Date: \_\_\_\_\_

## Important Information For Our Patients

### **Dental Insurance:**

We are glad to assist you with your dental insurance plan. To help us assist you in obtaining your maximum benefit, please *bring your insurance explanation booklet, your dental insurance card, and a completed claim form to your first visit.* Once your plan coverage has been verified, we will accept assignment of payment from your insurance company. Most plans only cover a portion of the dental fee, which means you will be responsible for your deductible and any portion your plan does not cover. (*Payment of your estimated portion is expected at the time you are in our office for dental care*)

### **Payment Options:**

For your convenience, we accept VISA, MasterCard, American Express, Discover and personal checks. Your co-payment can also be put on a CareCredit Account, our in-office financing partner. Applications for CareCredit are available at our front office or you can call ahead at (800) 300-3046. You can go to the Care Credit link on our website @ [www.cosmeticedentistfranklin.com](http://www.cosmeticedentistfranklin.com).

**PATIENT'S COPY**