Parkway Commons Family Dentistry
Chad O. Edwards, DDS
3046 Columbia Avenue, Suite 201
Franklin, TN 37064
Phone 615-595-8070 Fax 615-595-1832
www.ParkwayCommonsFamilyDentistry.com

PATIENT REGISTRATION

Date ______________________

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.

Who Referred You?: ____________

Primary Insurance information

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

Insured Soc. See: ____________ 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

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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.

	Yes	No	
Are you under a physician's care now?	◯	◯	If yes, please explain: ______________
Have you ever been hospitalized or had a major operation?	◯	◯	If yes, please explain: ______________
Have you ever had a serious head or neck injury?	◯	◯	If yes, please explain: ______________
Are you taking any medications, pills, or drugs?	◯	◯	If yes, please explain: ______________
Do you take, or have you taken, Phen-Fen or Redux?	◯	◯	______________
Are you on a special diet?	◯	◯	______________
Do you use tobacco?	◯	◯	
Do you use controlled substances?	◯	◯	

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 (check if yes)?

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

☐ Other If yes, please explain: ______________________________

Do you have, or have you had, any of the following? **Please check if Yes**

◯ AIDS/HIV Positive
◯ Alzheimer's Disease
◯ Anaphylaxis
◯ Anemia
◯ Angina
◯ Arthritis/Gout
◯ Artificial Heart Valve
◯ Artificial Joint
◯ Asthma
◯ Blood Disease
◯ Blood Transfusion
◯ Breathing Problem
◯ 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 Pace Maker
◯ Heart Trouble/Disease
◯ Hemophilia
◯ Hepatitis A
◯ Hepatitis B or C
◯ Herpes
◯ High Blood Pressure
◯ Hives or Rash
◯ Hypoglycemia
◯ Irregular Heartbeat
◯ Kidney Problems
◯ Leukemia
◯ Liver Disease
◯ Low Blood Pressure
◯ Lung Disease
◯ Mitral Valve Prolapse
◯ 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, please explain:

____

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 Broken Appointment Fee will be charged to my account for 2 consecutive broken and/or last minute cancellations. I am aware that to hold down operating costs, 24 hours notice of cancellation is required.

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

Check 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

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:**_______________

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 Dr. Chad O. Edwards, 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

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 Care Credit Account with our in-office financial partner. Applications for CareCredit are available at our front office or you can call ahead at (800) 859-9995. You can securely apply online by clicking the CareCredit Apply Now graphic on our Financial Policies page at:

www.ParkwayFamilyCommonsDentistry.com/Financial_Policies.