PORTIS
FAMILY
DENTAL

554 Franklin Rd, Suite 104, Franklin, TN 37069 | 615.465.8030

DENTAL REGISTRATION AND HEALTH HISTORY

PATIENT INFORMATION

Whom may we thank for referring you?
Google___ Social Media___ Insurance Website___ Current Patient_____

Name _____ Preferred Name _____
Address _____ City/St/ZIP _____
Date of Birth _____ Age _____ SS# _____ Sex M F
Home Phone (___) _____ Work Phone (___) _____ Cell Phone (___) _____
Email _____ Best time & place to reach you _____
Preferred confirmation method: Email Text Message Phone Call Other _____
Occupation _____ Employer _____

Single Married Widowed Separated Divorced

Spouse's Name _____ Preferred Name _____
Work Phone (___) _____ Cell Phone (___) _____ Email _____
Date of Birth _____ Age _____ SS# _____
Spouse's Occupation _____ Employer _____

IN CASE OF EMERGENCY, PLEASE CONTACT:
Name _____ Preferred Name _____
Home Phone (___) _____ Work Phone (___) _____ Cell Phone (___) _____

INSURANCE INFORMATION

Name of Insured _____ Is he/she a patient at P.F.D? Y N
Your relationship to insured: Self Spouse Child Other _____
Insurance Plan Name _____ Phone Number (___) _____
Driver's License Number _____ State _____
Is there secondary insurance coverage? Y☐ N☐ If yes, please fill out the following:
Name of Insured _____ Is he/she a patient at P.F.D.? Y N
Your relationship to insured: Self Spouse Child Other _____
Insurance Plan Name _____ Phone Number (___) _____

PHARMACY

Do you have a pharmacy that you prefer to use?
Name _____ Phone _____
Address or Cross Streets & City _____

Name _____ **Date of Birth** _____

DENTAL HISTORY

Reason for Today's Visit _____ Last Dental Cleaning _____
Former Dentist _____ City/State _____

Indicate if you have, or have had, any of the following:

Y☐ N☐ Bad breath/sour taste in mouth
Y☐ N☐ Burning sensation in mouth
Y☐ N☐ Dry mouth
Y☐ N☐ Grinding of teeth
Y☐ N☐ Headaches/Migraines
Y☐ N☐ Sensitivity to hot and cold
Y☐ N☐ Soreness in jaw
Y☐ N☐ Bleeding Gums
Y☐ N☐ Clicking or popping in jaw
Y☐ N☐ Food catching between teeth
Y☐ N☐ Hard to open mouth wide
Y☐ N☐ Pain/soreness around ears or eyes
Y☐ N☐ Snoring
Y☐ N☐ Stiff neck muscles

HEALTH HISTORY

Indicate if you have, or have had, any of the following:

Y N AIDS/HIV
Y N Arthritis
Y N Asthma
Y N Chemical Dependency
Y N Diabetes
Y N Fainting or Dizziness
Y N Heart Murmer
Y N Herpes
Y N Joint Replacement/Implants Date_____
Y N Osteoporosis
Y N Pacemaker
Y N Respiratory Problems
Y N Sinus Trouble
Y N Swollen Neck Glands
Y N Thyroid Problems
Y N Tuberculosis
Y N Other _____
Y N Anemia or Blood Disorder
Y N Artificial Heart Valves
Y N Cancer
Y N Circulatory Condition
Y N Epilepsy or Seizures
Y N Venereal Disease
Y N Hepatitis Type ____
Y N High Blood Pressure
Y N Low Blood Pressure
Y N Mitral Valve Prolapse
Y N Psychiatric Care
Y N Rheumatic Fever
Y N Stroke
Y N Stomach Ulcer/Hyperacidity
Y N Tobacco Use
WOMEN: Y N Are you pregnant?

Have you had any serious illness, operation, or been hospitalized in the past 5 years? Y N
If yes, what was the illness or problem? _____
Physician's Name _____ Date of Last Visit _____
DO YOU HAVE ANY DISEASE OR PROBLEM NOT LISTED ABOVE THAT WE SHOULD BE AWARE OF? Y N
If yes, please explain._____
Please list any medications you are currently taking. Please include non-prescription medicines.
_____ _____
Please list all known allergies._____ None Known

Indicate what is important to you when making decisions regarding your dental health?

Y N Appearance/Esthetics
Y N Fear or Anxiety
Y N Health
Y N Remove Silver Fillings
Y N Replace Missing Teeth
Y N Straighter Teeth
Y N Comfort
Y N Finances
Y N Insurance Coverage
Y N Repair Chipped Teeth
Y N Replace Old Crowns
Y N Whiter Teeth

Are any teeth currently bothering you? If yes, please describe. _____
Do you have any concerns about your teeth? (color, shape, gaps, etc) _____
Rate your smile on a scale of 1-10. _____If you could change your smile, what would you change? _____

Authorization and Acknowledgment:

- I authorize my insurance company to pay the dentist all insurance benefits otherwise payable to me for services rendered.
- I authorize the use of this signature on all insurance submissions.
- I authorize the dentist to release all information necessary to secure the payment of benefits.
- I understand that I am financially responsible for all charges whether or not paid by insurance.
- I authorize the dentist to use mine and my family's photos for promotional purposes in the office, on the website, and for advertising.
- I certify that I have read and understand the above health history. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature _____ **Date** _____

Notice of Privacy Practices

Protecting Your
Confidential Health Information

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.

Our Promise!

Dear Patient:
This is not meant to alarm you! Quite the opposite! It is our desire to communicate to you that we are taking the new Federal (HIPAA – Health Insurance Portability and Accountability Act) laws written to protect the confidentiality of your health information seriously. We do not ever want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside of our office.

So what has changed?
Why a privacy policy now?
Very good questions!

The most significant variable that has motivated the Federal government to legally enforce the importance of the privacy of health information is the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the Internet, phone, faxes, copy machines, and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we use to ensure the protection of your health information everywhere it is used.

We want you to know about these policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures and your rights as our valuable patient.

We will use and communicate your **HEALTH INFORMATION** only for the purposes of providing your treatment, obtaining payment and conducting health care operations. Your health information will not be used for other purposes unless we have asked for and been voluntarily given your written permission.

Portis Family Dental (615) 465.8030

How your HEALTH INFORMATION may be used

To Provide Treatment
We will use your HEALTH INFORMATION within our office to provide you with the best dental care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between hygienist, dental assistant, dentist, and business office staff. In addition, we may share your health information with physicians, referring dentists, clinical and dental laboratories, pharmacies or other health care personnel providing you treatment.

To Obtain Payment
We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

To Conduct Health Care Operations
Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities us clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.

In Patient Reminders
Because we believe regular care is very important to your oral and general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family.

These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best preventive and restorative care modern dentistry can provide. They may include postcards, folding postcards, letters, telephone reminders or electronic reminders such as email (unless you tell us that you do not want to receive these reminders).

Protecting Your Confidential Health Information is Important to Us

Abuse or Neglect
We will notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when we believe we are specifically required or authorized by law or with the patient's agreement.

Public Health and National Security
We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

For Law Enforcement
As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

Family, Friends and Caregivers
We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want we will use our very best judgment when sharing your health information only when it will be important to those participating in providing your care.

Authorization to Use or Disclose Health Information
Other than is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

PatientAcknowledgment

Patient Name(s): _____

_____

_____

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not, we would appreciate very much your acknowledging your receipt of our policy by signing and returning this card. We look forward to seeing you again soon.

Patient Signature

Date: ____/____/____

Patient Rights
This new law is careful to describe that you have the following rights related to your health information.

Restrictions
You have the right to request restrictions on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable restriction preferences from our patients.
Kemp Dental is only required to maintain restrictions to the uses or disclosures of Personal Health Information (PHI) under regulatory requirements or agreed upon with the individual with whom the PHI applies. Kemp Dental will engage in open dialogue with individuals to ensure that they are aware that previously restricted PHI may be disclosed to the health plan (insurance company) unless the patient request an additional restriction to not disclose and pay out of pocket for the follow up care. If the patient wishes to change their insurance company, we have the responsibility to disclose previous PHI to the new company, even though it was not disclosed (by additional request) to your previous company.

ConfidentialCommunications
You have the right to request that we communicate with you in a certain way. You may request that we only communicate your health information privately with no other family members present or through mailed communications that are sealed. We will make every effort to honor your reasonable fee to duplicate and assemble your copy.

Inspect and Copy Your Health Information
You have the right to read, review, and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

Amend Your Health Information
You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe your reason for the change.
Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete.

Documentation of Health Information
You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health operations. Our documentation procedures will enable us to provide information on health information usage from April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We may need to charge you a reasonable fee for your request.

Request a Paper Copy of this Notice
You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you. We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all of our patients receive a copy of the revised Notice. *You have the right* to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. Please let us know of your concerns or complaints in writing.

PORTIS
FAMILY
DENTAL

554 Franklin Rd, Suite 104, Franklin, TN 37069 | 615.465.8030

PORTIS FAMILY DENTAL FINANCIAL AGREEMENT

Insurance Information

Our first task is to verify your insurance to determine your coverage (amount of deductible, percent that insurance will pay, any limitations, etc.). This is not a promise of payment. Until your insurance is verified, services must be paid at the time they are rendered. At your appointment, you will be responsible for any deductible and co-payment. In the event that your insurance company pays less than anticipated, you will be responsible for the remaining balance.

Fee Agreement

Payment is expected when services are rendered. Those who have dental insurance are responsible at the time of service for estimated co-pays based on the information received from your insurance company. Unpaid balances will be subject to a late payment charge of $4.00 per month per account over 60 days. In case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection on this account.

Authorization

I hereby authorize payment directly to the dental office of group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the dental office to administer such medication and perform such diagnosis and therapeutic procedures as necessary for proper dental care. The information on the attached patient information sheet and medical history are correct to the best of my knowledge. I acknowledge communicating with my insurance company, a specialty practice, or in completing my financial obligations, as may be necessary to share personal information for me or family members and authorize Portis Family Dental to do so. I understand this information will not be used for any purpose other than my dental office care.

_____ _____

Signature of Responsible Party Date

Medical Information Release Form

(HIPAA Release Form)

Name: _____ Date of Birth _____/_____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records, examination rendered to me, and claims information. This information may be released to:

[ ] Spouse _____

[ ] Child(ren)_____

[ ] Parent(s)_____

[ ] Other_____

[ ] Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

Messages

Please call: [ ] my home_____[ ] leave a message [ ] do not leave message

[ ] my cell _____ [ ] leave a message [ ] do not leave message

[ ] my work _____[ ] leave a message [ ] do not leave message

By signing this form, I agree to receive text message notification from Portis Family Dental unless noted otherwise.

Signed: _____Date: _____/_____/_____