PATIENT INFORMATION

Last Name _____ First _____ MI _____

Preferred Name _____ SSN _____ - _____ - _____

Birthday _____/ _____/ _____ Age _____ Gender: Male _____ Female _____

Family Status: Married _____ Single _____ Widow _____ Child _____

Address _____

City _____ State _____ Zip _____

I authorize Family & Cosmetic Dentistry of Memphis to contact me by the following

Home Phone _____ Cell Phone _____ Work Phone _____

Email _____

Emergency Contact _____ Phone _____

IF PATIENT IS UNDER 18 YEARS OF AGE FILL OUT THIS SECTION

Name _____ Relationship to Patient _____

Address _____ City/ State/ Zip _____

Phone _____ SSN _____/ _____/ _____ DL# _____

Employer Name: _____

I HEREBY AUTHORIZE THE FOLLOWING PERSON(S) TO BRING MY MINOR CHILD TO THE OFFICE FOR TREATMENT & GIVE THEM THE AUTHORITY TO MAKE DENTAL TREATMENT DECISIONS REGARDING MY CHILD, AND TO MAKE EMERGENCY DECISIONS IF NEEDED.

Anyone under the age of 18 years must have an adult present at all times in the building in order for services to be provided.

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

_____
Print Name Here

_____ Date: _____
Signature of Parent/ Legal Guardian

Dental Insurance Information

(Please fill all spaces in order to file with insurance company)

Patient Name: _____ Date: _____

Primary Insurance Co. _____ Phone # _____

Group Number _____

Name of Subscriber _____ DOB ____/____/____

Subscriber's SSN _____/_____/_____

Relationship to Patient _____

Employer _____

Secondary Insurance Co. _____ Phone # _____

Group Number _____

Name of Subscriber _____ DOB ____/____/____

Subscriber's SSN _____/_____/_____

Relationship to Patient _____

Employer _____

☐ **By Checking this box,**

I authorize my insurance company to pay Family & Cosmetic Dentistry all insurance benefits rendered.

I authorize the use of this electronic 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 also understand that it is not Family & Cosmetic Dentistry's responsibility to ensure that my insurance pays.

Patient Name: _____

Date of Birth: _____

Financial Agreement

Please read entire form carefully, then sign & date the bottom.
The following defines the financial policies of this practice.

Thank you for choosing *Family & Cosmetic Dentistry of Memphis (FCD of Memphis)* we consider it an honor to have been chosen for your care. Our philosophy in serving people is to be informative, honest, and forthright. Nowhere is that more important than in the area of finances. This Financial Agreement is indicative of our respect for your right to know ahead of time what our expectations are in the area of finances.

The following is our Financial Policy. If you have any questions or concerns about our payment policies, please do not hesitate to ask. We ask that all patients read and sign our Financial Policy as well as completing our patient information forms prior to seeing the doctor.

Patient's portion of payment, as well as any past due balance, are due at the time services are rendered. We accept cash and credit cards for payment. We do our best to inform you of an estimated cost of services prior to your visit.

You are responsible for our fees and not what your insurance company allows or considers "usual, customary, and/or reasonable" all of which vary from one company to another.

Although we may estimate your insurance benefits we are not responsible for their accuracy. Knowledge of benefits as well as benefit amounts, limitations, exclusions, waiting periods, etc. is entirely YOUR responsibility. Receiving our services indicates your acceptance of responsibility to pay regardless of our estimate. The actual out- of- pocket expense may be less than or greater than the amount estimated and collected. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

All charges not paid by your insurance company are your responsibility regardless of the reason for nonpayment. Not all services we provide are covered benefits. Fees for non-covered services, along with deductibles and copayments are due at the time of treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time of services are performed unless other arrangements are made.

I understand that any estimate (treatment plans) given by our office (FCD of Memphis) for your dental care can only be extended for a period of six months from the date of the patient examination, unless otherwise noted.

Patient Name: _____

Date of Birth: _____

Financial Agreement

Please read entire form carefully, then sign & date the bottom.
The following defines the financial policies of this practice.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, and I further agree to pay all collection costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to FCD of Memphis to telephone me to discuss the financial obligations of my treatment.

I further authorize FCD of Memphis to discuss my treatment or financial obligations with the following listed person (s):

1. _____ 2. _____

_____ **Date:** _____

Signature of Responsible Party

_____

Print Name

Name: _____

Address: _____

Phone No. _____

Consent for Internet Communications

I grant my permission to the dental practice to upload and store confidential patient information (which includes but is not limited to the following: account information, appointment information, clinical information, and insurance filing) to the secured website for the dental practice. I understand that for security purposes, the site requires a user ID and password for access and use.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload, and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the website on my behalf.

I have read the information above regarding the secured uploading of patient information to the website for the dental practice, and grant the dental practice permission to securely upload my patient information to the website.

Signature: _____ **Date:** _____

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization. I understand that at any time, this authorization may be revoked, when this office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my healthcare and the payment for my healthcare will not be affected if I refuse to sign this form. I understand that information used or disclosed, pursuant to this authorization, could be subjected to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

Signature: _____

Print Name: _____ **Date:** _____

PATIENT MEDICAL HISTORY FORM

Name: _____

Date of Birth: _____

PRIMARY CARE PHYSICIAN NAME: _____

PCP PHONE: _____

PHARMACY NAME: _____

PHARMACY PHONE: _____

Please circle all those that apply:

Yes, No	Conditions:
Yes, No	Alzheimer
Yes, No	Anemia
Yes, No	Arthritis
Yes, No	Artificial Bones/Joints
Yes, No	Artificial Heart Valve
Yes, No	Asthma
Yes, No	Autism
Yes, No	Back Problems
Yes, No	Bleeding/Clotting Problems
Yes, No	Blood Disease
Yes, No	Blood Transfusion
Yes, No	Cancer- Chemotherapy
Yes, No	Circulatory Problems
Yes, No	C.O.P.D.
Yes, No	Cold Sores
Yes, No	Cough Up Blood
Yes, No	Cough, Persistent
Yes, No	Developmental Disorders
Yes, No	Diabetes
Yes, No	Dizziness
Yes, No	Epilepsy
Yes, No	Fainting Spells
Yes, No	Gastrointestinal problems
Yes, No	Glaucoma
Yes, No	HIV+ AIDS
Yes, No	Head/Neck Injury
Yes, No	Headaches
Yes, No	Heart Murmur
Yes, No	Heart Condition/Disease

Yes, No	Conditions:
Yes, No	Hemophilia
Yes, No	Hepatitis
Yes, No	High Blood Pressure
Yes, No	Jaw Pain/TMJ
Yes, No	Jaundice
Yes, No	Kidney Problems
Yes, No	Liver Disease
Yes, no	Mitral Valve Prolapse
Yes, No	Nervous Problems
Yes, No	Pacemaker
Yes, No	Physical problems
Yes, No	Psychiatric Problems
Yes, No	Radiation Therapy
Yes, No	Rheumatic Fever
Yes, No	Scarlet Fever
Yes, No	Seasonal Allergies
Yes, No	Shortness of Breath
Yes, No	Sinus Problems
Yes, No	Steroid Treatments
Yes, No	Stroke
Yes, No	Swollen Feet/Ankles
Yes, No	Thyroid Problems
Yes, No	Tonsillitis
Yes, No	Tuberculosis
Yes, No	Tumors/Growths
Yes, No	Ulcers
Yes, No	Venereal Disease

Do you smoke or use tobacco?
Yes, No

Yes, No	Allergic to:
Yes, No	Amoxicillin
Yes, No	Aspirin
Yes, No	Clindamycin
Yes, No	Codeine
Yes, No	Dental Anesthetics
Yes, No	Doxycycline
Yes, No	Epinephrine
Yes, No	Erythromycin
Yes, No	Jewelry
Yes, No	Keflex
Yes, No	Latex
Yes, No	Metals
Yes, No	Morphine
Yes, No	Penicillin
Yes, No	Sulfa
Yes, No	Tetracycline

Other

_____

_____

WOMEN ONLY

Are you taking Birth Control?
Yes, No

Are you pregnant?
Yes, No

If so, how many weeks? ____

Are you nursing?
Yes, No

PLEASE LIST ALL CURRENT MEDICATIONS & DOSAGES:

Have you had any serious illnesses or operations in the last 5 years? YES NO If yes, please describe:

(OFFICE USE ONLY) Dr. Signature: Date: