Indian Hills Dentistry
2850 South Church St.
Murfreesboro, TN 37127

Patient/Guardian Information:

Patient or Family Name: _____

Please provide all that apply, but place a check next to your preferred method of contact.

- Email address: _____
- Home Number (if applicable): _____
- Work Number (if applicable): _____
- Cell Number: _____(text or call) circle preference
- Postal Mail Address: _____

I consent to have my cell number added to a list for automatic text message updates of any appointment reminder or changes. **$50 missed appointment fee if cancellation is less than 24 hour notice.

Patient/Guardian Signature: _____

615-396-8578 office 615-225-8749 fax
ihdentistry@live.com

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Special Authorization

I give consent for Indian Hills Dentistry to use dental/medical photos for my patient chart. Indian Hills Dentistry will remain within HIPAA regulations.

I have been informed that I am not required to sign this consent.

I understand I am not financially compensated for this authorization.

This consent may be revoked by written notice and delivered to Indian Hills Dentistry.

Indian Hills Dentistry

Name of Practice

By:_____

Authorized Staff Member Date

_____ _____

Patient Signature Date

_____

Print Patient Name

_____

Guardian/Parent Date

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I, _____, have read and understand the Notice of
(print name)
Privacy Practices that I received from Indian Hills Dentistry.

Signed:_____
(Signature)

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Chart #: _____
FOR OFFICE USE ONLY

Patient Information

Patient Name_____ Date_____
Last, First MI (Preferred Name)

Gender: _____ Marital Status: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ (Cell): _____

Email Address: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Former Dentist: _____

How often do you brush?: _____ How often do you floss?_____

Reason for today's visit: _____

Please circle if you have or have had problems with any of the following:

AIDS/HIV
Allergies (please list):
_____
_____
Anemia
Arthritis
Artificial heart valves
Artificial joints, pins, etc.
Asthma
Back problems
Blood Disease
Cancer
Chemical Dependency
Chemotherapy
Circulatory problems
Congenital heart defects
Cortisone treatments
Cough, persistent
Diabetes
Dizziness
Epilepsy
Excessive bleeding
Fainting
Glaucoma
Growths/tumors
Hay Fever
Head Injuries
Headaches
Heart Disease
Heart Murmur
Hemophilia
Hepatitis
High Blood Pressure
Jaundice
Kidney Disease
Liver Disease
Mental Disorders
Mitral Valve prolapsed
Nervous Disorders
Pacemaker
Pregnancy
Due date:_____
Nursing? Yes or No
Radiation Treatment
Respiratory Problems
Rheumatic Fever
Rheumatism
Scarlet fever
Shortness of breath
Skin rash
Sinus Problems
Stomach Problems
Stroke
Thyroid problems
Tuberculosis
Tobacco habit
Ulcers
Venereal Disease
Codeine Allergy
Penicillin Allergy
OTHER:
☐ _____
☐ _____

**Please list medications that you are currently taking: _____
_____
_____

Please circle if you have or have had problems with any of the following:

Bad breath
Bleeding gums
Clicking or popping jaw
Food collecting between the teeth
Grinding teeth
Loose teeth or broken fillings
Periodontal treatment
Sensitivity to cold
Sensitivity to hot
Sensitivity to sweets
Sensitivity when biting
Sores or growths in mouth

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you had any serious illnesses or operations? ☐ Yes ☐ No
  If yes, please explain: _____

- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

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.

_____ Date: _____
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed. To accommodate you, we accept cash, personal checks, and all major credit cards except Discover. For extensive plans, we do offer no-interest plan with credit approval.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the *assumption* that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 30 days, unless previously written financial arrangements are satisfied. In the unfortunate event that your balance becomes 90 days past due, we reserve the right to turn your account over to a collections specialist. Any fees associated with the collections of a past due account will be your responsibility. If you should encounter financial hardship, please stay in constant communication as we might not assign your account to a collection specialist.

Finally, please remember that we reserve an appointment time especially for you. Therefore, we request at least 24 hours notice in order to reschedule your appointment. When you cancel your appointment at the last minute or do not show up for an appointment, everyone loses-you, the doctor and other patients that would like to have utilized your appointment time. **Therefore, a missed appointment fee of $50.00 will be assessed if 24 hours is not given for changing or cancelling a reserved appointment.**

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party