PATIENT REGISTRATION

Patient First Name:____________________ Patient Last Name: ____________________ Middle Initial:________

Preferred Name: ____________________

Patient Information:

Address: ______________________________ Mailing Address: ______________________________

City, State, Zip: ______________________________

Home Phone: ______________ Work Phone: ______________ Cell Phone: ______________

Sex: ○ Female ○ Male Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth date: ____________ Social Security #: ______________ Drivers Lic#: ______________ State_____

E-mail: ______________________________

Employment Status: ○ Full Time ○ Part Time ○ Self Employed ○ Retired ○ Unemployed

Place of Employment ______________________________

Student Status: ○ Yes ○ No Preferred Pharmacy: ______________ Street ______________

*** I am the Dental Policy Holder ○ Yes Name of Dental Insurance Co ______________________________

Emergency Information:

Name of person to contact in case of emergency: ______________________________

Relationship to you: ______________________________

Phone Number: ______________________________

*** If you checked yes to the question above, ***, you may **STOP** here

Financial Responsible Party for Billing: (if someone other than the patient or for a minor child)

I have DENTAL Insurance ○Yes ○ No Name of Dental Insurance Co ______________________________

I have Secondary DENTAL Insurance ○Yes ○ No Name of Dental Insurance Co ______________________________

○ Responsible Party, I am the Policy Holder for Patient

○ I am the Primary Insurance Policy Holder ○ I am the Secondary Insurance Policy Holder

○ Responsible Party Place of Employment ______________________________

Your First Name: ______________ Last Name: ______________ Middle Initial:__________

Address: ______________________________ Mailing Address: ______________________________

City, State, Zip: ______________________________

Home Phone: ______________ Work Phone: ______________ Cell Phone: ______________

Birth date: ____________ Social Security #: ______________ Drivers Lic#: ______________

Dr. Bethany Thomas D.D.S.
Seymour Family Dental
119 Maryville Highway Suite B
Seymour TN 37865
865-773-0552
info@bethanythomasdds.com

NOTICE OF PRIVACY PRACTICES

You may request a copy of our Privacy Practice at any time. In the meantime an office copy is available for your viewing.

Ask the front office team for a copy, call 865-773-0552 and request a copy to be mailed, faxed or e-mailed.

OUR PRIVACY PRACTICE 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. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your dental health information. We must follow the privacy practices that are described in the Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.
We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all dental health information that we maintain, including dental health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the top of this Notice.

I was given the opportunity to review the office copy

____ ____________________
Signature Date

FOR OFFICE USE ONLY
We attempted to obtain written acknowledgment of receipt of our NOTICE of PRIVACY PRACTICES, as required by law, but acknowledgment could not be obtained because:

[ ] Individual refused to sign
[ ] An emergency situation prevented us from obtaining the acknowledgment
[ ] Communication barriers prohibited obtaining the acknowledgment
[ ] Other (Please specify ____

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Financial Policy

Unless another financial option is PRE-ARRANGED, payment in full is due the day of treatment. Should a patient have dental insurance, the estimated patient portion will be the amount due.

Payment Options:

1. We will accept cash, check, credit cards and Care Credit.
2. We also offer short and long-term financing options. (Interest-free options may apply)

For Patients with Dental Insurance:

We accept insurance. We will file your claim at no charge. It is the patient's responsibility to provide us with information prior to the date services will be performed.

Dental insurance plans often pay less than the actual fee for service, therefore the patient or guarantor is the responsible party for all dental services provided. Dental insurance in most cases is a benefit with limitations and should not be expected to take care of all your costs. Your dental benefits and how they relate to your specific needs will be explained to you during the Treatment Plan Discussion appointment.

Finance Charges and Fees:

Returned checks will be charged a $20.00 accounting fee
Balances in excess of 30 days will be charged a monthly interest rate of 1.17% (Maximum of 14% annually)
**Balances in excess of 60 days will be sent to collections.

**You agree to reimburse us the fees of any collection agency, which will be 30% of the principle balance of the debt, and all costs and expenses, including reasonable attorneys' fees, we incur in such collection efforts, which will be added at the time the account is sent to collections.

I acknowledge I have read and understand the above Financial Policy of Seymour Family Dental, Inc.

Print Name:______________________________

Signature: ______________________________ Date: ____________
(Financial Responsibility) **(Must be over the age of 18)**

Insurance Benefits

Seymour Family Dental, Inc accepts insurance as a courtesy for our patients. However, due to the complicated nature of the many various insurance plans, we are under their mercy. We will make every attempt to obtain accurate information regarding your benefits but can not always predict final payment. We will be happy to provide you with a copy of your Plan Benefits from your insurance company.

If your insurance provides c overage for alternate services or downgrades any service "not covered" you will be responsible for the complete charge. We will file pre-treatment estimates at YOUR REQUEST ONLY. Please be aware that some insurance companies may not honor a pre-treatment estimate or may alter it. In all cases, it may delay important dental care.

Insurance limitations and regulations vary with all insurance plans. We do not base your treatment plan on what insurance plan covers or doesn't cover. It's ultimately YOUR responsibility to be aware of your dental plan coverage, regulations and limitations to avoid confusion and any surprises.

I acknowledge that I have read and understand the above explanations of Insurance Benefits.

Print Name:______________________________

Signature: ______________________________ Date: ____________
(Financial Responsibility) **(Must be over the age of 18)**

Informed Consent Of General Dentistry

Please initial each number and sign at the bottom

1. EXAMINATIONS AND X-RAYS

I understand that the initial visit may require radiographs in order to complete the examination, diagnosis and treatment plan. I understand I am to have work done as detailed in the attached treatment plan.
Initials______

2. DRUGS, MEDICATION AND SEDATION

I have been informed and understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). I have informed the Dentist of any known allergies. They may cause drowsiness, lack of awareness and coordination which can be increased by the use of alcohol or other drugs. I understand and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of the anesthetic, medication and drugs that may have been given to me in the office for my care. I understand that failure to take medications prescribed may offer risks of continued or aggravated infection and pain and potential resistance to effective treatment of my condition. I understand that antibiotics can reduce the effectiveness or oral contraceptives (birth control pills). **Initials**______

3. CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary and I will be fully responsible for any lab fees & office preparation if treatment is canceled or postponed. **Initials**______

4. TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMD)

I understand that popping, clicking, locking and pain can intensify or develop in the joint of the lower jaw (near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. Although symptoms to routine dental treatment are usually transitory in nature and well tolerated by most patients, the cost of which is my responsibility. **Initials** ______

5. DENTAL PROPHYLAXIS (CLEANING)

I understand the treatment involves the removal of plaque and calculus above the gum line and will not address gum infections below the gum line called periodontal disease. I understand bleeding could last several hours. Should it persist, particularly if it is severe in nature, it should receive attention and this office must be contacted. **Initials** ______

6. PERIODONTAL TREATMENT

I understand that gum disease is serious condition causing gum inflammation and/or bone loss, and that it can lead to the loss of my teeth and/or negative systemic conditions (including uncontrolled diabetes, heart disease, and pre-term labor, etc.). Alternative treatment plans have been explained to me, including non-surgical therapy, antibiotic/antimicrobial treatment, gum surgery, and/ or extractions. I understand the success of any treatment depends in part on my efforts to brush and floss daily, receive regular therapeutic cleanings as directed, follow a healthy diet, avoid tobacco products and follow other recommendations. I understand bleeding could last for several hours. Should it persist, particularly if it is severe in nature, it should receive attentions and this office must be contacted. I understand that periodontal disease may have a future adverse effect on the long-term success of dental restoration work. **Initials** ______

How did you hear of us ?

____105.5 Mix Radio

____QI00.3 Country Music

____ Praise Radio

____ The Mountain Press Newspaper

____ Knox Focus Newspaper

____ Seymour "The Herald" Newspaper

____ Volunteer Coupon Book

____ Postcard in the mail

____ Website / Internet

____ Phone Book

____ School

____ Teeth 4 Tots

____ Walk In / Drive By

____ Word of mouth / Patient's Name

Name of person for whom we may thank ____________

____ Insurance Company

____ Doctor Referral

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Cancellation / No Show Policy

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment you may be preventing another patient from getting much needed treatment. Conversely the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book. **If an appointment is not canceled at least 24 hours in advance you will be charged a thirty five dollar ($35) fee; this will not be covered by your insurance company. Repeated cancellations or missed appointments will result in the loss of future appointment privileges.**

Scheduled Appointments

We understand that delays can happen, however, we must try to keep the other patients and providers on time. **If a patient is 15 minutes past their scheduled time we will have to reschedule the appointment.**

Account Balances

We require that patients will self-pay balances pay their account balances to zero prior to receiving further services by our practice, unless payment options have been previously arranged. Patients who have questions about their bills may call and ask to speak to a business office representative with whom they can review their account and concerns.

Unforeseen Circumstances

We recognize that situations can occur which are unforeseen and, as such, the following procedure is required in order to waive the "No Show Fee." Illness' Must provide Emergency Room Report or Physician Excuse.

I ________________________________ have read and understand the above policy.

Patient Signature: ______________________________ **Date:** ___________________

Witness: _____________________________________ **Date:** ___________________

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Consent to Share Confidential Dental Information

To be valid, this form must be filled out COMPLETELY, including what information you are giving us permission to share.

Patient's Legal Name:___________________________________

Birth Date:_________________

O I DO NOT AUTHORIZE SEYMOUR FAMILY DENTAL TO SHARE MY INFORMATION

I HEREBY AUTHORIZE SEYMOUR FAMILY DENTAL TO SHARE:

O Dental Records (xrays, treatment, doctors notes)

O My Insurance Benefit information (benefits available, benefits used, contract limits, dates of service)

O Insurance claim information (status, type of service, diagnosis, provider)

O My appointment times, dates and reasons for the visits

O Medication we have prescribed

O The following information (specify):____

WITH THE FOLLOWING PEOPLE:

Full Name:______________________________ Relationship:____________________________

Full Name:______________________________ Relationship:____________________________

Full Name:______________________________ Relationship:____________________________

I understand that I may cancel this consent at any time (by writing to Seymour Family Dental), but that canceling it will not affect any information that has already been released.

Signature:_____________________________________ Date: ____________________

Witness: _____________________________________ Date: ____________________

Relationship to minor patient (if parent or legal guardian):______________________________

If you are not the minor patient's parent, you must give us proof of guardianship (for example, a court order or power of attorney)

This authorization expires:

On Date____/_____/______ or on Event ____

If no expiration date or event is specified, this authorization will expire one(1) year after the date it is signed.