



PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____

Preferred Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: __/__/____ Age: _____ Employer/School: _____

Gender: Male Female Social Security Number: _____ - _____ - _____

Marital Status: Single Married Widowed Separated Divorced

Home Phone: _____ Cell Phone: _____

Email: _____

Preferred method of contact: Text Email Phone Call

Who may we thank for referring you? _____

Emergency Contact Outside of Immediate Family:

Name: _____

Phone Number: _____ Relationship to Patient: _____

SPOUSE OR PARENT/GUARDIAN (if a minor) INFORMATION

Spouse

Parent/Guardian

Name: _____

Date of Birth: __/__/____ Social Security Number: _____ - _____ - _____

Address: _____

Employer: _____

Phone: _____

If applicable:

Parent/Guardian Name: _____

Date of Birth: __/__/____ Social Security Number: _____ - _____ - _____

Address: _____

Employer: _____

Phone: _____

DENTAL INSURANCE INFORMATION

Primary Insurance: _____ Insurance Phone: _____

Insurance is through: Self Spouse Mother Father Guardian

Subscriber Identification Number: _____

Group Number: _____

Secondary Insurance: _____ Insurance Phone: _____

Insurance is through: Self Spouse Mother Father Guardian

Subscriber Identification Number: _____

Group Number: _____

MEDICAL HISTORY

PATIENT NAME: _____ BIRTH DATE: _____

Are you under a physician's care now? Yes No _____

Have you ever been hospitalized or had a major operation? Yes No _____

Have you ever had radiation treatment or injury to the head or neck? Yes No _____

Do you take, or have you taken, Phen-Fen or Redux ? Yes No _____

Are you on a special diet? Yes No _____ Do you use tobacco? Yes No _____

Are you taking any bone sparing Medications? Yes No Are you taking any blood thinners? Yes No _____

Do you use controlled substances? Yes No _____

Do you have any known drug allergies? Yes No

Do you have any allergies to the following?
 Aspirin Penicillin Ibuprofen Codeine Acrylic Metal Latex Local Anesthetics Sulfa Other

If yes, please explain: _____

WOMEN: Are you pregnant /trying to get pregnant? Yes No Nursing? Yes No

Do you have, or have you had, any of the following?							
AIDS/ HIV Positive	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cortisone Medicine	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hemophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Renal Dialysis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alzheimer's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis A	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anaphylaxis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Drug Addiction	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis B or C	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Easily Winded	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Angina	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shingles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis/Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy or Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hives or Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sickle Cell Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valve	<input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive Thirst	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hypoglycemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joint	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting Spells/ Dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Irregular Heartbeat	<input type="checkbox"/> Yes <input type="checkbox"/> No	Spina Bifida	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach/Intestinal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Leukemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Transfusion	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swelling of Limbs	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breathing Problem	<input type="checkbox"/> Yes <input type="checkbox"/> No	Genital Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bruise Easily	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lung Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hay Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Attack/ Failure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain in Jaw Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors or Growths	<input type="checkbox"/> Yes <input type="checkbox"/> No

Chest Pains	€ Yes € No	Heart Murmur	€ Yes € No	Parathyroid Disease	€ Yes € No	Ulcers	€ Yes € No
Cold Sores/ Fever Blisters	€ Yes € No	Heart Pace Maker	€ Yes € No	Psychiatric Care	€ Yes € No	Venereal Disease	€ Yes € No
Congenital Heart Disorder	€ Yes € No	Heart Trouble/ Disease	€ Yes € No	Radiation Treatments	€ Yes € No	Yellow Jaundice	€ Yes € No
Convulsions	€ Yes € No	Excessive Bleeding	€ Yes € No	Recent Weight Loss	€ Yes € No		

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:** _____

Patient Dental History Information

DENTAL HISTORY & SYMPTOMS

What is the reason for your visit today?

Are you currently experiencing any dental pain for discomfort? Yes / No. If yes, where?

Are you taking any medications, pills, or drugs? € Yes € No If yes, please list medications: _____

Please mark an "X" in the box ONLY if this applies to you:

- Is it hard to open your mouth?
- Does it hurt to chew, bite or swallow?
- Do your gums bleed when you brush or floss your teeth?
- Have you ever had periodontal (gum) treatments like scaling and root planing?
- Do you have, or have you ever had, any sores or growths in your mouth?
- Do you clench or grind your teeth?
- Does your jaw click, pop or hurt?
- Do you have earaches or neck pain?
- Does dental treatment make you nervous?

Have you ever experienced any of these sleep-related breathing disorders?

Mouth Breathing? Snoring? Trouble breathing during sleep?

Have you ever had a serious injury to your head or mouth? If yes, please describe what happened and when it happened:

Have you ever had a reaction to, or problem with, dental anesthesia? If yes, please describe what happened:

Are you unhappy with your smile? Yes / No

Are you happy with the color of your teeth? Yes / No

Are you happy with the shape and position of your teeth? Yes / No

Other. Please describe: _____

Patient's Name: _____ Date: _____

Signature: _____

Patient Consent Form

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient's Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____



Notice to Our Insurance Patients

We take pride in being transparent and honest with our patients. With that in mind, we would like to inform you that our office participates as an **out-of-network provider** with dental insurance plans. As a courtesy, we are happy to submit claims on your behalf so you may take advantage of any out-of-network benefits available. However, our fees and treatment recommendations are not dictated by insurance contracts, allowing us to focus on the highest quality care for your individual needs.

As part of our commitment to transparency, we submit all completed procedures to your insurance using our standard office fees. Please note that your hygiene claim may reflect a higher amount than what you are actually responsible for, as Dr. Dotson provides a courtesy discount known as the **"Hygiene Loyalty Adjustment."**

***New Patient** We accept what insurance pays as a courtesy

***Established Hygiene** visits are discounted to **\$250.**

Any remaining balance not paid by your insurance is your financial responsibility.

Any remaining balance for non-hygiene treatment is the patient's financial responsibility.

We appreciate having you in the office and will look forward to helping you with any of your dental needs.

Effective as of January 1, 2022

Signature

Date



Financial Agreement

Thank you for choosing Tatum Highlands Dentistry as your DENTAL home. We are committed to your treatment being successful and appreciate the trust and value you have placed in our office for your dental needs. Please take a moment to read the following.

Payment for services rendered are expected at the time of service. For your convenience we accept MasterCard, Visa, Discover, American Express, Check, Cash, Cherry and CareCredit. For appointments longer than two (2) hours, a deposit of \$100 per hour is required at the time of scheduling. This deposit is **nonrefundable** if the appointment is canceled with less than one (1) week's notice (business days only). When scheduling with a Specialist or Surgeon, **50% of the patient's copay** is due at the time of scheduling. This amount is **nonrefundable** if the appointment is canceled with less than one (1) week's notice (business days only). The remaining balance of the copay is due **the day before** the scheduled procedure.

If applicable, insurance balances are ultimately the patient's obligation. We will file most primary insurances at no cost to you as a courtesy. Dental insurance is not meant to be a pay-all. It is only meant to help with the cost of your dental needs. We do our best to present you with an estimation of what your insurance may pay. Some of your treatment may not be covered by your insurance carrier & the cost for such charges will be your responsibility. Insurance balances that are not paid within 45 days may be billed to you. Some necessary routine dental services are not covered by dental insurance at all. We do not believe it is in your best interest to compromise your treatment in order to accommodate insurance policy restrictions that may provide you with a quality of care that is considerably less than you deserve. The type of treatment we recommend is based on professional judgement, not whether you are covered by a dental benefit plan. We strongly feel that you, not your dental insurance company should choose the treatment best for you.

Patients are asked to confirm their appointments at least 2 business days prior by directly contacting our office or by responding to our confirmation contact. Failure to cancel your appointment within the designated time will incur an appointment fee of \$250. If you have an insurance plan that remits payments to the patients directly, you are required to pay your treatment charges on the day of service.

There will be a minimum fee of \$100 for any checks returned as Non-Sufficient Funds (NSF).

Unpaid balances over 30 days old will be subject to monthly interest of 1.5% (APR 18%). Patient balances that go unpaid for 60 or more days may be referred to a collection company or attorney. In the event this occurs, you will be liable for the collection fees. Further, in the event any unpaid account balance is referred to an attorney for collection, you may also be responsible for all costs and reasonable attorney's fees incurred in connection therewith.

I have thoroughly read and understand the above information. I understand Tatum Highlands Dentistry can only provide an estimation of my patient portion, which is owed on the date of service. I understand that my insurance company determines the exact patient portion only after treatment has been completed and after

the claim has been processed. I understand and agree to be responsible for payment of all services rendered on my behalf or my dependents' behalf.

Patient Name: _____ Date: _____

Signature: _____