Terry Hayes DDS, Jessica Jordan DDS
Cosmetic and Emergency Dentistry

Patient Information

Date: _____________

Patient Name: ____
Last First MI Preferred Name

☐ Male ☐ Female ☐ Married ☐ Widowed ☐ Divorced ☐ Single ☐ Child ☐ Other

Social Security #: ______________________________ Birth Date: _______________________________

Phone Number: (Home) _______________ (Cell) _______________ Best time to call:_____________

Address: ____
Street Address Apartment # City State Zip

____
Email

Patient Employment Information

Employer: ____________________ Work Phone Number: _____________ Occupation: _______________

Address: ____
Street City State Zip Code

Health Information

Date of Last Dental Visit: ________________ Reason for today's visit: __________________________________

Have you ever had any of the following? Please check those that apply:

☐ AIDS
☐ Allergic to any meds?
____
____
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Mitral Valve Prolapse
☐ Pacemaker
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Codeine Allergy
☐ Penicillin Allergy

Medications:
☐ ________________
☐ ________________
☐ ________________
☐ ________________

- Are you currently pregnant, or do you anticipate pregnancy? ☐ Yes ☐ No Due date?_________
- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain:____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain:____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain:____
- Have you ever taken drugs that categorized as bisphosphonates (such as Aredia, Actonel, Zometa, Boniva, and/or Fosamax)? ☐ Yes ☐ No Do you plan to take such drugs? ☐ Yes ☐ No
- Have you taken diet pills in the past such as Fen-Phen, Pondimen, or Redux? ☐ Yes ☐ No
  If yes, did you have a medical exam for heart disease? ☐ Yes ☐No

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient/friend______________________

☐ Mail Out ☐ Yellow Pages ☐ Insurance Network ☐ Website ☐ Another Dr. Office _________ ☐ Other _________

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Spouse Information

Name: ____

☐ Male ☐ Female ☐ Separated?

Social Security #: ____________________ Birth Date: ____________________

Phone Number: (Home) ____________ (Cell) ____________ (Work) ____________ Ext:______

Address: ____
(if different) Street city state zip

Employer____
name address city state zip

Insurance Information

PRIMARY

Name of Insured: ______________________________ Is the 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: ____

____

To the best of my knowledge, all of the proceeding answers and information provided are true and correct. If I ever have any change in my health, I will inform Dr. Hayes at the next appointment. Also, I grant my permission to you or your staff to contact me about matters related to this form or my dental treatment.

Signature on File: I authorize the use of this form on all my insurance submissions. I authorize release of patient information to my insurance companies, as well as authorizing payment directly to the doctor unless otherwise specified.

X______________________________ ______________________________ ______________
Signature of Responsible Party Relationship to Patient Date

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FINANCIAL POLICY

This is an agreement between Terry S. Hayes, D.D.S., P.C. as a creditor and the patient or debtor named on this form. In this agreement the words "you", "your," and "yours" refers to the Patient/Debtor. The word "account" refers to the account that has been established in your name to which charges are made and payments are credited. The words "we," "us," and "our," refers to Terry S. Hayes, D.D.S., P.C. located in Collierville, TN. **By executing this agreement, you are agreeing to pay for all services that are received.**

Payment if you have insurance: Please be aware that we will file dental claims with your insurance carrier only when eligibility has been verified. **Insurance verification does not guarantee that your carrier will pay for your services.** As a courtesy, we will give you a good faith estimate of the carrier's payment and your out of pocket expenses based on the verification information we have received.

- **You will be required to pay your estimated out of pocket expenses upon arrival for treatment.**
- You may choose to pay in full for your treatment and have the insurance carrier send their payment directly to you.
- Your insurance carrier must pay within 90 days or the balance becomes your responsibility.
- You will need to pay out of pocket for your visit if you fail to give updated insurance information 24 hours before your scheduled appointment. This is due to the amount of time need to verify your insurance.

Insurance is a contract between you and your insurance company. We are NOT a party to this contract. We will bill your primary insurance company as a courtesy to you. Although we will estimate your insurance company's payment, it is the insurance company that makes the final determination upon processing your claim. You agree to pay any portion of the charges that are not covered. If your insurance requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or pre-authorization may result in a lower payment from the insurance company.

Payment if you have no insurance:

- You will be required to pay at least ½ of your estimated expenses at your appointment. If your treatment takes more than one appointment, the remainder of your expenses will be collected upon completion.
- For extensive treatment, you may prefer to secure a third party financing party for the entire amount and make payments to the lending institution. For your convenience, we do have applications in the office for Care Credit.

Emergency Exams: All emergency dental services, or any dental services performed without prior arrangements, must be paid in full prior to insurance filing, if applicable, since insurance cannot be verified over the weekend. Also, a **$150 after-hours fee** will be applied to after-hours care.

Statements: If you have a balance on your account, we will send you a statement. It will show separately the previous balance, any new charges to the account, the financial charge if applicable, and any payment or credits applied to your account. Unless other arrangements are approved in writing, the balance on your statement is due and payable when the statement is issued, and is past due by the end of the month.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency; a $50.00 collector's fee will be assessed to your account. In addition, you agree to pay all legal fees and court costs which may incur.

Returned Checks: There is a fee of $35.00 for all checks returned by the bank.

Use of Composite Fillings: We do not use amalgam (silver) fillings. We believe the composite (white) material that we use to be a far more superior material. We will match the shade of the composite material to the remaining tooth structure as well as to the surrounding teeth. Many insurance companies will only cover amalgam fillings in posterior (back) teeth. You will be responsible for the fee difference between the insurance company allowance for the amalgam fillings and our price for the composite fillings.

Missed Appointment Fee: Patients who fail to provide 24 hours notice or no show for an appointment will be charged a $50.00 fee per hour(s) of scheduled time. We understand that your time is very important and we ask that you respect the time of other patients and Dr. Hayes as well. If you cannot keep your appointment, please provide at least 24 hours notice so that we may give this time to another patient. We strive to get each patient back at their appointed time. In order to stay on schedule throughout the day, we will reschedule your appointment if you arrive 15 minutes or more past your appointment time. The missed appointment will be considered a no show appointment.

Effective Date: Once you have signed this agreement you agree to all of the terms and conditions contained herein and the agreement will be in full force and effective.

______________________	______________________	______________________
Signature of Responsible Party	*Relationship to Patient*	*Date*

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HIPAA PRIVACY FORM

Consent for Use and Disclosure of Health Information

Purpose: In cases where Terry S. Hayes, D.D.S., P.C. has directed not to rely on acknowledgments as a basis to use or disclose health information, this form is used to obtain a patient's consent to our use and disclosure of the patient's protected health information to carry out treatment, payment activities, and healthcare operations, as described more fully in our Notice of Privacy Practices.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations; and of the used, disclosures and other important matters about your protected health information. A copy of our Notice is available at the front desk. Upon your request, we will provide a copy for your review, and you are welcome to keep it. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions for our Notice, at any time by contacting our office. Phone:(901) 850-0700, Fax:(901) 850-0770, E-Mail: ColliervilleSmiles@Comcast.net

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the office. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent. At your request, we will provide a revocation of consent for you to sign.

I have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information, to carry out treatment, payment activities and health care operations.

______________________________	______________________________	__________________
Signature of Responsible Party	***Relationship to Patient***	***Date***

YOU ARE ENTITLED TO A COPY OF THIS CONSENT ONCE YOU HAVE SIGNED IT

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SMILE EVALUATION

NAME:	**DATE:**
Do you like the appearance of your teeth? Is there anything about the appearance of your teeth that you'd like to change? Shade/Color Shape/Position Spacing/Gaps Crowding/Overlapping	
Are your teeth all in alignment (straight)? Have you ever considered orthodontic treatment?	
Do you have any missing teeth?	Are any chipped?
Is your bite comfortable for chewing/biting?	
Do you have frequent headaches? How often? Migraines?	
Do you have any old dental work that you don't like?	

DENTAL HISTORY

Are you nervous about dental treatment?	Have you ever needed Nitrous Oxide (gas) for treatment?
Is there anything about your mouth that concerns you?	
Are any of your teeth mobile (loose)?	
Have you ever been told that you have gum disease? Have you had treatment for gum disease?	When?
Do you smoke?	Chew Tobacco?
Do you feel you have unpleasant breath at times?	
How would you describe your dental health? Good Fair Poor	
Do you snore during sleep?	Do you have sleep apnea?
Have you ever been told you clench or grind your teeth during sleep? Do you clench or grind your teeth during the day? Do you now wear or have you ever worn a night guard appliance?	

REMARKS