Tri Star Dental Studio

3046 Columbia Ave Suite 201 Franklin, TN 37064 615.599.7775 Fax 615.628.8962

Patient Information

Name: ______________________________Preferred Name: _______________Male _____Female_______

Address: ____City, State/ Zip: _________________________

Home Phone: ___________________ Work Phone: _______________Cell Phone: _________________

Email: ____________________________________Best time to reach you: _________________________

Preferred contact method: Email _____ Text _____ Phone _____ Other __________________

DOB: ________________ Age: ______ SSN#: ____

Employer: _____________________________ Occupation: _____________________________________

Single _____ Married _____ Widowed _____ Separated _____ Divorced _____ Student ______

Spouse's Name: ________________________ DOB: _____________ SSN#: _______________________

Work Phone: _________________ Cell Phone: _______________ Email: ___________________________

Spouse's occupation: _____________________ Employer: _______________________________

Who may we THANK for referring you? ____

Responsible Party

(If someone other than the patient is responsible for the account)

Relationship to Patient: Self _____ Spouse _____ Parent _____ Other ______

Name: ______________________________ Phone: ______________________________ SSN#________________

Address: ______________________________________ City/ State/ Zip: ___________________________________

Employer: ____ Work Phone: ___________________________________

Insurance

Name of Insured: __________________________ DOB: _______________________SSN#: ______________________

Relationship to patient: Self ____ Spouse _____ Child _____ Other _____Ins Company Phone #: ______________

Insurance Company: _______________ Group Number: ________________ ID#: ___________________________

Insurance Company Address: ____

Medical History

Although dental personnel primarily treat the area in and around your mouth, you mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under physicians care now? YES _______ NO ______

Have you ever been hospitalized or had a major operation? YES _____ NO _____

Have you ever had a serious head or neck injury? YES _____ NO _____

Are you taking any medications, pills, or drugs? 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 _____

Do you use controlled substances? YES _____ NO ______

If you have answered YES to any of the questions above , please explain:

____

____

Women:

Are you Pregnant/ Trying to get pregnant? YES ___ NO ___Taking oral contraceptives? YES ___NO ___

Nursing? YES _____ NO _____

Are you allergic to any of the following?

Aspirin ____ Penicillin____ Codeine ____ Acrylic ____ Metal ____ Latex_____ Local Anesthetics ____

Other _____ If YES, please explain: ____

Do you have, or have had any of the following?

Y___N___ AIDS/ HIV	Y___ N___ Asthma	Y___ N___ Cold Sores/ Fever Blisters
Y___N___ Alzheimer's Disease	Y___ N___ Blood Disease	Y___ N___ Congenital Heart Disorder
Y___N___ Anaphylaxis	Y___ N ___Blood Transfusion	Y___ N___ Convulsions
Y___N___ Anemia	Y ___N ___Breathing Problems	Y___ N___ Cortisone Medicine
Y___ N___ Angina	Y ___N ___ Bruise Easily	Y___ N___ Diabetes
Y___ N___ Arthritis/Gout	Y___ N___ Cancer	Y___ N ___Drug Addiction
Y___ N___ Artificial Heart Valve	Y___ N ___Chemotherapy	Y___ N ___Artificial Joint

Do you have, or had had, any of the following? Continued ....

Y___ N ___ Easily Winded
Y___ N___ Emphysema
Y___ N___ Epilepsy or Seizures
Y___ N___ Excessive Bleeding
Y___ N___ Excessive Thirst
Y___ N___ Fainting Spells / Dizziness
Y___ N___ Frequent Cough
Y___ N___ Frequent Diarrhea
Y___ N ___ Frequent Headaches
Y___ N ___ Genital Herpes
Y___ N___ Glaucoma
Y___ N___ Hay Fever
Y___ N___ Heart Attack/ Failure
Y___ N___ Heart Murmur
Y___ N___ Heart Pace Maker
Y___ N___ Heart Trouble/ Disease
Y___ N___ Hemophilia
Y___ N___ Hepatitis A

Y___ N___ Hepatitis B or C
Y___ N___ Herpes
Y___ N___ High Blood Pressure
Y___ N___ Hives or Rash
Y___ N___ Hypoglycemia
Y___ N___ Irregular Heartbeat
Y___ N___ Kidney Problems
Y___ N___ Leukemia
Y___ N___ Liver Disease
Y___ N___ Low Blood Pressure
Y___ N___ Lung Disease
Y___ N___ Mitral Value Prolapse
Y___ N___ Pain in Jaw Joints
Y___ N___ Parathyroid Disease
Y___ N___ Psychiatric Care
Y___ N___ Radiation Treatment
Y___ N___ Recent Weight Loss
Y ___N___ Renal Disease

Y___N___ Rheumatic Fever
Y___N___ Rheumatism
Y___N___ Scarlet Fever
Y___N___ Shingles
Y___N___ Sickle Cell Disease
Y___N___ Spina Bifida
Y___ N___ Stomach/Intestinal
Y___ N___ Stroke
Y___ N___ Swelling of Limbs
Y___ N___ Thyroid Disease
Y___ N___ Tonsillitis
Y___ N___ Tuberculosis
Y___ N___ Tumors/ Growths
Y___ N___ Ulcers
Y___ N___ Venereal Disease
Y___ N___ Yellow Jaundice

Have you ever had a serious illness not listed above? Y______ N_____
If YES please explain: ____

____

Please list any medications you are currently taking. Please include non-prescription medications:

____

Signature Needed

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**______________

THIS NOTICE DESCRIBES HOW MEDICAL INFORAMTION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT and HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment, or health care operation. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care services; or getting copies of your health information for another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are; asking you about your health or dental care plans, or other sources of payment; preparing and sending bill or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney).

"Health care operation" means those administrative and managerial that we must do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records. We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for the reasons, we usually will not ask you for special written permission.

USES and DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSIONS

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state federal law mandates that certain health information be reported for a specific purpose:
- for public health purposes, such as contagious disease reporting, investigation or surveillance;
- and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of the doctors;
- for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceeding, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office;
- or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death;
- or to a funeral director to aid in burial;
- or to organizations that handle organ or tissue donations;
- uses or disclosures for health-related research;
- uses and disclosures to prevent a serious threat to health safety;
- uses and disclosures for specialized government functions, such as for the protection of the president or high rankling government officials;
- for lawful national intelligence activities; for military purposes;

- or for the evaluation and health of members of the foreign service; disclosures of de-identified information; disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by – product of permitted uses or disclosures;
- disclosures to a "business associates" who preform health care operations for us and who commit to respect the privacy of your health information;

Unless you object, we will also share relevant information about your care with your family and friends who are helping you with your dental care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatment or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and or leave you a reminder message on your answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined be federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if its your idea for us to send your information to someone else.

Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours. If we initiate the process an ask you to sign an authorization form, you do not have to sign it, if you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we already acted in reliance upon it.

Revocations must be in writing. Send them to the office contact person.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can: ask to restrict our uses and disclosures for purpose of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want.

- To ask for a restriction, send a written request to the office contact person at our office.
- To ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using email to your personal email address. We will accommodate these requests if they are reasonable, and if you pay us for the extra cost. If you want to ask for confidential communications, send a written request to the office contact person.
- To ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit or coping. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off- site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30-day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person.
- To ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days form when you ask us. We will send the corrected information

to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of your position and / or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information, by law, we can have one 30-day extension of time to consider a request for amendment if we notify you in written of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person.

- Get a list of the disclosures that we have made your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for the purpose of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent list, you will have to pay for them in advance. We will usually respond to your request within 6o days of receiving it, but by law we can have one 30-day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person.
- Get additional paper copies of the Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this notice, the new privacy practices will apply to your health information we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post on our web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person. If you prefer, you can discuss your complaint in person or by phone.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I received a copy of Tri Star Dental Studio's Notice of Privacy Practices.

Patient Name: ____

Signature: ______________________________ Date: ________________

Financial Policy

In our continued commitment to provide the highest quality dental care available to all our patients and to have those services comfortably, we are pleased to offer you these options for payment.

Visa, Mastercard, America Express, Discover, Cash, Check and Care Credit
* returned checks will have a $35.00 dollar return check fee.

We are pleased to offer a third party extended payment financing through Care Credit. Please a member of the staff for details and credit applications.

We are committed to support you in understanding your dental health, so that you will be able to make the best choice.

We will, as a courtesy, process your insurance claim in our office, which will relieve you of of this time consuming and sometimes complicated task. We will always recommend treatment based upon your dental needs, not based on insurance coverage, which can be inadequate with some dental plan.

I agree that I am fully responsible for the total payment of all procedures performed in this office, this includes any treatment that is not a benefit of any dental insurance that I may have. I understand that all services are due and payable at the time of services are rendered, regardless of whether my insurance benefits have been received. One and one-half percent (1.5%) per month interest (18% per year) will be charged on accounts 60 days from treatment date.

I understand and agree that if the amount for which I am responsible delinquent, I will pay all cost associated with the collection process. This includes but not limited to collections fees, attorney fees, court filing fees and any other cost as allowed by law.

Missed Appointments

Appointment times are reserved especially for you. If you arrive late, the doctor may request that you reschedule the appointment and you may be charged a fee of $50.00. If for any reason you should need to change your appointment, there will be no change, provided you give us a 48-hour notice. Please help us serve you better by keeping your scheduled appointments. We are here to assist you in any way possible. Please make your questions and concerns known to our team. Our goal is to ensure that you have an outstanding experience.

Office Manager: ______________________________

Patient Signature: ______________________________ Date: __________