TIME 09:21 AM DATE 4/14/2021

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

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

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

Referred By

Previous Dentist

Emergency Contact

Emergency Contact #

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Emerald Dental PLLC

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Are you under a physician's care now?	○ Yes ○ No	If yes
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes
Are you taking any medications, pills, or drugs?	○ Yes ○ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes
Are you on a special diet?	○ Yes ○ No	
Do you use tobacco?	○ Yes ○ No	
Do you use controlled substances?	○ Yes ○ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

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

AIDS/HIV Positive ○ Yes ○ No	Cortisone Medicine ○ Yes ○ No	Hemophilia ○ Yes ○ No	Radiation Treatments ○ Yes ○ No
Alzheimer's Disease ○ Yes ○ No	Diabetes ○ Yes ○ No	Hepatitis A ○ Yes ○ No	Recent Weight Loss ○ Yes ○ No
Anaphylaxis ○ Yes ○ No	Drug Addiction ○ Yes ○ No	Hepatitis B or C ○ Yes ○ No	Renal Dialysis ○ Yes ○ No
Anemia ○ Yes ○ No	Easily Winded ○ Yes ○ No	Herpes ○ Yes ○ No	Rheumatic Fever ○ Yes ○ No
Angina ○ Yes ○ No	Emphysema ○ Yes ○ No	High Blood Pressure ○ Yes ○ No	Rheumatism ○ Yes ○ No
Arthritis/Gout ○ Yes ○ No	Epilepsy or Seizures ○ Yes ○ No	High Cholesterol ○ Yes ○ No	Scarlet Fever ○ Yes ○ No
Artificial Heart Valve ○ Yes ○ No	Excessive Bleeding ○ Yes ○ No	Hives or Rash ○ Yes ○ No	Shingles ○ Yes ○ No
Artificial Joint ○ Yes ○ No	Excessive Thirst ○ Yes ○ No	Hypoglycemia ○ Yes ○ No	Sickle Cell Disease ○ Yes ○ No
Asthma ○ Yes ○ No	Fainting Spells/Dizziness ○ Yes ○ No	Irregular Heartbeat ○ Yes ○ No	Sinus Trouble ○ Yes ○ No
Blood Disease ○ Yes ○ No	Frequent Cough ○ Yes ○ No	Kidney Problems ○ Yes ○ No	Spina Bifida ○ Yes ○ No
Blood Transfusion ○ Yes ○ No	Frequent Diarrhea ○ Yes ○ No	Leukemia ○ Yes ○ No	Stomach/Intestinal Disease ○ Yes ○ No
Breathing Problems ○ Yes ○ No	Frequent Headaches ○ Yes ○ No	Liver Disease ○ Yes ○ No	Stroke ○ Yes ○ No
Bruise Easily ○ Yes ○ No	Genital Herpes ○ Yes ○ No	Low Blood Pressure ○ Yes ○ No	Swelling of Limbs ○ Yes ○ No
Cancer ○ Yes ○ No	Glaucoma ○ Yes ○ No	Lung Disease ○ Yes ○ No	Thyroid Disease ○ Yes ○ No
Chemotherapy ○ Yes ○ No	Hay Fever ○ Yes ○ No	Mitral Valve Prolapse ○ Yes ○ No	Tonsillitis ○ Yes ○ No
Chest Pains ○ Yes ○ No	Heart Attack/Failure ○ Yes ○ No	Osteoporosis ○ Yes ○ No	Tuberculosis ○ Yes ○ No
Cold Sores/Fever Blisters ○ Yes ○ No	Heart Murmur ○ Yes ○ No	Pain in Jaw Joints ○ Yes ○ No	Tumors or Growths ○ Yes ○ No
Congenital Heart Disorder ○ Yes ○ No	Heart Pacemaker ○ Yes ○ No	Parathyroid Disease ○ Yes ○ No	Ulcers ○ Yes ○ No
Convulsions ○ Yes ○ No	Heart Trouble/Disease ○ Yes ○ No	Psychiatric Care ○ Yes ○ No	Venereal Disease ○ Yes ○ No
			Yellow Jaundice ○ Yes ○ No

Have you ever had any serious illness not listed above? ○ Yes ○ No If yes

Comments:

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:

X Date:_____

Consent for Services

In consideration for the professional services rendered to me, or at my request, by the Dr. Paul Gardner, I agree to pay 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.

_____	_____	_____
Signature of patient/parent or guardian/guarantor	Date	Relationship to Patient

HIPAA Policy

HIPAA: Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our notice before signing the Consent. The terms of our notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may then condition treatment upon the execution of this consent.

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

Please check:

□ I authorize release of necessary information to the insurance company.
□ I authorize payment of benefits directly to the provider.

_____	_____	_____
Signature of patient/parent or guardian/guarantor	Date	Relationship to Patient

Financial Policy

Thank you for choosing Emerald Dental as your dental care provider. Our office is committed to providing you with the best care possible. Please understand that payment of your bill is considered as part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

Please initial to acknowledge that you understand and agree to the following...

_____Your reserved time in our office is important. We ask that you kindly give us a minimum of 2 business days advanced notice for any appointment changes or cancellations. ***Your account will be charged a broken appointment fee of $50.00 for repeatedly missed appointments without proper notification.***

_____Payment for services is due at the time services are rendered unless prior arrangements have been made. Payment options include cash, check, MasterCard, VISA, American Express, and Discover. We also offer Care Credit and other financing options. If at any time you do not understand your treatment plan or financials, please notify us and we will be happy to review treatment cost and payment options.

_____Outstanding balances on your account are discouraged, and should be cleared within 30 days of treatment. Any balance that is over 90 days old will be considered delinquent and will be referred to our collection agency for further action. You are responsible for any additional costs incurred in collecting this debt, including collection agency fees (which could be up to 50% of your balance), attorney fees and court costs.

_____Checks that are returned to our office from your financial institution are subject to a $25.00 returned check fee. This fee covers the processing fees that are charged to our office. The balance (plus the fee) must then be paid by cash, money order, or credit card.

I have read and understand the financial policy of Emerald Dental and accept all terms and conditions outlined above.

_____ _____ _____

Patient Signature Witness Date

Consent for Electronic Communication

_____ (Initial) I give consent for Emerald Dental to contact me via email to confirm dental appointments, discuss treatment details and financial information.

_____ (Initial) I give consent for Emerald contact me via text message to confirm dental appointments.

Please choose any following methods of contact that you **prefer to opt out of:** Email Text Message

EMERALD DENTAL
PAUL GARDNER D.D.S.

Missed Appointment Policy

At Emerald Dental, we put our faith in you to keep your appointment. When we set up an appointment, a specific amount of time is reserved especially for you. If for any reason you must cancel your appointment, it is important that you give our office **at least 24hours notice** to offer that spot to someone else.

1st missed appointment: If an appointment is missed or canceled within 24hour window, a fee of $50 will be added to your account. A statement will be sent to your home showing the charge of $50 as a missed appointment fee.

2nd missed appointment: After your second missed appointment you will be required to pay a deposit to schedule future appointments. The deposit will be 50% of the cost of that appointments treatment or $50 whichever is greater. Upon Arrival, this fee is credited toward the cost of the patient's treatment. **If the patient does not show up to the appointment the deposit is non-refundable.** If you choose not to pay the deposit you have the option of being placed on a short list and will be notified of last minute scheduling opportunities.

After the Third missed appointment the doctor reserves the right to dismiss all patient/patients including Tenn Care. We understand true emergencies happen. If this is the case, please contact the office as soon as possible.

If you are more than 15mins late your Hygiene/Preventative appointment your appointment may be rescheduled in order to meet the needs of those who are on time for their pre-reserved visit.

I have read the policy above. I understand and agree to abide by the listed terms.

Sign _____ **Date** _____

EMERALD DENTAL
PAUL GARDNER D.D.S.

PHOTO RELEASE FORM

I hereby authorize Emerald Dental to publish photographs taken of me and/or with my child, for use of advertisement on social media platforms and website.

I release Emerald Dental from any expectation of confidentiality regarding the Photograph.

I acknowledge that since participation in publications and website produced by Emerald Dental confers no rights of ownership whatsoever. I release Emerald Dental, its contractors and its employees from liability for any claims by me or any third party in connection with my participation.

Patient Signature/ Guardian Signature: _____
Printed name of patient: _____
Date: _____

Dental Insurance Information and Disclaimer

It is our pleasure to assist you by filing your dental insurance claims. Please understand that your insurance policy is a contract between you and the insurance company, and we take no responsibility for what is (or is not) covered. Many dental plans have exclusions, waiting periods, age and frequency limitations, missing tooth clauses, and alternate benefit provisions (for example, fee allowed for silver filling vs white filling) which can impact your claim benefits. These limitations are not considered when preparing a treatment plan. We will give you a comprehensive treatment plan with your best interest in mind – regardless of whether dental insurance may contribute. ***You will be responsible for any difference in amounts your insurance does not pay***.

_____ _____

Patient Signature or Parent (if minor) Date

_____

Printed name of patient