MARK S. DILL, DDS, PC
CHATTANOOGA DENTISTRY
General and Cosmetic Dentistry

6106 Shallowford Road • Suite 116
Chattanooga, Tennessee 37421
Office: 423.296.1053 • Fax: 423.521.7796

Welcome

Date: ____________________

Name: ____ Nickname: ________________
Last First Middle

Address: ________________________ City: ______________________ State: ______ Zip: __________

Mailing Address
if Different: ________________________ Date of Birth: __________ Social Security: ______________

Sex: __________ Single ☐ Married ☐ Spouse's Name: ______________________________

Home Phone: ________________ Business Phone: ______________ Cell/Pager: ______________

Employer: ________________________________ Occupation: ______________________________

In case of an emergency who may we contact? ________________________ Phone: ______________

Who may we thank for referring you? ____

Dental Insurance

Primary

Insurance Company: ______________________________

Insurance Company Address: ______________________
____

Insurance Company Phone: ________________________

Insured's Name: ________________________________

Relationship to Patient: __________________________

Insured's Employer: _____________________________

Insured's SS#: _________________________________

Insured's Birthday: ______________________________

Insurance Card ID#: _____________________________

Group #: ______________________________________

Secondary

Insurance Company: ______________________________

Insurance Company Address: ______________________
____

Insurance Company Phone: ________________________

Insured's Name: ________________________________

Relationship to Patient: __________________________

Insured's Employer: _____________________________

Insured SS#: __________________________________

Insured's Birthday: ______________________________

Insurance Card ID#: _____________________________

Group#: _______________________________________

I UNDERSTAND THAT THE PORTION OF MY TREATMENT NOT COVERED BY INSURANCE IS DUE AND PAYABLE AT EACH VISIT. IF MY INSURANCE COMPANY HAS NOT PAID THEIR PORTION WITHIN 60 DAYS OF BEING PROPERLY BILLED. I UNDERSTAND THAT THE BALANCE WILL BECOME DUE AND PAYABLE FROM ME.

A MISSED APPOINTMENT IS A LOSS TO EVERYONE. A NO-SHOW FEE WILL BE CHARGED FOR MISSED APPOINTMENTS, LESS THAN 48 HOUR NOTICE.

IF THE BALANCE OF MY ACCOUNT IS NOT PAID WITHIN 60 DAYS, I UNDERSTAND THAT I WILL BE CHARGED A FINANCE CHARGE FOR THE CURRENT MONTHLY BILLING PERIOD. THE FINANCE CHARGE WILL BE AN APR OF 18%. I AGREE TO PAY ANY INTEREST, COLLECTION COST AND ATTORNEY FEES INCURRED TO EFFECT COLLECTION ON THIS ACCOUNT.

I UNDERSTAND AND AUTHORIZE THE DOCTOR TO TAKE X-RAYS, STUDY MODELS, AND/OR ANY OTHER DIAGNOSTIC AIDS DEEMED APPROPRIATE BY THE DOCTOR FOR A THOROUGH DIAGNOSIS OF MY DENTAL NEEDS, AND PERFORM ANY TREATMENT THAT MAY BE INDICATED.

THE INFORMATION THAT I HAVE GIVEN IS CORRECT TO THE BEST OF MY KNOWLEDGE, AND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES IN MY MEDICAL STATUS.

______________________________ ______________ ______________________________
SIGNATURE OF RESPONSIBLE PARTY DATE RELATIONSHIP TO PATIENT(S)

Medical History

Do you have a personal physician? q Yes q No

Physician Name: ______________________________ Phone: ____________________

Are you currently under the care of any physician? q Yes q No

If yes, explain: ____

Do you smoke or use tobacco in any other form? q Yes q No

Are you presently taking any drugs prescribed by a physician

or dentist? q Yes q No If yes, explain: ____________________

Have you had major surgery? q Yes q No

(If female) Are you taking hormones or birth control? q Yes q No

Are you pregnant or nursing? q Yes q No

Do you need to pre-medicate with antibiotics for dental treatment? q Yes q No

Are you allergic to: q Penicillin q Codeine q Local Anesthetics q Latex q Other ____________

HAVE YOU HAD OR DO YOU NOW HAVE:

	Yes	No
AIDS or HIV	q	q
Allergies	q	q
Anemia	q	q
Angina	q	q
Arthritis	q	q
Artificial heart valves	q	q
Artificial joints	q	q
Asthma	q	q
Cancer	q	q
Chemotherapy	q	q
Congenital heart lesions	q	q
Diabetes	q	q
Drug dependency	q	q
Epilepsy	q	q
Fainting	q	q
Glaucoma	q	q
Heart Disease	q	q
Heart murmur	q	q

	Yes	No
Hepatitis (A or B or C)	q	q
Herpes	q	q
High blood pressure	q	q
Jaundice	q	q
Kidney disease	q	q
Liver disease	q	q
Mitra valve	q	q
Organ Transplant	q	q
Pacemaker	q	q
Polio	q	q
Prolonged bleeding	q	q
Prolonged cough	q	q
Radiation therapy	q	q
Rheumatic fever	q	q
Sickle cell anemia	q	q
Stroke	q	q
Thyroid disease	q	q
Tuberculosis	q	q
Ulcers	q	q
Venereal disease	q	q

Have you any disease, condition, or problem not previously listed? ____________________

____

Dental History

When was your last dental visit? ____________________

Who was your last dentist? ____________________ Phone: ____________

Are you having any dental problems that require immediate attention? ____________

Do your gums bleed when brushing? ____________ Are they tender or swollen? ____________

Have you had periodonial or gum treatment? ____________ When? ____________

Have you ever had orthodontic treatment (braces)? ____________ When? ____________

How do you feel about the appearance of your smile? ____________________

Have you ever had an unpleasant dental experience? ____________________

ALL TREATMENT IS BY APPOINTMENT. A NO-SHOW FEE WILL BE CHARGED FOR MISSED APPOINTMENTS.

THE INFORMATION THAT I HAVE GIVEN IS CORRECT TO THE BEST OF MY KNOWLEDGE, AND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES IN MY MEDICAL STATUS.

____________________ ____________ ____________________

SIGNATURE OF RESPONSIBLE PARTY DATE RELATIONSHIP TO PATIENT(S)

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: ________________

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITYS IN THE FUTURE.

______________________________ ______________________________

Please ***print*** your name Please ***sign*** your name

______________________________ ______________________________

Legal Representative Description of Authority

Your comments regarding Acknowledgements or Consents: ______________________________

____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

☐ First Name Only ☐ Proper Sir Name ☐ Other ________________________

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: ________________________ Relationship: ____________________________

Name: ________________________ Relationship: ____________________________

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation ☐ Text Message to my Cell Phone
☐ Home Phone Confirmation ☐ Email Confirmation
☐ Work Phone Confirmation ☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation ☐ Text Message to my Cell Phone
☐ Home Phone Confirmation ☐ Email Confirmation
☐ Work Phone Confirmation ☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

☐ Phone Message ☐ **Any of the Above**
☐ Text Message ☐ **None of the above** (opt out)
☐ Email

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment _____
I could not communicate with the patient _____
The patient refused to sign _____
The patient was unable to sign because _____
Other (please describe) ____ ________________________________

Signature of Privacy Officer

HIPAA made EASY™
©All Rights Reserved