Welcome TO OUR PRACTICE

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us.

Patient # _____

SS # _____

Date _____

PATIENT INFORMATION

Name _____ Birthdate _____ Phone (____) _____

Address _____ City _____ State _____ Zip _____

Sex ☐ M ☐ F ☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

E-mail _____ Alt. Phone #1 (____) _____ Alt. Phone #2 (____) _____

Employer/School _____ Employer/School Phone (____) _____

Employer/School Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone (____) _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone (____) _____

RESPONSIBLE PARTY

Name of Person Responsible for this Account _____ Relation to Patient _____

Address _____ Home Phone (____) _____

Driver's License # _____ Birthdate _____ Bank _____

Employer _____ Work Phone (____) _____

Currently a patient in our office? ☐ Yes ☐ No E-mail _____ Cell Phone (____) _____

INSURANCE INFORMATION

Name of Insured _____ Relation to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Employer _____ Work Phone (____) _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Union or Local # _____

Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit _____

ADDITIONAL INSURANCE

Name of Insured _____ Relation to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Employer _____ Work Phone (____) _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Union or Local # _____

Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit _____

– O V E R –

DENTAL HISTORY

Reason for today's visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental X-rays _____

Address _____

Check (✓) if you have had problems with any of the following:

☐ Bad breath	☐ Grinding teeth	☐ Sensitivity to hot
☐ Bleeding gums	☐ Loose teeth or broken fillings	☐ Sensitivity to sweets
☐ Clicking or popping jaw	☐ Periodontal treatment	☐ Sensitivity when biting
☐ Food collection between the teeth	☐ Sensitivity to cold	☐ Sores or growths in your mouth

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Physician's Name _____ Date of last visit _____

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. ☐ Yes ☐ No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, describe _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates _____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Anemia	☐	☐	Congenital Heart Lesions	☐	☐	Hepatitis	☐	☐	Scarlet Fever
☐	☐	Arthritis, Rheumatism	☐	☐	Cortisone Treatments	☐	☐	Hernia Repair	☐	☐	Shortness of Breath
☐	☐	Artificial Heart Valves	☐	☐	Cough, Persistent	☐	☐	High Blood Pressure	☐	☐	Skin Rash
☐	☐	Artificial Joints, Pins, etc.	☐	☐	Cough up Blood	☐	☐	HIV/AIDS	☐	☐	Stroke
☐	☐	Asthma	☐	☐	Diabetes	☐	☐	Jaw Pain	☐	☐	Swelling of Feet or Ankles
☐	☐	Back Problems	☐	☐	Epilepsy	☐	☐	Kidney Disease	☐	☐	Thyroid Problems
☐	☐	Bleeding Abnormally	☐	☐	Fainting	☐	☐	Liver Disease	☐	☐	Tobacco Habit
☐	☐	Blood Disease	☐	☐	Glaucoma	☐	☐	Mitral Valve Prolapse	☐	☐	Tonsillitis
☐	☐	Cancer	☐	☐	Headaches	☐	☐	Pacemaker	☐	☐	Tuberculosis
☐	☐	Chemical Dependency	☐	☐	Heart Murmur	☐	☐	Radiation Treatment	☐	☐	Ulcer
☐	☐	Chemotherapy	☐	☐	Heart Problems	☐	☐	Respiratory Disease	☐	☐	Venereal Disease
☐	☐	Circulatory Problems	☐	☐	Hemophilia	☐	☐	Rheumatic Fever			

List medications you are currently taking and the correlating diagnosis:

_____

_____

_____

Allergies:

_____

_____

_____

AUTHORIZATION AND RELEASE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)

Dr._____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

Payment is due in full at time of treatment unless prior arrangements have been approved.

Appalachian Dental

Patient Policies

It is hard for us to put into words the tremendous pride we take in assuring that our patients receive the absolute best care that dentistry has to offer. We put forth our best effort to make sure that, from the simplest dental treatment to complex treatment each patient is treated with the utmost care, skill and compassion. A very important component of this care is a full understanding by all of our patients of our financial policies and appointment policies. These policies are in place to help assure that the care for our patients remains at the level we are so proud of. If you have any questions, please feel free to discuss them with any member of our team.

Payment is due when services are rendered. For your convenience, we accept cash, check, visa, Master Card, Discover, American Express and Care Credit. We also have outside financing options available. Please contact a team member for more information.

For crowns, bridges, implant restorations, cosmetic procedures, denture, partials or any other treatment that involves a dental laboratory, we will expect at least half of the fee to be paid when the procedure is started, and the remaining balance paid the day the procedure is finished.

If you have dental insurance coverage, we ask that you pay your portion of the treatment cost the day the services are rendered. Your portion is an estimate, so please understand that after insurance pays there could be a balance remaining. (No one can predict what insurance companies will actually pay) **Even though you have insurance coverage, you are ultimately responsible for your account balance with us. Any claim not paid to us, regardless of coverage specifics or determination of usual and customary fees, within 60 days of service, will become immediately due by the patient or responsible party.** We will gladly file your insurance claim a second time, provided you supply us with accurate coverage information. If your insurance company pays their overdue balance after the claim is re-filed by our office, we will absolutely refund your payment.

If you are unable to keep a scheduled appointment, we ask that you give at least 24 hours notice so we can fill your reserved time with someone who needs our help. **A charge of $50.00 per hour for hygiene appointments and $250.00 per hour for appointments with Dr. Cook will apply if we do not receive a cancellation request from you.** If you should fail to keep or cancel two appointments in a row you may be dismissed from the practice. This policy is subject to change without further notice.

You must know and understand that a finance charge of 15% per month will be added to my account on any balance over 60 days past due. **In the event that my account is placed with a collection agency/attorney/etc., I will be responsible for paying all collection/court/and or attorney fees incurred.**

Thank you for taking the time to read this letter. We truly appreciate the trust you have shown for our office and look forward to working with you for a very long time. If at anytime in the future you find there is anything extra we can do to help you, your friends or family, please don't hesitate to call upon us. We will be here for you!

_____ _____

Responsible Party Date

_____ _____

Witness Date

GREG S. COOK, D.D.S.

Appalachian Dental
GREG S. COOK D.D.S.

(865) 379-7555

134 Rankin Road
Alcoa, Tennessee 37701

Acknowledgement of Notice of Privacy Practices

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 this information can and will be used to:

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

I have received, read and understand your *Notice Of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. 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 above 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 health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Please list any and all persons that you wish to have privileges to your healthcare information:

I. _____
II. _____
III. _____
IV. _____
V. _____

PATIENT NAME: _____
Please Print
RELATIONSHIP TO PATIENT: _____

SIGNATURE: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of the *Notice of Privacy Practices*, but was unable to do so as documented below:

Date	Reason
	☐ Emergency ☐ NOP Mailed to Patient and not returned ☐ Patient refused ☐ Other _____
Initials	

LOCAL ANESTHESIA INFORMED CONSENT

GREG S. COOK, D.D.S.
134 N. RANKIN ROAD
ALCOA, TN 37701
(865)379-7555

1. I accept and understand that during the administration of local anesthesia, I will be awake, fully conscious, aware of my surroundings, and able to respond rationally to inquires and directions.
2. I accept and understand that the purpose of local anesthesia is to make it more comfortable for me to receive the necessary dental care with less pain and/or anxiety.
3. **I accept and understand that local anesthesia will be administered by way of injection of an anesthetic agent into the oral mucosa of the mouth.**
4. **I accept and understand that the following can be used in conjunction with:**
   a. **Nitrous Oxide:** Commonly called laughing gas and provides relaxation, although I will be awake, fully conscious, aware of my surroundings, and able to respond rationally to inquires and directions; it is administered by way of the inhalation route.
   b. **Anxiolysis:** A pharmacologically induced state of consciousness where an individual is awake but has decreased anxiety to facilitate coping skills, retaining interactive ability.
5. The use of local anesthesia has been **fully explained to me**, including all risks involved. I have been fully informed that complications may include, but are not exclusive of: (a) allergic reaction(s); (b) loss of, or disturbed senstion of the tongue and lip on the side of the injection.
6. I accept and understand that while the loss of, or disturbed senstion of the tongue and lip on the side of the injection is often only temporary, it may become permanent.
7. I accept and understand that the position of the nerves under the tissue at the site of the injection of local anesthesia **cannot be determined prior to the administration of the anesthetic agent**.
8. I accept and understand that injection of an anesthetic agent into the body could result in allergic reaction(s). I also accept and understand that individual reactions to local anesthesia cannot be predicted, and that if I experience any unanticipated reactions I must immediately report them to Dr. Greg S. Cook.
9. **I have had the opportunity to discuss the use of local anesthesia in conjunction with my dental care, and have had an opportunity to ask questions, and am fully satisfied with the answers I received.**
10. I accept and understand that I play a major role in the maintenance of my teeth and restorations.
11. I accept and understand that I must follow all recommended instructions.
12. I agree to maintain good oral hygiene and keep regular dental check-ups and cleaning appointments with Dr. Cook, at least every six (6) months.
13. **I have informed the doctor of my complete medical history including any recent surgeries or changes in my medical history involving lung, respiratory, ear infection or common cold. I also accept and understand that I must notify the doctor of my present mental and physical condition.**
14. I accept and understand that I must notify the doctor if I: (1) am pregnant, (2) have sensitivity to any medication, (3) have recently consumed alcohol, and/or (4) am presently on psychiatric mood altering drugs or other medications.

Patient Name _____ Date _____

Patient/Guardian Signature _____ Date _____

Doctor Signature _____ Date _____