Signature Smile Center
Family Dentistry and Cosmetic Center

800 Weatherly Dr Ste 103 B Clarksville, TN 37043
931-647-8438

Patient Personal Information

Title		Nickname		Birth Date		Age	
Last, First				Marital Status		Sex	
Address				Home #		Work #	
				Cell #		Drive Lic	
City, State, Zip				Emergency Contact		Emergency Phone #	
Email				Student		SSN	
Health Care Guardian Name				School Name			
Health Care Guardian Phone #				Referral Type			

Person responsible/guarantor for paying bills

Title		Nickname		Birth Date		Age	
Last, First				Marital Status		Sex	
Address				Home #		Work #	
				Cell #		Drive Lic	
City, State, Zip				SSN			
Email							

Do you have Primary Dental Insurance? __ Yes __ No			Do you have Secondary Dental Insurance? __ Yes __ No		
Group No/Name			Group No/Name		
Insurance Name			Insurance Name		
Phone #			Phone #		
Employer Name			Employer Name		
Subscriber Last, First			Subscriber Last, First		
Subscriber Address			Subscriber Address		
City, State, Zip			City, State, Zip		
Relationship to Patient		Birth Date	Relationship to Patient		Birth Date
Subscriber ID			Subscriber ID		

Patient Medical Information

Allergic To

- ☐ Y ☐ N Aspirin
- ☐ Y ☐ N Barbiturates / Sleeping Pills
- ☐ Y ☐ N Codeine
- ☐ Y ☐ N Erythromycin
- ☐ Y ☐ N Iodine
- ☐ Y ☐ N Latex Rubber
- ☐ Y ☐ N Local Anesthetics
- ☐ Y ☐ N Metals
- ☐ Y ☐ N No Epinephrine
- ☐ Y ☐ N Penicillin
- ☐ Y ☐ N Seasonal Allergies
- ☐ Y ☐ N Sulfa Drugs
- ☐ Y ☐ N Other Narcotics

Check, if applicable

- ☐ Y ☐ N Arthritis
- ☐ Y ☐ N Asthma
- ☐ Y ☐ N Autoimmune Disease
- ☐ Y ☐ N Bladder Trouble
- ☐ Y ☐ N Blood Clotting Problems
- ☐ Y ☐ N Blood Transfusion
- ☐ Y ☐ N Bulimia
- ☐ Y ☐ N Bronchitis
- ☐ Y ☐ N Cancer / Tumor or Growth
- ☐ Y ☐ N Cardiac Pacemaker
- ☐ Y ☐ N Cardiovascular Disease
- ☐ Y ☐ N Chemotherapy
- ☐ Y ☐ N Chest Pain Upon Exertion
- ☐ Y ☐ N Color Blindness
- ☐ Y ☐ N Congenital Heart Defect
- ☐ Y ☐ N Frequent Headaches
- ☐ Y ☐ N Frequently Dry Mouth / Sjogren
- ☐ Y ☐ N Gag Reflex
- ☐ Y ☐ N Gall Bladder Trouble
- ☐ Y ☐ N Hay Fever
- ☐ Y ☐ N Heart Attack
- ☐ Y ☐ N Heart Disease
- ☐ Y ☐ N Heart Murmur
- ☐ Y ☐ N Hepatitis
- ☐ Y ☐ N Prior Hepatitis
- ☐ Y ☐ N Herpes
- ☐ Y ☐ N High Blood Pressure
- ☐ Y ☐ N Hives
- ☐ Y ☐ N Jaundice
- ☐ Y ☐ N Joint Replacement
- ☐ Y ☐ N Premedicate
- ☐ Y ☐ N Radiation Treatment
- ☐ Y ☐ N Rheumatic Fever
- ☐ Y ☐ N Rheumatic Heart Disease
- ☐ Y ☐ N Rheumatoid Arthritis
- ☐ Y ☐ N Seizures
- ☐ Y ☐ N Sexually Transmitted Disease
- ☐ Y ☐ N Shortness of Breath
- ☐ Y ☐ N Skin Rash
- ☐ Y ☐ N Sinus Trouble
- ☐ Y ☐ N Stomach Ulcers
- ☐ Y ☐ N Stroke
- ☐ Y ☐ N Thyroid Problems
- ☐ Y ☐ N Tuberculosis
- ☐ Y ☐ N Unusual Weight Loss

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- ☐ Y ☐ N No Change Since Last Recorded
- ☐ Y ☐ N Abnormal Bleeding
- ☐ Y ☐ N AIDS/HIV Infection
- ☐ Y ☐ N Alcohol/Drug Abuse
- ☐ Y ☐ N Angina
- ☐ Y ☐ N Anemia
- ☐ Y ☐ N Ankles Swell
- ☐ Y ☐ N Anorexia
- ☐ Y ☐ N Arteriosclerosis
- ☐ Y ☐ N Contact Lenses
- ☐ Y ☐ N Congestive Heart Failure
- ☐ Y ☐ N Damaged Heart Valve
- ☐ Y ☐ N Diabetes
- ☐ Y ☐ N Emphysema
- ☐ Y ☐ N Environmental Allergies
- ☐ Y ☐ N Epilepsy
- ☐ Y ☐ N Fainting Spells
- ☐ Y ☐ N Fever Blisters
- ☐ Y ☐ N Kidney
- ☐ Y ☐ N Leukemia
- ☐ Y ☐ N Liver Disease
- ☐ Y ☐ N Low Blood Pressure
- ☐ Y ☐ N Lupus
- ☐ Y ☐ N Mental Health Problems
- ☐ Y ☐ N Mitral Valve Prolapse
- ☐ Y ☐ N Pacemaker
- ☐ Y ☐ N Persistent Diarrhea
- ☐ Y ☐ N Urinate Frequently

Other

- ☐ Y ☐ N See Scanned Documents: Pt Note

By signing below, I certify that all of the above information is true to the best of my knowledge.

Patient/Guardian Signature _____ **Date** _____

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Patient Name:_____ DOB:_____ SSN:_____

Consent for Disclosure:

By signing this form, you are consenting to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations. We abide by and adhere to all HIPAA rules and regulations. By signing below you are allowing us to disclose your protected health information as needed to verify insurance and submit claims on your behalf to insurance companies as warranted. Unless noted below we will not provide any information regarding your health information or confirm whether or not you are a patient at our clinic. You may revoke any permission on our disclosures at any time.

Financial Policy:

Thank you for choosing our practice to provide your dental needs. We are committed to your treatment being successful. Please understand that payment of services provided is considered part of your treatment and this amount will be collected upfront. Treatment estimates are estimates only and are subject to change due to the amount of benefit dollars remaining when the claim is received by your insurance company. If you receive a bill in the mail this is because insurance did not pay what was originally estimated.

Minor Patients:

Patients under the age of 18 must be accompanied by an adult at their first appointment and any treatment appointments. Whoever is accompanying the patient, regardless of financial responsibility, will be responsible for any out of pocket expenses that have been accrued.

Missed Appointments:

We do require a 24 hour cancellation notice. If you must cancel your appointment within the 24 hour period you may be subject to a **$100.00** cancellation fee. If you miss your scheduled appointment you may be subject to a **$100.00** failed appointment fee. Once you have accrued 3 or more failed or missed appointments you may be dismissed from the practice at that time. Our goal is to keep our schedule as productive as possible, and by not cancelling your appointment timely or missing the appointment this does not allow for us to use our schedule productively, and it also causes inconveniences to other patients that could have taken advantage of your appointment time. As a professional courtesy we do a lot a **10** minute grace period for your appointment time; meaning if you arrive to your appointment within 10 mins of the scheduled time we will not cancel your appointment or charge you a missed appointment fee.

Insurance:

As a courtesy to all of our patients we take the liberty of billing all of your claims directly to your insurance company for you. If you do not wish for us to bill your insurance directly, please let one of our staff members know and note that you will be responsible for all treatment expenses at your appointment.

HIPAA Authorization:

We will not disclose any protected health information to any persons without your written expressed consent. To authorize disclosure of protected health information to anyone please list the individual(s) below.

1._____ Date:_____ Relation:_____

2._____ Date:_____ Relation:_____

I have read and understand the above policies. I understand that all out of pocket expenses are due at time of the appointment when services are to be rendered. I also understand that Tennessee Dental Spa cannot release any of my information to anyone, other than myself, without written consent. I also understand that I can revoke consent at any time. I acknowledge that I have been given ample time to review this form and ask any questions as necessary and that by signing below I acknowledge that I have read and agree to the aforementioned policies.

Signature:_____ Date:_____

Relationship (if patient is a minor): _____