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## Patient Information Form

1. Today's Date: \_\_\_\_\_
  2. Patient's Name: \_\_\_\_\_
  3. Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_
  4. Patient's Home Number: \_\_\_\_\_  
Contact Number: \_\_\_\_\_
  5. Email Address: \_\_\_\_\_
  6. Patient's Social Security Number: \_\_\_\_\_
  7. Patient's Birth Date: \_\_\_\_\_
- Sex (circle one):     Male             Female
- Marital Status (circle one): Single   Married   Widowed
8. Patient's Employer: \_\_\_\_\_
  9. Whom may we thank for referring you to our office?  
\_\_\_\_\_

### **Insurance Information**

- Dental Insurance: Yes \_\_\_\_\_ No \_\_\_\_\_
10. What is patient's relationship to dental insurance policyholder (if applicable):  
Self: \_\_\_\_\_ Spouse: \_\_\_\_\_ Child: \_\_\_\_\_
  11. Policyholder's Name: \_\_\_\_\_
  12. Policyholder's Birth Date: \_\_\_\_\_
  13. Policyholder's Social Security Number: \_\_\_\_\_
  14. Policyholder's Employer: \_\_\_\_\_
  15. Name of Insurance Company: \_\_\_\_\_
  16. Group Number: \_\_\_\_\_
  17. Subscriber ID: \_\_\_\_\_

## Patient Information

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Last, First MI (Preferred Name)

Birth Date: \_\_\_\_\_

## Health Information

Reason for this visit: \_\_\_\_\_ Previous Dentist's name: \_\_\_\_\_  
Date of Last Dental Visit: \_\_\_\_\_

**Have you ever had any of the following? Please check those that apply:**

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> AIDS                  | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Jaundice             | <input type="checkbox"/> Stomach Problems     |
| <input type="checkbox"/> Allergies _____       | <input type="checkbox"/> Dizziness           | <input type="checkbox"/> Kidney Disease       | <input type="checkbox"/> Stroke               |
| _____  | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Liver Disease        | <input type="checkbox"/> Taken Fen-phen/Redux |
| <input type="checkbox"/> Allergy to Codeine    | <input type="checkbox"/> Excessive Bleeding  | <input type="checkbox"/> Mental Disorders     | <input type="checkbox"/> Tuberculosis         |
| <input type="checkbox"/> Allergy to Latex      | <input type="checkbox"/> Fainting            | <input type="checkbox"/> Nervous Disorders    | <input type="checkbox"/> Tumors               |
| <input type="checkbox"/> Allergy to Penicillin | <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Pacemaker            | <input type="checkbox"/> Ulcers               |
| <input type="checkbox"/> Anemia                | <input type="checkbox"/> Growths             | <input type="checkbox"/> Currently Pregnant   | <input type="checkbox"/> Venereal Disease     |
| <input type="checkbox"/> Arthritis             | <input type="checkbox"/> Hay Fever           | Due date: _____                               | Other:  |
| <input type="checkbox"/> Artificial Joints     | <input type="checkbox"/> Head Injuries       | <input type="checkbox"/> Radiation Treatment  | <input type="checkbox"/> _____                |
| <input type="checkbox"/> Asthma                | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> _____                |
| <input type="checkbox"/> Blood Disease         | <input type="checkbox"/> Heart Murmur        | <input type="checkbox"/> Rheumatic Fever      |   |
| <input type="checkbox"/> Cancer                | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Rheumatism           |   |
| <input type="checkbox"/> Chemotherapy          | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sinus Problems       |   |

- Have you been told by a dentist or physician to take antibiotics before dental visits?  Yes  No
- Are you on any blood thinners? (eg. Coumadin, Warfarin, Plavix...)  Yes  No
- Have you had any recent surgery including eye surgery?  Yes  No
- Have you been admitted to a hospital or needed emergency care during the past two years?  Yes  No
- Are you now under the care of a physician?  Yes  No

If yes to any of above please explain:

\_\_\_\_\_

- **List all** medications/substances you are taking (prescription, herbal or other) **and the conditions** being treated:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

• Name of your Physician(s): \_\_\_\_\_ Phone(s): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ Phone: \_\_\_\_\_

- Do you have any health problems that need further clarification?  Yes  No  
If yes, please explain: \_\_\_\_\_

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

\_\_\_\_\_  
Signature of patient, parent or guardian Date: \_\_\_\_\_

Elizabeth Bassett DDS  
8527 Hixson Pike  
Hixson, TN 37343



Telephone (423) 842-1402

Patient Name: \_\_\_\_\_

Date of Birth \_\_\_\_\_

### ***Dental Information***

**Circle the appropriate answer. If you don't know write "Don't Know"**

• Have you ever had any problems or complications with previous dental treatment?      YES    NO

• Have you lost any teeth or have any been removed?    YES    NO

• Why? \_\_\_\_\_

• Have your missing teeth been replaced?      YES    NO  
If so, how? (Circle All That Apply)

Fixed bridge    Removable bridge (partial)    Denture    Implant

• Do you clench or grind your teeth?      YES    NO

• Does your jaw pop?      YES    NO

• Do your gums bleed?      YES    NO

• Have you ever had gum treatment, deep cleaning or surgery?      YES    NO

• Do you have any questions, fears, or concerns about your mouth or dentistry?      YES    NO

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Date: \_\_\_\_\_

Signature of patient, parent or guardian

Elizabeth Bassett DDS  
8527 Hixson Pike  
Hixson, TN 37343



Telephone (423) 842-1402

Consent for treatment: Patients Name \_\_\_\_\_  
Date \_\_\_\_\_

I have authorized Dr. Elizabeth Bassett Stanford, DDS to be my general dentist and further authorize the release of any information relating to the dental treatment filed on insurance claims in my behalf. **I understand that in spite of dental insurance coverage that I am responsible for all costs of dental treatment.**

Signed (patient, or parent if minor) \_\_\_\_\_

I hereby authorize payment of dental benefits otherwise payable to me directly to the above named dental entity.

Signed (Insured person) \_\_\_\_\_

**I will be paying for services as follows:** Cash/Check \_\_\_\_\_ or Charge Card \_\_\_\_\_

I understand that payment is due when services are rendered and will pay finance charges (12% apr) on balance over 30 days old. I further agree to the following financial arrangements:

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or her 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.

**Important (please read): We can file your insurance claim on the very day of service as a courtesy only. We do not guarantee coverage or payments from your insurance carrier, that in spite of dental insurance coverage you are responsible for all costs of dental treatment. The above finance charges do apply to your total account balance over 30 days old, including any unpaid insurance claim amounts.**

Financially Responsible party must sign agreement:

Signature \_\_\_\_\_ Date \_\_\_\_\_

Elizabeth Bassett DDS  
8527 Hixson Pike  
Hixson, TN 37343



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## Personal Health Information Disclosure Agreement for Bassett Family Dentistry

I, \_\_\_\_\_, do hereby grant permission for Bassett Family Dentistry, to disclose my personal health information to the following personal representative(s):  
(Spouse, sibling, parent, child, friend, etc.)

**Names:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Information to be disclosed (please check):

- Appointment dates and times
- Treatment plans and referrals
- Financial and billing information
- Any other pertinent dental health information related to treatment at this office.
- None of the above

I understand that this permission will remain in effect unless a written cancellation has been provided to Bassett Family Dentistry.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Date of Birth

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF  
PRIVACY PRACTICES, and authorization for notices about pending dental  
appointments**

I, \_\_\_\_\_, have received a copy of this office's Privacy Practices.

Please print name \_\_\_\_\_

Signature \_\_\_\_\_,

Date \_\_\_\_\_

I hereby authorize the use and disclosure of the patient information as described below. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA Privacy regulations. Description of the patient information to be used or disclosed:

Patient's Name, Address, and appointment time  
USPS Mailings of post card notices of pending dental appointments, and/or unsecured e-mail notices of pending dental appointments. Messages about pending dental appointments left on telephone answering services. Unsecured emails to specialists for referrals including x-rays.

Initial \_\_\_\_\_

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For office use only

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We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
  - Communications barriers prohibited obtaining the acknowledgement.
  - an emergency situation prevented us from obtaining acknowledgement.
  - Other (Please specify)
- 
- 
-

## Internet Communications

- Send text messages with questions and appointment requests.
- Receive appointment reminder and confirm appointments through text.
- Send and receive Email messages and appointment reminders.

### Please Verify Your Contact Information

#### Current Information

Name

\_\_\_\_\_

Cell Phone

\_\_\_\_\_

Email

\_\_\_\_\_

Opt In to Text  
Messages

Opt Out to Text  
Messages

Opt In to Email

Opt Out to Email

We use this information to provide you with excellent treatment. We may disclose Patient Health Information (PHI) to third parties that perform services for Bassett Family Dentistry in the administration of your benefits in accordance with HIPAA. These parties are required by law to sign a contract agreeing to protect the confidentiality of your PHI. Your PHI may be disclosed to an affiliate that performs services for Bassett Family Dentistry in the administration of your benefits. Our affiliates do not sell, share or rent our users' personally identifiable information unless required by law, do not send any e-mail or other communications without user permission, and do not send spam.

Signature \_\_\_\_\_

Date \_\_\_\_\_