Howard Rowe DDS
Elizabeth Bassett DDS
8527 Hixson Pike
Hixson, TN 37343

BASSETT FAMILY DENTISTRY

Telephone (423) 842-1402

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:

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

Other:
- ☐ _____
- ☐ _____

- 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.

_____ Date: _____
Signature of patient, parent or guardian

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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

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Consent for treatment: Patients Name_____

Date _____

I have authorized Dr. Howard Rowe DDS or Dr. Elizabeth P. Bassett, 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 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.

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**_____

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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_____

For office use only

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)

_____

_____

_____

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We invite you to participate in our online system. Features include:

- Request Appointments Online
- Confirm Appointments via Email
- Receive Text Message Appointment Reminders
- Refer Your Friends Online
- Submit Patient Satisfaction Surveys

Please Verify Your Contact Information

Current Information

Name _____

Cell Phone _____ ☐ Opt In to Text Messages

Email _____ ☐ Opt In 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.

I agree to allow Demandforce to use this information in providing my services.

Signature _____ Date _____