Nashville Smiles PLLC
Raymond C. Branch, DMD

Date ____________

PATIENT REGISTRATION

ID: ____________ Chart ID: ____________

First Name: ____________ Last Name: ____________ Middle Initial: ____

Patient Is: ☐ Policy Holder ☐ Responsible Party

Preferred Name: ____________

Responsible Party (if someone other than the patient)

First Name: ____________ Last Name: ____________ Middle Initial: ____

Address: ____________ Address 2: ____________

City, State, Zip: ____________ Pager: ____________

Home Phone: ____________ Work Phone: ____________ Ext: ______ Cellular: ____________

Birth Date: ____________ Soc Sec: ____________ Drivers Lic: ____________

○ Responsible Party is also a Policy Holder for Patient ○ Primary Insurance Policy Holder ○ Secondary Insurance Policy Holder

Patient Information

Address: ____________ Address 2: ____________

City: ____________ State / Zip: ______ ______ Pager: ____________

Home Phone: ____________ Work Phone: ____________ Ext: ______ Cellular: ____________

Sex: ○ Male ○ Female Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth Date: ____________ Age: ______ Soc. Sec: ____________ Drivers Lic: ____________

E-mail: ____________ ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ○ Full Time ○ Part Time ○ Retired

Student Status: ○ Full Time ○ Part Time

Medicaid ID: ____________ Pref. Dentist: ____________

Employer ID: ____________ Pref. Pharmacy: ____________

Carrier ID: ____________ Pref. Hyg.: ____________

Section 3

Cell Phone #: ____________

Pager #: ____________

Emergency Contact #: ____________

Primary Insurance information

Name of Insured: ____________ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: ____________ Insured Birth Date: ____________

Employer: ____________ Ins. Company: ____________

Address: ____________ Address: ____________

Address 2: ____________ Address 2: ____________

City,State,Zip: ____________ City,State,Zip: ____________

Rem. Benefits: ______.00 Rem. Deduct: ______.00

Secondary Insurance Information

Name of Insured: ____________ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: ____________ Insured Birth Date: ____________

Employer: ____________ Ins. Company: ____________

Address: ____________ Address: ____________

Address 2: ____________ Address 2: ____________

City,State,Zip: ____________ City,State,Zip: ____________

Rem. Benefits: ______.00 Rem. Deduct: ______.00

TIME 10:05 AM | Nashville Smiles | DATE 2/27/2015

MEDICAL HISTORY

PATIENT NAME ______________________________ Birth Date ____________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: ____________

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: ____________

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: ____________

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: ____________

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No ____________

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No ____________

Are you on a special diet? ◯ Yes ◯ No

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Women: Are you

Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: ____________

Do you have, or have you had, any of the following?

AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Easily Winded	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Angina	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Excessive Thirst	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No
Blood Transfusion	◯ Yes ◯ No	Frequent Diarrhea	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No
Breathing Problem	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Genital Herpes	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No
Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Convulsions	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No
						Yellow Jaundice	◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No ____________

Comments: ____________

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN ______________________________ DATE ____________

Nashville Smiles PLLC
Raymond C. Branch, DMD
8090 Tennessee 100
Nashville, TN 37221
Phone: (615) 646-3549
Fax: (615) 646-3684

In an effort to acknowledge our referral sources we would like to know who referred you to our office or how you heard about us. Please check all that apply:

☐ Newspaper Ad

☐ Yellow Pages Ad

☐ Current Patient (name of patient: ____________________)

☐ Another Doctor's Office (name of Doctor: ________________)

☐ Nashville Smiles Website

☐ Insurance PPO List

☐ Other (please specify: ______________________)

CONSENT

I authorize Dr. Raymond Branch and Staff to take all necessary X-RAYS AND STUDY MODELS as needed to make a thorough diagnosis.

I authorize Dr. Raymond Branch to PERFORM ALL RECOMMENDED AND AGREED UPON TREATMENT. I also authorize the use of anesthetics (as needed) and I am fully aware that using anesthetics agents involves certain risks

____
Signature/Responsible Party Date

PAYMENT POLICY

I AM RESPONSIBLE FOR PAYMENT for all services rendered on my behalf and my dependents. I have been informed that **PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED.** I am aware that a 1.5% finance charge is automatically tabulated if my account is 60 days or older. Should my account become delinquent, I will assume all additional collection costs and legal fees.

____
Signature/Responsible Party Date

BROKEN APPOINTMENT POLICY

Our office operates on an appointment-only basis. **For this reason, failed or no-show appointments are not tolerated.** Please be courteous and give a 24-hour notice if you are unable to keep your appointment. **All patients who have failed/no show appointments will either be charged a $50.00 fee or will be dismissed from this practice.**

____
Signature/Responsible Party **Date**

****

INSURANCE PATIENTS

I authorize Dr. Raymond Branch to release to staff, insurance companies, self-insurers, or their representatives, any and all information, records and x-rays regarding my dental history, services rendered and treatment necessary.

I authorize Dr. Raymond Branch to submit claims for payment for services rendered or pre-authorizations if necessary to my insurance company on my behalf and in my name listed as "Signature on File," and assign to Dr. Raymond Branch the dental insurance benefits. **I understand that I am responsible for payment regardless of the coverage provided.**

____
Signature/Responsible Party **Date**

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

RAYMOND C. BRANCH, DMD

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 that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare 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 you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: ______________________________

Relationship to Patient: ______________________________

Signature: ______________________________

Date: ______________________________

OFFICE USE ONLY

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

Date:	Initials:	Reason:

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

RAYMOND C. BRANCH, DMD

I ______________________ (patients name) authorize the office of Nashville Smiles to leave messages regarding any appointments that I have. I also authorize the office of Nashville Smiles to discuss any treatment plans and account information with the following individuals:

____________________________ relation to patient __________________

____________________________ relation to patient __________________

____________________________ relation to patient __________________

Signature_______________________________ date __________________