PIPPIN DENTAL CARE

PATIENT REGISTRATION

Today's Date

Welcome! How did you find out about our practice?

PATIENT'S DETAILS

First Name:

Last Name:

Middle Name:

Preferred Name:

Gender:

☐ Male ☐ Female

Birth Date:

Address:

City:

State:

Zip:

Home Phone:

Mobile Phone:

Work Phone:

Social Security No.:

Email Address:

Employer:

Occupation:

Name of Emergency Contact:

Emergency Contact Phone:

Relationship of Emergency Contact:

Marital Status:

☐ Single ☐ Married ☐ Domestic Partner ☐ Separated ☐ Divorced ☐ Widowed

Preferred Contact Method:

☐ Mobile Phone ☐ Home Phone ☐ Work Phone ☐ Email ☐ Text Message

PARENT/PARTNER/SPOUSE/GUARDIAN (circle one)

Full Name:

Address (if different than patient):

City:

State:

Zip:

Home Phone:

Mobile Phone:

Work Phone:

Extension:

Employer:

Employer City:

Occupation:

Form continued on reverse

1106 Glennhill Lane, Sevierville, TN 37862 • 865-453-6789 • wecare@pippindentalcare.com

PRIMARY INSURANCE

Policy Holder Name:

Dental Insurance Company: | Insurance Company Phone: | Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other

Address: | Policy Holder Phone:

Group Number: | Policy Holder SS#: | Policy Holder ID#: | Policy Holder DOB:

SECONDARY INSURANCE (if applicable)

Policy Holder Name:

Dental Insurance Company: | Insurance Company Phone: | Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other

Address: | Policy Holder Phone:

Group Number: | Policy Holder SS#: | Policy Holder ID#: | Policy Holder DOB:

OPTIONAL

In order to help us get to know you better, please answer the following questions.

How long have you lived in the area? _____

Where have you lived previously? _____

Do you have any hobbies, special interests or skills? _____

_____

Have you taken any interesting vacations or trips? _____

_____

Are you currently employed? Where? Position? _____

Do you have any family members in our practice? _____

_____ _____

Patient/Guardian Signature *Date*

PIPPIN DENTAL CARE

MEDICAL HISTORY

PLEASE COMPLETE ALL INFORMATION - THANK YOU

Patient Last Name: _____ **Patient First Name:** _____

Are you under a physician's care? Yes❑ No❑ Physician's name_____ Date of last visit_____

Have you ever had been hospitalized or had a major operation? Yes❑ No❑ If yes, please describe:_____

Have you ever had a serious head or neck injury? Yes❑ No❑ If yes, please list: _____

Are you taking any medications, pills, or drugs? Yes❑ No❑ If yes, please list: _____

Do you use controlled substances? Yes❑ No❑ If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? Yes❑ No❑ If yes, please explain:_____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphophonates? Yes❑ No❑ If yes, please describe: _____

_____

Are you on a special diet? Yes❑ No❑ Do you use tobacco? Yes❑ No❑ Do you use recreational drugs? Yes❑ No❑

(Women) Are you pregnant/trying to become pregnant? Yes❑ No❑ Due date_____ Nursing? Yes❑ No❑ Taking oral contraceptives? Yes❑ No❑

Are you allergic to any of the following?

❑ Aspirin ❑ Penicilin ❑ Codeine ❑ Acrylic

❑ Metal ❑ Latex ❑ Suifa Drugs ❑ Local Anesthetic

❑ Other _____

Have you ever had a serious illness not listed above? Yes❑ No❑ If yes, please describe:_____

Please check if you have/had:	Yes	No	Please check if you have/had:	Yes	No	Please check if you have/had:	Yes	No
Acid Reflux			Allergies or hay fever			Anemia		
Angina or chest pain			Anxiety or panic attack			Arthritis, Rheumatism		
Artificial heart valve			Artificial joint			Asthma		
Autoimmune disease			Bleeding abnormally with surgery			Blood disease, clotting disorder		
Blood thinner			Cancer			Chemical dependency		
Chemotherapy			Cough, persistent or bloody			Depression		
Diabetes			Emphysema			Epilepsy or seizures		
Fainting			Glaucoma			Headaches		
Heart murmur			Heart problems			Hepatitis Type B or C		
HIV or AIDS			High blood pressure			Jaundice		
Kidney disease			Low blood pressure			Osteopenia		
Pacemaker			Psychiatric treatment			Radiation treatments		
Respiratory disease			Rheumatic fever			Scarlet fever		
Shortness of breath			Sinus problems			Sickle cell anemia		
Skin rash or hives			Snoring or sleep apnea			Stroke		
Swelling of feet or ankles			Substance abuse			Thyroid problems		
Tonsilitis			Tuberculosis			Tumor or growth on head/neck		
Ulcers of stomach			Weight loss, unexplained			Alzheimers or dementia		
Bruise easily			Osteoporosis			Mitral Valve Prolapse		
Circulatory problems			Cortisone/Steroid treatment			COPD		

AUTHORIZATION AND RELEASE

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.

Patient/Guardian Signature: _____ Date:_____

Over...

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PIPPIN DENTAL CARE

DENTAL HISTORY

Patient Last Name: _____ **Patient First Name:** _____

Please state the purpose of your visit: _____

_____

_____

_____

Please check if you have/had:	Yes	No	Please check if you have/had:	Yes	No	Please check if you have/had:	Yes	No
Sensitivity to chewing pressure			Sensitivity to sweets			Sensitivity to cold		
Sensetivity to heat			Chewing on one side only			Food collection between teeth		
Cigar,cigarette, or pipe smoking			Smokeless tobacco use			Vaping		
Frequent dry mouth			Jaw joint or TMJ pain			Jaw joint popping		
Jaw locked open or closed			Clenching or grinding of teeth			Bite appliance or night guard		
Lip, cheek, or nail biting			Braces or orthodontics			CPAP		
Snoring or sleep apnea			Bad breath			Bleeding gums		
Periodonntal or gum surgery			Receeding gums			Frequent mouth sores or ulcers		
Tumor or growth on face, mouth, neck			Difficulty getting numb			Reaction to local anesthetic (Novacaine)		
Nitrous oxide gas			Tinnitus or ringing in ears			Bleaching or whitening of teeth		
Gag easily								

Are you uncomfortable or self-concious about the appearance of your teeth? Yes❑ No❑ If yes, please describe:_____

Have you been disappointed with the appearance of previous dental work? Yes❑ No❑ If yes, please describe _____

Are your teeth becoming more crooked or overlapping? Yes❑ No❑ If yes, please describe: _____

Are your teeth becoming worn, shorter, or thinner? Yes❑ No❑ If yes, please describe: _____

Are you interested in whiter teeth? Yes❑ No❑ If yes, please describe: _____

Are you interested in straighter teeth or having spaces closed? Yes❑ No❑ If yes, please describe: _____

Are you interested in replacement of missing teeth? Yes❑ No❑ If yes, please describe: _____

Have you had complications with previous dental treatment? Yes❑ No❑ If yes, please describe: _____

Are you interested in facial wrinkle reduction? Yes❑ No❑

Are you interested in lip enhancement? Yes❑ No❑

On a scale of 0-5 how high would you score your level of anxiety regarding dental treatment? _____

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

_____

Patient/Guardian Signature

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PIPPIN DENTAL CARE

FINANCIAL POLICY

Payment in full is due when services are rendered. All other arrangements must be made prior to your appointment.

Insured Patients

- Although your insurance may assist you with partial payment of your treatment, the estimated portion that is not covered is due when services are rendered.
- As a courtesy to our patients, we will file your primary insurance for you. If your insurance has not paid within 60 days, you will be responsible for the entire unpaid balance and payment in full will be expected at this time. We will however, continue to work with you and your insurance company to expedite your reimbursement.
- Payment may be made by cash, check, and credit/debit card.
- Information is available upon request for third party financing through Care Credit, and/or Knoxville TVA Employees Credit Union.
- I understand and agree that I am ultimately responsible for all fees incurred for my dental treatment regardless of payment or denial of my insurance claim(s) by my insurance company.
- I agree to pay any and all unpaid balance on my account.
- I authorize all insurance benefits paid directly to William H. Pippin, DDS.
- If payment by the insurance company is made to the insured, I agree to endorse or have the insured endorse the benefits check to William H. Pippin, DDS or make payment immediately to William H. Pippin, DDS.
- I authorize the release of information to my insurance company, attorney or legal representative to obtain reimbursement of any claim(s) or for other reasons.
- A finance charge of 1.5% will begin to accrue after 60 days from the date of service on the unpaid balance of my account even though insurance may be pending.
- A fee of $50.00 will be incurred for each returned check.
- In the event that my account is turned over to a collection agency or attorney for collection, I agree to pay collection costs, attorney's fees, court costs, and interest from the date of treatment.
- I authorize this office to discuss my account with a spouse or responsible party.
- If the patient is a minor or adult using insurance of someone other than his/her own, I authorize this office to discuss this account with the subscriber of the insurance, parent, step parent or responsible party.

_____

Minor Patients

No treatment will begin on a minor until the legally responsible party has signed the necessary forms. The adult accompanying a minor is responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa/Mastercard, or payment by cash or check at time of service has been verified.

Missed Appointments

In the event you cannot keep a scheduled appointment, please notify the office at least 24 hours in advance. A charge in the amount of $50.00 will be applied to an appointment missed without 24-hour prior notification.

_____ _____

Responsible Party Signature *Date*

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PIPPIN DENTAL CARE

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

PURPOSE: Pippin Dental Care hereafter referred to as "Practice," follow the privacy practices described in this Notice. The Practice is required by law to maintain the privacy of your health information and to protect the integrity, confidentiality, and availability of your health information when it is collected, maintained, and transmitted. You may access or obtain a copy according to the following options: 1) our website at www.pippindentalcare.com 2) contact the office and request a copy to be sent to you by mail or email, 3) request a copy at the time of your next appointment.

1. USES & DISCLOSURE OF PHI: Your PHI may be used and disclosed by our Practice's dentist, administrative and or clinical staff and other outside of our Practice who are involved in your care and treatment for the purpose of providing healthcare service to you.

A) Treatment: We will use and disclose your PHI to provide, coordinate or manage your dental care and any related services. We may disclose PHI to other providers who may be treating you such as a specialist.

B) Payment: We will use your PHI to obtain payment for the dental care services provided by this Practice. For example, if we are working with your insurance plan, we may verify eligibility or coverage for benefit determination. We may use or disclose your information so that a bill may be sent to you that may include service provided.

C) Healthcare Operations: The Practice may use or disclose, as needed, your PHI in order to support its business activities such as quality performance reviews regarding our services or the performance of our staff. i) Business Associates: We may share your PHI with third party business associates such as answering services, transcriptionists, billing services, consultants, trainers and legal counsel. We obtain a written agreement between our Practice and the business associate to assure the protection and privacy of your PHI.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object: We may use or disclose your PHI in the following situations without your authorization or providing you the opportunity to agree or object as follows:

D) Required or Permitted by Law: We may use or disclose your PHI as required by law. This may include public health activities such as controlling a communicable disease or compliance with health oversight agencies authorized by law. We may disclose PHI to a public health authority authorized to receive reports of child abuse or neglect. We may disclose your PHI if we believe you have been a victim of abuse, neglect or domestic violence to a governmental agency authorized to receive such information in compliance with state and federal law. We may disclose your PHI to the Food and Drug Administration for the quality, safety, or effectiveness of FDA-regulated products or activities. We may disclose your PHI in the course of a legal proceeding in response to a subpoena, discovery request or other lawful process. We may also disclose PHI to law enforcement providing applicable legal requirements are satisfied. We may disclose PHI to a coroner or medical examiner for identification purposes. We may disclose PHI to researchers when the information does not directly identify you as the source of the information and such research has been approved by an institutional review board to ensure the privacy of the PHI. We may disclose PHI as authorized to comply with workers' compensation laws. We may use and disclose your PHI if you are an inmate of a correctional facility and this information is necessary for your care.

Authorization for Other Uses and Disclosures of PHI: Use and disclosure of your PHI not addressed in the Notice of Privacy Practices will be made only with your written authorization. You may revoke this authorization in writing at any time. If you revoke this authorization, we will no longer use or disclose your PHI; however, we are unable to retrieve previous disclosures made with your prior authorization.

Other Permitted and Required Uses and Disclosures that Require Your Permission or Objection:

i) Students: We may share PHI with students working in our Practice to fulfill their educational requirements. If you do not wish a student to observe or participate in your care, please notify your provider.
ii) Appointment Reminders: We may contact you as a reminder of your appointment. Only limited information is provided on an answering machine or an individual other than you answering the call. We may issue a post card or letter notifying you that it is time to make an appointment. You may provide a preferred means of contact such as a mobile telephone number or email address. Reasonable requests will be accommodated.
iii) Family, Close Friends, Personal Representatives & Care Givers: Our staff may disclose to person involved in your care your PHI relevant to that person's involvement in your care or payment of the services providing you identify these individual(s) and authorize the release of information. If you are unable to agree or object to such disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgement. If a young adult age eighteen (18) requests that his or her information not be released to a parent or guardian, we must comply with this request in compliance with state law. For minor children living in divided households, both parents (mother and father) have access to the PHI unless their parental

rights have been terminated. Payment of services is addressed in your Final Divorce Decree; however, we obtain payment from the parent who brings the child in for treatment. We will provide you a statement to send to the other parent for your reimbursement.
iv) Disaster Relief: If applicable, we may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your care.

2. YOUR RIGHTS. The following is a statement of your rights regarding PHI we gather about you:

A) Copy of this Notice: You have the right to a copy of this notice including a paper copy.
B) Inspect and Copy PHI: You have the right to inspect and obtain a copy of PHI about you maintained by our Practice to include dental and billing records. You must submit a written request and indicate whether you prefer a paper or electronic copy. According to state and federal law, we may charge you a reasonable fee to copy your records. Our Practice does not transmit unsecure PHI via email. However, if you prefer this information emailed to you with encryption or security measures, we will comply with your request and will verify your email address. We suggest sending our Practice an email and we will reply with the attachment. (Note: Under federal law, you may no inspect or copy psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding. Please contact the Privacy Officer for more details).
C) Amendment: You have the right to have your provider amend your PHI about you in a designated record set. Please consult with the Privacy Officer. We may deny this request and you may respond with a statement. We may include a rebuttal statement in your record. Reasons we may deny amending such information, but not limited to these reasons, is if we did not create the information, or if the individual who created the information is no longer available to make the amendment or it is not part of the information maintained at our Practice.
D) Restrictions: You have the right to request a restriction of your PHI. If you paid out-of-pocket for a service or item, you have the right to request that information not be disclosed to a health plan for purposes of payment or health care operations and we are required to honor that request. You may request in writing to our Privacy Officer not to use or disclose any part of your PHI for the purposes of treatment, payment or health care operations such as to family members or friends involved in your care or for notification purposes as described in this Notice of Privacy Practices. However, your provider is not required to agree to this restriction. You may discuss restrictions with the Privacy Officer.
E) Confidential Communications: You have the right to request to receive confidential communications from our Practice by alternative means or at an alternative location. For example, you may prefer our Practice to use your mobile telephone or email rather than a residential line. Please make this request in writing to the Privacy Officer. Our staff will not ask personal questions regarding your request.
F) Disclosures: You have the right to request an accounting of disclosures of your PHI including those made through a Business Associate as set forth in CFR 45 § 164.528. The HITECH Act removed the accounting of disclosures exception to PHI to carry out treatment, payment and healthcare operations if such disclosures are made through the EHR. To request an accounting, you must submit your request in writing to the Privacy Officer.
G) Breach Notification: According to the HITECH Act, you have the right to be notified following a breach of unsecured PHI that affects you. “Unsecured” is information that is not secured through the use of technology or methodology identified by the Secretary of the U.S. Department of Health and Human Services to render the PHI unusable, unreadable and undecipherable to unauthorized users. Breach notification applies to our Business Associates who are obligated to notify our Practice if a breach of unsecured PHI occurs that affects you.
H) Fundraising: If PHI is used for fund raising which is considered “health care operations,” basic requirements must be satisfied to include notice to the individual and a process for individuals to opt-out. If the individual consents, only specific parts of the PHI may be used for fund raising. Note: Your PHI will not be used in this manner at our Practice.

3. Complaints: You have the right to file a complaint if you believe your privacy rights or that of another individuals’ have been violated. You may contact our Privacy Officer and your issue will be addressed. You may also file a complaint with the Secretary of Health and Human Services at: U.S. Department of Health & Human Services, Office of Civil Rights, 200 Independence Avenue, SW, Washington, D.C. 20201. Your complaint must be filed in writing, either on paper or electronically, by mail, fax, or email; name the covered entity or business associate involved and describe the acts or omissions you believe violated the requirements of the Privacy, Security, or Breach Notification Rules; and be filed within 180 days or as determined by this State when you knew that the act or omission complained of occurred. You may visit the Office of Civil Rights website at www.hhs.gov/ocr/hipaa/ for more information.

If you have any questions, would like additional information or want to report a problem regarding the handling of you PHI, you may contact the Privacy Officer at:

Pippin Dental Care
1106 Glennhill Lane
Sevierville, TN 37862
Telephone: 865-453-6789
You will not be penalized for filing a complaint.