Lenox Village Dentistry, LLC
6905 Lenox Village Drive
Nashville, TN 37211
(615) 832-2095

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any concerns please do not hesitate to call us.

Patient # _____

Date _____

PATIENT INFORMATION

Name _____ Birthdate _____ SSN _____
Address _____ City _____ State _____ Zip _____
Sex: ☐ **M** ☐ **F** ☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ Partnered for _____ years
Home Phone (_____)_____ Cell Phone (_____)_____ Email Address _____
Employer _____ Employer Phone (_____)_____
Employer Address _____ City _____ State _____ Zip _____
Spouse or Parent Name _____ Employer _____ Work Phone (_____)_____
Whom may we thank for referring you? _____
Person to contact in case of an emergency? _____

RESPONSIBLE PARTY

Name of person responsible for this account _____ Relation to patient _____
Address _____ Home Phone (_____)_____
Birthdate _____ Currently a patient in our office? ☐ Yes ☐ No
Employer _____ Work Phone (_____)_____
Email _____ Cell Phone (_____)_____

INSURANCE INFORMATION

Name of Insured _____ Relation to patient _____
Birthdate _____ SSN _____ Date Employed _____
Employer _____ Employer Phone (_____)_____
Employer Address _____ City _____ State _____ Zip _____
Insurance Company _____ Group # _____ Union or Local # _____
Address _____ City _____ State _____ Zip _____
How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit _____

ADDITIONAL INSURANCE

Name of Insured _____ Relation to patient _____
Birthdate _____ SSN _____ Date Employed _____
Employer _____ Employer Phone (_____)_____
Employer Address _____ City _____ State _____ Zip _____
Insurance Company _____ Group # _____ Union or Local # _____
Address _____ City _____ State _____ Zip _____
How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit _____

☐ I authorize payment of insurance benefits directly to the Doctor otherwise payable directly to me, and
☐ I authorize the Doctor to release any information relating to my dental service to my insurance company and I understand I am responsible for all costs of dental treatment.

DENTAL HISTORY

Reason for today's visit? _____ Date of last dental care _____

Former Dentist _____ Date of last dental x-ray _____
Address _____
Check ☑ if you have or have had problems with any of the following:

☐ Bad Breath	☐ Grinding Teeth	☐ Sensitivity to Hot
☐ Bleeding gums	☐ Loose teeth or broken fillings	☐ Sensitivity to sweets
☐ Clicking or popping jaw	☐ Periodontal treatment	☐ Sensitivity when biting
☐ Food collecting between the teeth	☐ Sensitivity to cold	☐ Sores or growths in mouth

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

MEDICAL HISTORY

Physician's Name _____ Date of last visit _____
Have you ever taken any of the group of drugs collectively referred to as "Fen-Phen"? these include combinations of Lonimin, Adipex, Fastin (brand names of Phentermine), Pndimin (Fenfluramine) and Redux (Dexfenfluramine)? ☐ YES ☐ NO

PLEASE CIRCLE ALL THAT MAY APPLY:

Have you ever had any serious illnesses or operations? Yes No If yes, describe _____
Have you ever had a blood transfusion? Yes No If yes, give approx. dates _____
(Women) Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

PLEASE CIRCLE IF YOU HAVE OR HAVE HAD PROBLEMS WITH ANY OF THE FOLLOWING:

Anemia	Congenital Heart Lesions	Hepatitis A/B/C/D/E	Scarlet Fever
Arthritis, Rheumatism	Cortisone Treatments	Hernia Repair	Shortness of Breath
Artificial Heart Valves	Cough, Persistent	High Blood Pressure	Skin Rash
Artificial Joints, Pins, etc	Cough of Blood	HIV/AIDS	Stroke If so, Date____
Asthma	Diabetes Type1/Type2	Jaw Pain	Swelling of Feet or Ankles
Back Problems	Epilepsy	Kidney Disease	Thyroid Problems
Bleeding Abnormally	Fainting	Liver Disease	Tobacco Habit
Blood Disease	Glaucoma	Mitral Valve Prolapse	Tonsillitis
Cancer	Headaches	Pacemaker	Tuberculosis
Chemical Dependency	Heart Attack If so, Date____	Radiation Treatment	Ulcer
Chemotherapy	Heart Murmur	Respiratory Disease	Venereal Disease
Circulatory Problems	Hemophilia	Rheumatic Fever	

List medications you are currently taking:

_____ _____
_____ _____
_____ _____

Allergies:

☐ Aspirin	☐ Local Anesthetic	☐ Iodine	☐ Other _____
☐ Barbiturates (Sleeping Pills)	☐ Penicillin	☐ Latex	_____
☐ Codeine	☐ Sulfa	☐ None	

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

FINANCIAL POLICY

The following is a statement of our financial policy. We ask that you read and sign prior to treatment. Thank you.

We accept most dental insurance plans and as a courtesy to you, we will process your claims without an additional fee. In return, ***we require that your deductible and co-insurance be paid in full at the time of your visit***. We will ***estimate*** your co-insurance based upon the information received from your dental insurance company.

Please note, your dental insurance is a contract between your employer (sometimes you) and the dental insurance company. We are NOT a party to the contract, but we will verify coverage and benefits to the best of our ability. Sometimes, what is quoted by your insurance company, is not what is actually paid.

All accounts are due in full at the time services are rendered. To accommodate you, we accept cash, personal checks, and all major credit cards except Discover. For extensive plans, we do offer no-interest payment plans with credit approval.

Returned checks and balances over 30 days may be subject to a 1% monthly interest charge. In the unfortunate event that your balance becomes over 90 days past due, we reserve the right to turn your account over to a collections specialist. Any fees associated with the collection of a past due account will be your responsibility. If you should encounter financial hardship, please stay in constant communication as we might not assign your account to a collections specialist.

Finally, please remember that we reserved an appointment time especially for you. Therefore, we request at least 48 hours notice in order to reschedule your appointment. This will enable us to offer your cancelled time to other patients that desire to get an appointment. When you cancel your appointment at the last minute or do not show up for an appointment, everyone loses - you, the doctor and other patients that would like to have utilized your appointment time. Therefore, ***a missed appointment fee of $50.00 will be assessed if 48 hours notice is not given for changing or cancelling a reserved appointment.***

Thank you for taking the time to read and understand our financial policy. We are committed to providing excellent treatment to you and your family. Please let us know if you have any questions regarding this financial policy.

I HAVE READ AND FULLY AGREE TO THIS FINANCIAL POLICY.

_____ _____

Signature of Responsible Party *Date*

LENOX VILLAGE DENTISTRY, LLC

Patient HIPAA Acknowledgement and Consent Form.

Patient name:_____
Date of Birth:_____

____(**Patient Initials**) **Notice of Privacy Practices.** I acknowledge that I have received Lenox Village Dentistry's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described/permitted uses and disclosures. I understand that I may contact the Privacy officer designated on the notice if I have questions or complaints. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

____(**Patient Initials**) **Release of Information.** I hereby permit Lenox Village Dentistry LLC or other healthcare professionals involved in patient care to release healthcare information for purposes or treatment, payment or healthcare operations.

- Healthcare information may be released to any person or entity liable for payments on the patient's behalf in order to verify coverage or payment questions, or for any purpose related to benefit payment. Healthcare information may also be released to my employers designee when the services delivered are related to a claim under worker's compensation.

- This consent specifically includes the release of information to other treating healthcare professionals, dentists, dental specialists, insurers, and/or authorities concerning x-rays, treatment plans, infectious diseases including, but not limited to, blood borne diseases, such as (HIV and AIDS), psychological conditions, intellectual disability conditions, and genetic information.

____(**Patient Initials**) **Disclosures to Family Members and/or Friends**
I give permission for my Protected Health Information (PHI) to be disclosed for purposes of communication results, findings, care decisions, and financial obligations to the family members and others listed below:

NAME/RELATIONSHIP/CONTACT#_____

NAME/RELATIONSHIP/CONTACT#_____

NAME/RELATIONSHIP/CONTACT#_____

___(**Patient Initials**)**Consent to Communications.** I consent to receive voice messages, texts, and/or emails from Lenox Village Dentistry on my cell phone or any other designated number or email to receive communication regarding but not limited to, appointments, insurance, and account information.

Prescription Order Pick-Up. There are times when a family member or friend may need to pick up a prescription from our office. In order to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.

___(**Patient Initials**) I wish to designate the following family member/friend to pick up on my behalf.

NAME:_____ DATE:_____

NAME:_____ DATE:_____

____(**Patient Initials**) I do not want to designate anyone to pick up my prescription order.

Patient Signature/Legal Guardian if patient is a minor:_____

Patient Name(Printed):_____ **Date**:_____