SCHMITT DENTAL

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Patient Information:

Name _____ Birthdate _____ SSN: _____
Last First Middle MM/DD/YYYY

Address _____
Number and Street City/State Zip

Phone: _____ / _____ / _____
Home Work Cell

Employer: _____ Occupation: _____

Email: _____ Emergency Contact: _____

Single ☐ Married ☐ Widow ☐ Separated ☐ Divorced ☐ Child ☐

Name of Spouse / Parent / Guardian: _____ Birthdate: ___/___/___ SSN: _____
Last First

How did you hear about us? ☐ Sign ☐ Directory ☐ Friend/Family- Name: _____
☐ Radio ☐ Other: _____

Responsible Party/ Military Sponsor If Applicable:

Name _____ Birthdate _____ SSN: _____
Last First Middle MM/DD/YYYY

Phone: _____ / _____ / _____
Home Work Cell

Employer: _____ **MILITARY ONLY** - Rank: _____

Insurance Information:

Dental Insurance: ☐ Yes ☐ No If Yes, Name of Company: _____ Group #: _____

Name of Insured / Sponsor: _____ SSN or ID #: _____
Last First

Secondary Dental Insurance if applicable: Name of Company _____ Group #: _____

Name of Insured/Sponsor: _____ DOB: _____

SSN or ID for Secondary: _____

If any insurance information is incorrect, the patient will be responsible for filing their own claims for services rendered. Any claims not paid by the insurance company will become the patient's responsibility.

To avoid misunderstanding regarding dental insurance, we wish our patients to know that all services rendered are charged to the patient and that the patient is personally responsible for the fees. As a courtesy, we will assist you in preparing necessary forms and submit to your insurance company to help obtain your benefits from them. We do not render our services on the basis that your insurance company will pay the fee.

Our office operates on an appointment system. **If necessary for you to change an appointment, please give us 48 hour notice so that we may accommodate other patients**. If your appointment is failed without notice, a fee may be charged on a case by case basis for lost time we were unable to make available to another patient. Please also understand that by releasing your mobile number you are authorizing permission for automated calls for any billing and appointment reminders. Thank you!

Please complete the Medical History and Consent for Treatment Form on the reverse side, all answers are confidential.

Are you under the care of a physician now? ☐ Yes ☐ No If Yes, Reason for care? _____

Name of Physician: _____ Date of Last Exam: _____/_____/_____

Circle any of the following if you have now or have ever had in the past: (circle all that apply)

AIDS	Heart Ailments Describe: _____	Neurological Problems
Anemia	Artificial Heart Valves	Psychiatric Care
Arthritis	By-Pass Surgery	Radiation Treatment
Artificial Joints	Cardiac Pacemaker	Rheumatic Fever
Asthma	Heart Murmur	Rheumatism
Blood Disease	Mitral Valve Prolapse	Seizures
Cancer	High Blood Pressure	Sinus Problems
Chemical Dependency	Hemophilia	Stroke
Chemotherapy	HIV Positive	Syphilis
Colitis	Gonorrhea	Thyroid
Diabetes	Infectious Hepatitis	Tonsillitis
Epilepsy	Kidney Disease	Tuberculosis
Eye Disorders	Liver Disease	Ulcer
Fainting Spells	Other: _____	Venereal Disease

Allergies:

Are you allergic to or have you reacted adversely to any of the following?

Local Injected Anesthetics: ☐ Yes ☐ No

Penicillin or other antibiotics: ☐ Yes ☐ No

Latex: ☐ Yes ☐ No

Codeine or other narcotics: ☐ Yes ☐ No

Aspirin: ☐ Yes ☐ No

Hay fever or Allergies in general: ☐ Yes ☐ No

Excessive bleeding from a cut or extraction: Yes ☐ No ☐

Have you ever taken Fen-Phen: ☐ Yes ☐ No

Current Medications: *Prescribed and Over-the-Counter*

Are you taking any medications now? ☐ Yes ☐ No

If yes, please list the name and purpose of the medication:

_____ _____

_____ _____

Have you been out of the country in the last year? _____

Have you ever had any serious illness, operation or injury? ☐ Yes ☐ No

If yes, please describe: _____

Is there any information we should know about previous dental visits? _____

For Women: a. Are you pregnant or do you think you may be pregnant? ☐ Yes ☐ No If yes, Due Date: _____

b. Are you taking birth control pills? ☐ Yes ☐ No

Consent of Treatment:

The following information is not presented to worry you, but rather to conform to the principles of "Informed Consent". Any local injected anesthetic or oral surgical procedure may result in certain postoperative effects. Usually these effects are limited to discomfort, bleeding, swelling, and less frequently infection. On rare occasions, numbness of the lips, chin or tongue, prolonged healing, injury to other teeth, broken jaws, sinus openings, and injury to the ligaments of the jaw joint may occur. *The utmost care will be taken to minimize the possibility of these complications.*

"I have read and understand the above explanation. This is to certify that I, the undersigned, consent to the performing of the dental and oral surgical procedures agreed to be necessary or advisable, including the use of local anesthetics as indicated. I assign all dental insurance benefits directly to Steven T. Schmitt, DMD. I understand that I am financially responsible for all charges whether or not paid by the insurance company. I hereby authorize Steve T Schmitt, DMD to release all information to secure payment of benefits. I authorize the use of this signature on all insurance claim submissions."

Patient's Signature: _____ Date: _____

(Parent / Guardian Signature if patient is a minor) MM/DD/YYYY

Patient Rights

Access: You have the right to look at or get copies of your health information with limited exceptions. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this notice. You may also request access by sending us a letter to the address at the end of this notice.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities, for the last six years, but not before April 14, 2003.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: If you receive this notice on our website or by electronic mail (email), you are entitled to receive this notice in written form.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, letters, etc.)

Any questions, please contact our office at 931-647-3960 or 2313 Rudolphtown Rd, Clarksville, TN 37043. If you are concerned in that we may have violated your privacy rights, you may also submit a written complaint to the U.S Department of Health and Human Services. We support your right in privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S Department of Health and Human Services

Welcome to Schmitt Dental. We are happy to have you as our patient and look forward to offering you and your family the finest dental care available. We know that providing complete comprehensive dental services includes discussing all treatment and financial options.

Before treatment is performed, we will discuss treatment and financial options. This will allow you to fully understand your dental treatment, what to anticipate in fees, and allow you time to make any necessary financial arrangements.

Payment is due at the time services are rendered. For your convenience, we accept cash, checks, Visa, MasterCard, or money orders. Care Credit may also be available to you.

Emergency clients who are new to our practice should expect to make a payment at the time of service. Once established as a patient, we will be happy to discuss other payment options.

Insurance benefits are determined by your employer, not your dentist. Your insurance policy is a contract between you and your insurance company. Your insurance coverage and benefits are your responsibility and insurance is not a guarantee of payment; it often does not cover all the costs involved in treatment. As a courtesy, we will be happy to file your claim for you if you present your dental insurance wallet card and all required employer information. You will be expected to pay for services rendered if this office is unable to verify your insurance before treatment.

Any deductable or estimated co-payment amount will be due at the time of treatment.

If payment for services already rendered has not been paid in full within 45 days, either by you or by your insurance company, the remaining balance for your treatment is considered due and must be paid by you.

Appointments are reserved exclusively for you. As a benefit to you, we may offer to move your appointment to an earlier time if an opening arises. We reserve the right to charge and collect $75.00 for any broken appointment. Broken appointments are considered those that are missed (no-show) or cancelled with less than 24 hours notice.

Payment plans and financial arrangements are available for comprehensive dental treatment. Please speak to us to make arrangements prior to commencing treatment.

I have read and understand this financial policy.

_____ _____

Printed Name Date

_____ _____

Signature Staff Initials