DR. AUSTIN ROBERTS
Family and Implant Dentistry

PATIENT INFORMATION

LEGAL NAME _____ **PREFERRED NAME** _____

ADDRESS _____ **CITY** _____ **STATE AND ZIP** _____

HOME PHONE _____ **CELL PHONE** _____ **WORK PHONE** _____

BIRTH DATE _____ **SS#** _____

WHO MAY WE THANK FOR REFERRING YOU? _____

HAVE YOU SERVED IN THE ARMED SERVICES? _____ **IF YES EXPLAIN** _____

INSURANCE INFORMATION

SUBSCRIBER NAME _____ **RELATIONSHIP TO PATIENT** _____

SUBSCRIBER BIRTHDATE _____ **SUBSCRIBER SS#** _____

SUBSCRIBER EMPLOYER _____

INSURANCE COMPANY NAME _____

INSURANCE COMPANY ADDRESS _____

INSURANCE COMPANY PHONE _____

MEMBER ID/SUBSCRIBER ID _____ **GROUP ID** _____

SECONDARY INSURANCE INFORMATION

SUBSCRIBER NAME _____ **RELATIONSHIP TO PATIENT** _____

SUBSCRIBER BIRTHDATE _____ **SUBSCRIBER SS#** _____

SUBSCRIBER EMPLOYER _____

INSURANCE COMPANY NAME _____

INSURANCE COMPANY ADDRESS _____

INSURANCE COMPANY PHONE _____

MEMBER ID/SUBSCRIBER ID _____ **GROUP ID** _____

DR. AUSTIN ROBERTS
Family and Implant Dentistry

PATIENT NAME _____ **BIRTH DATE** _____

DENTAL HISTORY

What is the reason for today's visit? _____

When was your last visit to a dentist? _____

Have past dental experiences been satisfactory? _____

You feel about the appearance of your teeth? _____

Do you have or have you had any of the following? (Please check all that apply to you)

- ○ Bleeding gums
- ○ Broken fillings
- ○ Chronic bad breath
- ○ Decayed teeth
- ○ Griding or clenching of teeth
- ○ Injury to teeth or jaw
- ○ Orthodontic treatment
- ○ Periodontal treatment
- ○ Painful or locking jaw
- ○ Sensitivity to sweet, hot, cold, biting
- ○ Sores, growth or swelling in mouth
- ○ Food catches between teeth

DENTAL HISTORY

Do you have or have you had any of the following? (Please check all that apply to you)

- ○ Anema
- ○ Arthritis, rheumatism
- ○ Artificial heart valves
- ○ Artificial joints
- ○ Asthma, sinus problems
- ○ Autoimmune disease
- ○ Back problems
- ○ Blood disease
- ○ Abnormal bleeding, prolonged healing, bruising easily
- ○ Cancer
- ○ Chemical dependency
- ○ Chemotherapy
- ○ Circulatory problems
- ○ Cortisone treatments/steroids
- ○ Cough, persistent/chronic
- ○ Cough up blood
- ○ Diabetes
- ○ Epilepsy/seizures
- ○ Fainting
- ○ Glaucoma/eye disorders
- ○ Headaches, migraine headaches
- ○ Heart disease (Describe)
- ○ Heart murmur
- ○ Hemophilia
- ○ Hepatitis/liver diseases/ jaundice
- ○ High blood pressure
- ○ HIV positive
- ○ AIDS
- ○ Kidney disease
- ○ Mitral value prolapse
- ○ Malignancy or tumor/ cyst
- ○ Nervous disorders
- ○ Pacemaker
- ○ Psychiatric care
- ○ Radiation treatment
- ○ Respiratory disease
- ○ Rheumatic fever, rheumatic heart disease
- ○ Shortness of breath
- ○ Skin rash
- ○ Stroke
- ○ Congestive heart failure
- ○ Thyroid disease
- ○ Tobacco habit
- ○ Tuberculosis
- ○ Ulcer/digestive disorders
- ○ Venereal disease

Physician_____**Tel#**_____

Date of last physical exam:_____

Please list all medications you are currently taking as well as over-the-counter medications, herbal remedies, vitamins, homeopathic remedies:_____

_____

Allergies/reactions to medications, or other allergies:_____

(Women) Are you pregnant?_____ **Nursing?**_____ **Taking birth control pills?**_____

Are you presently under a physician's care?_____ **Explain**_____

Do you consider yourself in good health?_____

Please describe any impending operations, recent injuries or other information the dentist should be aware of:_____

Patient signature_____ **Date**_____ **Dentist's initials**_____

DR. AUSTIN ROBERTS
Family and Implant Dentistry

HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you (the patient). The Notice contains a Patient Rights section describing your rights under the law (this may be requested at the front desk). You have the right to review our full Notice before signing Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict protected health information about you that is used or disclosed for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of protected health information about your treatment, payment and healthcare operations. You have the right to revoke this Consent, in writing, signed by you. However, such revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The Patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policy.
- The patient has the right to restrict the use of their information.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon execution of this Consent. No insurance can be billed on the patient's behalf without this signed HIPAA consent form, therefore payment in full is required at the time services are rendered.

Information SHARING: Please list any individuals we can share your personal information with other than healthcare providers.

Name:_____ **Relationship:**_____

Name:_____ **Relationship:**_____

Name:_____ **Relationship:**_____

_____ _____

This HIPAA Consent/Sharing was signed by (Signature) *(Today's date)*

_____

Relationship to patient (if other than patient)

HIPAA AUTHORIZATION

FOR COMMUNICATIONS USING RHINOGRAM

Patient Name _____ Date of Birth _____

1. I authorize the access, use, and/or disclosure of my information by Dr. Austin Roberts Family And Implant Dentistry (including its providers and clinical administrative staff members) (the "Practice") in relation to our patient/provider relationship, as described below.

2. The type and amount of information to be accessed, used and/or disclosed is as follows: (1) communications between myself and the Practice for treatment payment and/or healthcare operations via Rhinogram's communications platform across digital, social media, texting and/or other communication channels (the "Platform"); and (2) transmissions of my patient information for treatment purposes only send and/or received between the Practice and my other treatment purposes only sent and/or received between the Practice and my other treatment providers (or other providers to who the Practice refers me) via the Platform.

3. I understand that I have the right to revoke this Authorization at any time. I understand that the revocation will not apply to information that has already been released in response to this Authorization.

4. Unless revoked earlier, this Authorization will expire on the following specified date, event or condition: expiration or termination of my patient/provider relationship with the Practice.

5. I understand the once information is disclosed pursuant to this Authorization, it may be re-disclosed by the recipient and may not be protected by federal privacy regulations.

6. I understand that the Practice may not condition, prohibit, or prevent my treatment, payment, enrollment, or eligibility for benefits on whether I sign this Authorization.

7. I understand that I will be given a copy of, or access to, this Authorization form after it is signed, upon request.

Signature of Patient or Personal Representative: _____

DR. AUSTIN ROBERTS
Family and Implant Dentistry

DR. AUSTIN ROBERTS
Family and Implant Dentistry

OFFICE GUIDELINES

Dr. Austin Roberts Family and Implant Dentistry is committed to providing all patients with exceptional service and quality care. Please review our office guidelines and sign/date below. Thank you.

Cancellation Guideline

We respect the importance of your time and work hard to schedule appointments that accommodate the scheduling needs of all of our patients. Broken and missed appointments create an inconvenience for other patients as well as our practice. As a result, we follow the model commonly used by many other dental practices in the area. If you find that you are unable to make your reserved appointment, we require a **24 hour notice**. You may text or leave a message at any time, within 24 hours, by calling or texting (423) 713-5555. There will be a $25 dollar fee assessed for every half hour missed without a 24 hour notification.

We understand that emergencies do occur and we do not wish to penalize patients for unavoidable situations; in such situations we waive the first offense. We record all appointments, cancellation and no show appointments and discourage repeat abuse of our scheduling guidelines.

Financial Obligation/Payment Guidelines

Patients with dental benefits: As a courtesy to our patients who have dental benefits, we are happy to file your claims electronically from our office. Please understand that it is your responsibility to know your specific plan/policy coverage. Your dental benefits may cover more or less than we estimate. Therefore, after we receive payment from your insurance we will send you a statement with any remaining balance.

Patients without dental benefits: Patients without dental benefits are required to pay in full at the time services are rendered.

Payment Plan Options

Dr. Austin Roberts Family and Implant Dentistry offers payment plan options through Care Credit. Care Credit offers interest free payment options along with extended payment plans. Log on to www.carecredit.com for more information. Brochures available upon request.

If you have any questions, please do not hesitate to ask. Thank you for your cooperation and understanding as we institute these policies. These policies will enable us to better serve the needs of all patients.

I have read and understand the above policies.

_____ _____

(Signature of patient or guardian) *(Today's Date)*