DOSS DENTISTRY

Patient Registration

Please complete all information that applies to you – Thank You

PATIENT INFORMATION

Name_____ Preferred Name _____ ( ) Male ( ) Female
First MI Last

SS# _____ Birth Date _____ ( ) Minor ( ) Single ( ) Married ( ) Divorced ( ) Widowed

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email_____

Employer Name and Address _____Work Phone _____

Whom may we think for Referring you? _____

Emergency Contact _____ Phone_____

ACCOUNT INFORMATION – RESPONSIBLE PARTY

Person Responsible for Account _____ ( ) Self ( ) Spouse ( ) Mother ( ) Father

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email_____

Employer Name and Address _____Work Phone _____

DENTAL INSURANCE

Primary Dental Insurance

Insurance Company _____ Phone # _____ Group No. _____

Insured's Name _____ Birth Date _____ Employer _____

Insured's SS # _____ Subscriber ID # _____Relationship to Patient _____

Secondary Dental Insurance

Insurance Company _____ Phone # _____ Group No. _____

Insured's Name _____ Birth Date _____ Employer _____

Insured's SS # _____ Subscriber ID # _____Relationship to Patient _____

ASSIGNMENT and RELEASE

I hereby authorize payment directly to this dental office for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above provider of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

I attest to the accuracy of the information on this page. Name _____

Signature _____ Date _____

Medical History

Please answer all questions accurately and report any changes at future appointments.
If minor, must be filled out by Parent or Guardian

DENTAL HISTORY

Former Dentist_____ City, State _____ Phone_____
Date of Last Visit _____ Date of Last X-Rays _____ Reason for Visit _____
How Often do you Brush_____ How often do you Floss _____ Do you like your smile? _____
Please check all that apply:

Bad Breath	( )	Loose Teeth or Broken Fillings	( )	Sensitivity to Sweets	( )
Bleeding Gums	( )	Orthodontic Treatment	( )	Sensitivity when Biting	( )
Blisters on Lips or Mouth	( )	Pain around Ear	( )	Frequent Headaches	( )
Finger Nail Biting	( )	Periodontal Treatment	( )	Jaw, Head, or Neck Injuries	( )
Grinding Teeth	( )	Sensitivity to Cold	( )	Jaw Difficulty (Clicking/Pain)	( )
Lip or Cheek Biting	( )	Sensitivity to Heat	( )	Tooth Pain	( )
Chew hard objects (Pencils, etc.)	( )	Bite / Chew Nails	( )	Clench Jaws	( )
Water Fluoridated	( )	Take Fluoride Supplements	( )	Suck Thumb/Finger	( )
Nervous / Scared	( )	Difficult Dental Visit in the past	( )		

MEDICAL HISTORY

Physician's Name _____Address _____ Phone # _____
Pharmacy / Location _____ Pharmacy Phone # _____

Please check all that apply:

Angina /Chest Pain	( )	Stomach Ulcers	( )	Fainting	( )
Artificial Heart Valve	( )	Acid Reflux	( )	Dizziness	( )
Heart Disease /Attack	( )	Hepatitis, Type _____	( )	Epilepsy / Seizures	( )
Heart Surgery	( )	Liver Disease / Jaundice	( )	Migraine Headaches	( )
Pace Maker	( )			Anxiety / Nervousness	( )
High Blood Pressure	( )	Asthma	( )	Psychiatric Treatment	( )
Irregular Heart Beat (arrhythmia)	( )	Emphysema / COPD	( )		
Mitral Valve Prolapse	( )	Sinus Problems	( )	Glaucoma	( )
Rheumatic Fever	( )	Tuberculosis (TB)	( )	Vision Problems, Type _____	( )
Heart Disorder (congenital)	( )	Breathing Problems	( )	Hearing Loss	( )
Stroke	( )				
		Kidney Problems	( )	Tobacco Use	( )
Anemia	( )	Dialysis	( )	Drug Addiction (past/present)	( )
Sickle Cell Disease	( )			Sexually Transmitted Disease	( )
Excessive Bleeding	( )	Diabetes, Type _____	( )	HIV/AIDS	( )
Blood Thinners	( )	Thyroid Disease / Problem	( )		
Tumor or Cancer	( )	Arthritis	( )	Handicaps / Disabilities	( )
Chemotherapy	( )	Artificial Joint, Type _____	( )	Please Explain any checks: _____	
Radiation Treatment	( )				

_____
_____

ALLERGIES: ( ) Aspirin ( ) Penicillin ( ) Codeine ( ) Local Anesthetics ( ) Latex ( ) Epinephrine Sensitivity
( ) Sulfa Drugs ( ) Iodine ( ) Sedatives ( ) Other Please explain _____

Women Only: Are You? ( ) Pregnant ( ) Trying to get Pregnant ( ) Nursing ( ) Taking Birth Control Pills

Do you have any health problems that were not listed above? _____
List any medications you are currently taking _____
_____

Signature of Patient (or Parent/guardian if minor) _____ Date_____

DOSS DENTISTRY

Appointment / Cancellation Policy

1. **Confirming appointments**
   - We have a confirmation system that will send out reminders for your upcoming appointments. These reminders will come in the form of email, phone, text, or all of the above. We will ask you to confirm your appointment between 24 & 48 hours prior to your scheduled appointment. Because of this, it is very important that we have the proper phone number and email for you. Please update us if anything changes. The confirmation system will also send you a quick reminder just a few hours before your appointment.
2. **Cancellation / No-Show Policy for Appointments:**
   - We understand there are times you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from being seen. Conversely, the situation may arise where another patient fails to cancel, and we are unable to schedule you for a visit due to a seemingly "full" schedule. Therefore, we ask that you give us 24-48 Hours' Notice if you need to cancel or reschedule an appointment.
   - If an appointment is not canceled at least 24 hours in advance you will be charged a $50 fee. This is not billable through your insurance and will be due before you will be seen again.
   - After 3 consecutive No-Show occurrences /repetitive cancellations or rescheduling appointments, Doss Dentistry may elect to terminate our relationship with you.
3. **Scheduled appointments:**
   - We understand that delays can happen, however, we must try to keep other patients and providers on time. If a patient is 15 minutes past their scheduled appointment time, it will be at the provider's discretion if we will need to reschedule the appointment or go ahead and see the patient.
4. **No-Show Policy for Extended Treatment Appointments:**
   - Due to the large block of time needed for some treatment, if a patient No-Shows for their Extended Treatment procedure, you will be charged a minimum of $100 up to a $250 fee depending on the length of your treatment appointment. This is not billable through your insurance and will be due before you will be seen again.

_____ _____

Patient/Guardian Signature Date

_____ _____

Email: Cell #

DOSS DENTISTRY

Financial Policy

Thank you for choosing us as your dental care provider. We are dedicated to serving your dental needs with the best professional advice, care, and service available. Please understand that payment of your dental bill is considered a part of your treatment. Your clear understanding of our Financial Policy is important to our professional relationship. Please read the following information, and if you have any questions, please ask.

Private Pay
Full payment is due at the time of service. We accept cash, personal check, Visa, Mastercard, Discover, and Care Credit.

Payment Plans
If you would like to make payments, we happily offer CareCredit as our third-party creditor. Apply at www.carecredit.com

Dental Insurance
All co-pays and deductibles are due at the time of each service. We will file insurance claims as a courtesy to our patients, but it does not relieve you of your responsibility for your bill. Please provide us with a copy of your current dental benefits card. If you do not have a current card, payment in full may be required at the time of service.

It is your responsibility to understand your dental benefits plan. Your dental insurance policy is a contract between you and the insurance company. Our dental team believes in recommending treatment for the sole purpose of optimizing our patient's dental health. This may not always align with your insurance plan.

Treatment Plans, Estimates, and Pre-Authorizations
We can provide treatment plans for any work that is needed including an estimate of your insurance coverage, however, these figures are only estimates as your insurance company will make the final determination when the claim is submitted. We can submit a Pre-Authorization with your insurance company for major services. These pre-authorizations often take weeks to come back but may provide a more accurate estimate. Remember, you have a right to refuse treatment if you think it may not be covered or payable by your insurance company.

Statements and Service Charges
I understand that if I fail to pay the entire balance within 30 days from the statement date, a 1.5% service charge will be assessed each month. I realize that failure to keep my account current may result in the denial of future dental services. In the case of default on this account, I agree to pay all collection costs and attorney fees incurred in collection attempts. I understand that I am responsible for all bank charges resulting from returned checks or closed accounts. A $35 processing fee will be charged for returned checks. If a patient has a balance that has been sent to collections, they will be required to pay that bill IN FULL and any Co-Pays for the next appointment before they will be scheduled.

You, as the patient, are always responsible for the investment you make toward your dental health.

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

_____ _____
Print Name of Patient, Parent, Guardian, or Representative Relationship to Patient

DOSS DENTISTRY

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name:_____

Address:_____

Telephone:_____ E-mail:_____

Social Security #:_____ Date of Birth:_____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Darla Doss

Telephone: (270)527-1448 Fax: (270)527-5647

E-mail: briandossdmd@dossdentstry.com

Address: 3000 US Hwy 641 N. – Benton, KY 42025

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation and that we may decline to treat you or to continue treating you if you revoke Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Signature:_____ Date:_____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name:_____ Relationship to patient:_____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT. Include completed Consent in the patient's chart.

HIPAA PRIVACY AUTHORIZATION FORM

Authorization for Use or Disclosure of Protected Health Information

Patient Name: _____ DOB: _____

Name of parent or guardian (if different than patient): _____

1. I hereby authorize all health care providers to use and/or disclose the protected health information ("PHI") described below to me or directed below. The purpose of this request is for personal reasons.
2. I hereby authorize the release of PHI, defined here as the patient's complete dental record, including treatment, prognosis, financial, billing, and insurance information. I understand that my personal billing, financial and insurance information may be disclosed to those in section 3 in order to be able to process claims with the insurance company and/or for personal reasons.
3. In addition to the authorization for release of my PHI, I authorize disclosure of information regarding my/my spouse or domestic partner/my dependent's billing, condition, treatment and prognosis to the following individual(s) (please caregivers that may accompany children to appointments):

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

4. This medical information may be used by the persons I authorize to receive this information for dental/medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
5. This authorization shall be in force and in effect until I am no longer a patient at this practice.
6. I understand that I have the right to revoke this authorization, in writing, at any time. Such revocation will not affect actions taken by the requesting person prior to the date he or she received the written revocation.
7. I understand that my dental provider cannot condition treatment on whether I sign this Authorization. However, if I refuse to sign this Authorization, I understand that payment will be collected at the time services are provided and I will be responsible for filing any claims with my dental insurance company.

Messages

Please call ( ) my home ( ) my work ( ) my cell number: _____

If unable to reach me:

( ) you may leave a detailed message

( ) please leave a message asking me to return your call

Signed: _____ Date: _____/_____/_____

Parent/Guardian:_____ Date: _____/_____/_____

DOSS DENTISTRY

GENERAL CONSENT TO PERFORM DENTISTRY

I authorize Dr. Brian Doss and/or any associate, dental hygienist, or assistant that he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s). for the purpose of these diagnostic and preventative procedures including but not limited to: exams (diagnosis), radiographs, preventative hygiene treatments (prophylaxis) and the administration of fluoride, and application of plastic "sealants" to the groove of teeth.

I authorize Dr. Brian Doss and/or any associate, dental hygienist, or assistant that he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to palliative, therapeutic, or restorative treatments.

I understand that the administration of local anesthetic may cause untoward reactions or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval. Occasionally drops of local anesthetic may contact the eyes and facial tissues and cause temporary irritation.

I understand that as part of the dental treatment, including preventive procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. Dental materials and medications may trigger allergic or sensitivity reactions.

After lengthy appointments, jaw muscles may also be sore or tender. Holding one's mouth open can, in a predisposed patient, precipitate a TMJ disorder. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases, sutures or additional treatment may be required.

I understand that as part of dental treatment items including, but not limited to crowns, small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require bronchoscopy or other procedures to ensure safe removal.

I understand the need to disclose to the dentist and/or auxiliary personnel ~~my~~ current medical history and listing of all medications being taken. I understand that taking the class of drugs prescribed for the prevention of osteoporosis, such as Fosamax, Boniva or Actonel, may result in complications of non-healing of the jaw bones following oral surgery or tooth extractions.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and restorative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward.

I agree that the success of dental treatments to be provided will require that the patient and/or parents of the patient follow post-operative and post-care instructions of the dentist and/or auxiliary and that regular office visits be maintained.

I recognize that during the course of treatment, unforeseen circumstances may necessitate additional or different procedures from those discussed. I, therefore, authorize and request the performance of additional or different procedures that are deemed necessary and desirable to oral health and well-being, in the professional judgment of the dentist.

I authorize the doctor(s) to use photographs, radiographs, or other diagnostic materials and treatment records for the purpose of teaching, research and scientific publications without disclosing your name and likeness, unless specific consent is given for that.

I further understand that this consent will remain in effect until such time that I choose to terminate it.

Patient Name: _____

Signature:_____ Date:_____
(Patient, legal guardian or authorized agent of patient)