

Paige Prather Smiles

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(615)771-2151

Please complete this paperwork at least 2 days prior to your appointment.
Please only use dashes (-) when entering phone numbers.

Chart#:

FOR OFFICE USE ONLY

Patient Name:

_____* _____* _____
Last First MI

Preferred Name

Title:

Gender:

*

Mr/Ms/Mrs/etc

Male Female

Family Status:

* Married Single Child Other

Birth Date:

_____*

SS#:

_____-_____-_____
_____-_____-_____

Prev. Visit:

Email Address:

Best time to call:

Phone:

_____* _____* _____* _____*
Home Mobile Work Ext

Fax

Other

Address:

_____*
Address 1

Address 2

City

State

_____*
Zip Code

In case of emergency, who is to be notified? (Please provide best contact phone number)

We send appointment updates to notify you of an upcoming appt. 1 week and 1 day in advance. How do you prefer to receive these notifications? *

Phone Call Text Msg Email

The following is for:

the patient the person responsible for payment both not applicable

Employer Name:

Phone:

Employer Address:

Address 1

Address 2

City

State

Zip Code

Dental Insurance Information

* I authorize Dr. Paige M Prather, PLLC, to release any and all identifying health information that will be necessary in filing a claim with my dental insurance carrier. I may revoke this consent in writing at any time, except to the extent that action has been taken in reliance on it.

Name of Insured:

_____ Last

_____ First _____ MI

Patient's relationship to insured:

Self Spouse Child Other

Insurance Plan Name:

ID Number: (Located on Front of your insurance card, may also be labeled as Enrollee ID #, sometimes the same as your Social Security #) If none please state "none".

Social Security Number and Date of Birth of Insured (Policy Holder)

Insurance Provider Contact Phone Number (Located on Insurance Card):

Please verify that the information you have provided is correct. It is your responsibility to provide us with accurate information about your insurance coverage. Failure to do so can result in delay of payment or declination of payment by your insurance and you will have to assume full responsibility for the cost of service.

Minor/Child Agreement:

I understand that any parent, who brings in a minor for treatment, is responsible for that patient's account balance. A Guardian must remain in the office for the entire duration of a minor's treatment. No patient, under the age of 18, will be treated without a documented guardian present in the office. I verify that I am the parent/guardian of the said patient and there are no court orders now in effect that prohibit me from signing this form. I do hereby authorize the dental staff of Dr. Paige Prather to perform any necessary dental services for the stated minor. Should a child be "dropped off" or left without an attending guardian, the dependent's appointment will be cancelled and charges will apply.

Cancellation Policy

* Your appointment time is especially reserved for you. We value your time and we ask that you value the time of our doctor and other patients. Having an accurate schedule allows our team to provide each patient with maximum attention and allows us to keep more closely to your scheduled appointment time. We pride ourselves on little to no wait time. A \$75 cancellation fee will be applied for any appointment 1 hr. or less in length canceled without 2 business days notice. Down payments are required to schedule any appointment over 1 hour in length. These down payments are nonrefundable if cancelled without 2 business days notice for any reason at a rate of \$250/hr. of reserved time. Cancellation of a sedation appointment will differ from this basic policy and these terms will be reviewed at the time of booking the appointment. If you arrive more than 15 minutes late you will be asked to reschedule your appt. out of consideration for our other patients' time and a cancellation fee will apply. If you cancel more than 2 times without 2 business days notice within a period of 6 months, you will be moved to our Priority Scheduling list, meaning appointments cannot be scheduled more than one day in advance of the appointment time. We provide complimentary reminders of your appointment via text, email, and phone calls. Most of our patients greatly appreciate this service. You may choose the reminder method that works best for you or opt out of this service entirely. However, all cancellation policies still apply. If you have questions or concerns about this policy, please consult with a team member prior to scheduling an appointment.

Financial Policy: Please read over thoroughly prior to receiving services.

* Payment is due, in full, at the time of service. We can accept Cash, Mastercard, Visa, Discover, American Express, Care Credit and insurance checks. We accept personal checks from patients with a record of 6 months with our practice. We charge a service fee of \$30.00 for any check that is returned.

* As a courtesy for insured patients with the exception of infant and therapy patients, a dental claim is filed on the date services are received. For all infant and therapy patients a claim is provided to the patient prefilled with the codes so the patient can file for reimbursement from their insurance carrier. We collect in full upfront for all services provided. We do work with some third party financing companies should you need this option to help keep your dental health on track. Payment is usually remitted from your insurance carrier within 30 days of the service date. If at 30 days, your claim is still unpaid you may contact your insurance carrier directly to ensure timely payment of the claim. We can resubmit your claim if necessary for up to 60 days. At 60 days if the claim is still unpaid, you will need to pursue reimbursement on your own and can contact your carrier directly for help with this. If for any reason payment is not collected prior to services being rendered all outstanding balances are due and payable no later than 30 days after services are rendered. Failure to do so will result in late fees and finance charges at a rate of 8% of the total amount owed. Should extensive measures be required to collect any past due balance you agree to be responsible for all fees associated with such collection including but not limited to attorneys fees. Insurance Policies have specified restrictions that limit a patient's treatment. If you choose to receive the services prescribed by Dr. Prather and they are not covered by your insurance, all costs associated with the non-covered services are your full financial responsibility. We always base treatment recommendation on what is best for you and your overall health, not on what insurance will cover. No guarantee or estimate can be given on your insurance coverage as this is an agreement and policy set up by your employer and your insurance carrier is liable to you only for these benefits.

* HIPAA NOTICE: Notice of Privacy Practices: Effective Date of Notice: January 24, 2007. We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it. This Notice is available at any time, for your review or personal copy, in the reception area of our practice. By checking this box you are confirming knowledge of your rights to privacy as a patient and the receipt of this Notice.

* By checking this box, I acknowledge that the information on this form is complete and correct. I understand that it is my responsibility to inform my doctor if I/my minor have any changes in contact/personal information. I realize that failure to do so can result in inability to reach me and or provide products and or notifications regarding my treatment and health and that additional costs may be incurred because of this.

We will have you sign this paperwork electronically upon arrival to our office. Upon signing you are stating you understand and agree to comply with all policies as outlined in this document.

Signature _____

Date _____

Response Date: _____

DENTAL HISTORY UPDATE

Please check any of the following that apply to you:	YES	NO	If I could change my smile, I would:	YES	NO
Tooth Sensitivity (Hot, Cold, Sweet)	<input type="checkbox"/>	<input type="checkbox"/>	Make Them Whiter	<input type="checkbox"/>	<input type="checkbox"/>
If so, Where: UR LR UL LL			Make Them Straighter	<input type="checkbox"/>	<input type="checkbox"/>
Headaches, Earaches, Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	Close Spaces	<input type="checkbox"/>	<input type="checkbox"/>
Jaw Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	Replace Black Metal Fillings with Tooth Colored		
Teeth or Fillings Breaking	<input type="checkbox"/>	<input type="checkbox"/>	Restorations	<input type="checkbox"/>	<input type="checkbox"/>
Grinding or Clenching Teeth	<input type="checkbox"/>	<input type="checkbox"/>	Repair Chipped Teeth	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding, Swollen or Irritated Gums	<input type="checkbox"/>	<input type="checkbox"/>	Replace Missing Teeth	<input type="checkbox"/>	<input type="checkbox"/>
Loose, Tipped or Shifting Teeth	<input type="checkbox"/>	<input type="checkbox"/>	Replace Old Crowns that Don't Match	<input type="checkbox"/>	<input type="checkbox"/>
Bad Breath	<input type="checkbox"/>	<input type="checkbox"/>	Have a Smile Makeover	<input type="checkbox"/>	<input type="checkbox"/>
History of Speech/Feeding Therapy	<input type="checkbox"/>	<input type="checkbox"/>			
History of Dental Braces, Headgear, Palatal expander	<input type="checkbox"/>	<input type="checkbox"/>			

What is your occupation? _____

What is the most important thing to you about your dental health and your visit today? _____

On a Scale of 1-10, with 10 Being the Highest:

How Important is your Dental Health to you? _____

Where Would you Rate your Current Dental Health? _____

Do you smoke or use chewing tobacco? _____

If so, how much? _____ **How Long?** _____

MEDICAL HISTORY UPDATE

Please Check Any of the Following That Apply to You:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Allergies (Seasonal) | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Emphysema/Bronchitis | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Jaw Joint Pain | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Fainting | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Bisphosphonates | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Conditions | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Heart Defect (Congenital) | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Nervousness/Depression | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Phen Fen (1 month +) | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Radiation (head/neck) | <input type="checkbox"/> Other: _____ |

For WOMEN Only

- Birth Control Pills Breast Feeding Pregnant - If Pregnant, 1-3mos 3-6mos 6-9mos

Do you have any of the following drug allergies?

- Aspirin Penicillin Darvon Codeine Erythromycin Valium Local Anesthetic Other: _____ NKDA

Please List ALL Medications you are Currently Taking:

Are you currently under a physician's care? What for?

Name of Physician: _____ **Phone Number:** _____

Other Medical or Dental Information We Should Know About: _____

Print Patient Name: _____ **Signature:** _____ **Date:** _____

Paige Prather

Smiles

Authorization for Release of Information to Family Members

Patient Name: _____ Date of Birth: _____
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Many of our patients allow family members such as their spouse, parents or others to call and request medical/dental or billing information. Under the requirements of HIPAA, we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical/dental or billing information released to family members, you must sign this form. Signing this form will only give information to family members indicated below.

I authorize Paige Prather Smiles to release my medical/dental and/or billing information to the following individual(s):

- 1. _____ Relation to Patient: _____
- 2. _____ Relation to Patient: _____
- 3. _____ Relation to Patient _____

Patient Information

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.

I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to redisclosure by the above recipient.

You have the right to revoke this consent in writing.

Signature: _____ Date: _____
