Welcome

865.588.1294 • FAX 865.588.6678
6001 WALDEN DR., SUITE 1 • KNOXVILLE, TN 37919

COSMETIC DENTISTRY of KNOXVILLE
RUTH E. BAILEY, D.D.S.

ABOUT YOU

Patient Name ______________________________ Today's Date _____/_____/_____
Last First MI

What you prefer to be called ______________________ Birthdate _____/_____/_____ Age ______

SS # ____________________

Mailing Address ____

____
City State Zip

Home Phone # (_____) ______________ Work Phone # (_____) ______________ Ext. _____

Cell Phone # (_____) ______________ Email Address ______________________

❑ Send me a text message ❑ Send me an email message

Referred By ____

Employer ____

Employer's Address____

____
City State Zip

Occupation ______________________

Status ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse's Name ____

ACCOUNT INFO

Person ultimately responsible for account

❑ Same as patient information above

Name ______________________

Relation ______________________

Billing Address (if different from above)

____

____
City State Zip

SS # ______________________

Work Phone # (_______) ______________

Payment Method ❑ Cash ❑ Check ❑ Credit Card

Initials ____ *I hereby acknowledge that payment is due in full at time of services rendered and I will be directly reimbursed by my insurance company (if applicable).*

INSURANCE INFO

Subscriber Name ______________________

Date of Birth ______________________

ID Number ______________________

Employer ______________________

ALSO, PLEASE BRING YOUR INSURANCE CARD TO BE PHOTOCOPIED.

IN THE EVENT OF EMERGENCY

Whom should we contact? ______________

Relation ______________________

Home Phone # (_______) ______________

Work Phone # (_______) ______________

Cell Phone # (_______) ______________

Who is your medical doctor? ______________

Dr's Phone # (_______) ______________

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DENTAL HISTORY

How would you rate the condition of your mouth? Excellent Good Fair Poor

Date of most recent dental exam ______ /______ /______ Date of most recent x-rays _______ /_______ / ______
Date of most recent treatment (other than a cleaning) ______ / _____ / ______
I routinely see my dentist every: 3 mo. 4 mo. 6 mo. 12 mo. Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? ____

PLEASE ANSWER YES OR NO TO THE FOLLOWING: **YES** **NO**

PERSONAL HISTORY

1. Have you ever had complications from past dental treatment?______________ ☐ ☐
2. Have you ever had trouble getting numb or had any reactions to local anesthetic?______________ ☐ ☐
3. Did you ever have braces, orthodontic treatment or had your bite adjusted? ______________ ☐ ☐
4. Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma?______________ ☐ ☐

GUM AND BONE

5. Do your gums bleed or are they painful when brushing or flossing? ______________ ☐ ☐
6. Have you ever been treated for gum disease or been told you have lost bone around your teeth? ______________ ☐ ☐
7. Have you ever noticed an unpleasant taste or odor in your mouth? ______________ ☐ ☐

TOOTH STRUCTURE

8. Do you experience dry mouth? ______________ ☐ ☐
9. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth? ______________ ☐ ☐
10. Do you frequently get food caught between any teeth? ______________ ☐ ☐

BITE AND JAW JOINT

11. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) ______________ ☐ ☐
12. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? ______________ ☐ ☐
13. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed? ______________ ☐ ☐
14. Are your teeth becoming more crooked, crowded, or overlapped? ______________ ☐ ☐
15. Are your teeth developing spaces or becoming more loose? ______________ ☐ ☐
16. Do you wear or have you ever worn a bite appliance? ______________ ☐ ☐

SMILE CHARACTERISTICS

17. Is there anything about the appearance of your teeth that you would like to change (shape, color, size)? ______________ ☐ ☐
18. Have you ever whitened (bleached) your teeth? ______________ ☐ ☐
19. Have you felt uncomfortable or self conscious about the appearance of your teeth? ______________ ☐ ☐

Patient's Signature ______________________________ Date ____________
Doctor's Signature ______________________________ Date ____________

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MEDICAL HISTORY

Name of Physician/and their specialty ____________________

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD:

	YES	NO
1. recent hospitalization (last 2 years) ____	☐	☐
2. an allergic or bad reaction to any of the following: ☐ aspirin, ibuprofen, acetaminophen, codeine ☐ antibiotics *(please list)* ____ ____ ____ ☐ latex ☐ other ____	☐	☐
3. heart problems, or cardiac stent within the last six months ____	☐	☐
4. artificial heart valve, repaired heart defect (PFO) ____	☐	☐
5. pacemaker or implantable defibrillator ____	☐	☐
6. orthopedic implant (joint replacement) ____	☐	☐
7. high or low blood pressure ____	☐	☐
8. a stroke (taking blood thinners) ____	☐	☐
9. anemia or other blood disorder ____	☐	☐
10. breathing or sleep problems (i.e. sleep apnea, snoring, sinus) ____	☐	☐
11. kidney disease ____	☐	☐
12. liver disease ____	☐	☐
13. diabetes (HbA1c =) ____	☐	☐
14. digestive or eating disorders (e.g., celiac disease, gastric reflux, bulimia, anorexia) ____	☐	☐

	YES	NO
15. osteoporosis/osteopenia (i.e. taking bisphosphonates) ____	☐	☐
16. arthritis ____	☐	☐
17. autoimmune disease ____ (i.e. rheumatoid arthritis, lupus, scleroderma)	☐	☐
18. epilepsy, convulsions (seizures) ____	☐	☐
19. viral infections and cold sores ____	☐	☐
20. STI/STD/HPV ____	☐	☐
21. hepatitis (type ____) ____	☐	☐
22. HIV/AIDS ____	☐	☐
23. cancer ____	☐	☐
24. radiation therapy ____	☐	☐
25. chemotherapy, immunosuppressive medication ____	☐	☐

ARE YOU:

	YES	NO
26. presently being treated for any other illness ____	☐	☐
27. experiencing frequent headaches ____	☐	☐
28. a smoker, smoked previously or use smokeless tobacco ____	☐	☐
29. currently pregnant ____	☐	☐

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)

____

List all medications, supplements, and or vitamins taken within the last two years or provide a list.

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature ____________________ Date ____________

Staff Signature ____________________ Date ____________

ASA ______ (1-6) ○ ○ ○

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OFFICE POLICIES AND CONSENT

We strongly believe in our work and professional efforts to care of you in a manner of excellence and efficiency. The following policies that we feel are important to accomplish this are expressed in the following commitments. Please read and sign at the bottom indicating you understand, agree and commit to follow through, allow us to meet your expectations.

COMMITMENT TO TREATMENT

We believe disease is disease, whether it's hard or soft tissue and should be completed. Incomplete treatment leads to greater pain, problems, complications, misunderstandings and further disease in your mouth or overall health.

COMMITMENT TO APPOINTMENTS

Any appointment on our schedule is a bond of trust that we count on you being here and us being able to serve and care for you with the utmost. We make every effort to stay on schedule and never have you wait unnecessarily before being seen. Occasionally circumstances cause delays, and we will do our very best to accommodate you if at all possible in order not to interfere with the next scheduled patient. Obviously there are situations for both the patient and our office that may result in a need to change or miss an appointment. We understand this, and ask that you give us a notice, we believe two or more changes or failed appointments without cause reflects a lack of commitment to your oral health and a lack of consideration for us. We cannot make available appointment time that is not going to be honored. Your signature indicates we will have a mutual respect for each other's time.

COMMITMENT TO FINANCIAL AGREEMENT

We believe we have the responsibility to use the best professional care, skill and judgement in diagnosing, recommending, planning and delivering your dental care. Your commitment to take care of these services at the time of care is our preferred method of keeping our costs low and passing saving on to you. By signing this policy/consent agreement, you are indicating that after any and all treatment you will fulfill your financial investment and commitment to our office on your appointment date. Payment is due in full at the time of service. There will be a 1.5% per month interest added to any outstanding balances and if necessary, collections and/or legal fees of 50% will be added to the balance at time of collection action.

We file and process all dental insurance plans for our patients, when you furnish us with all the correct information at the time of your visit. If you are a new patient, we are thrilled you have insurance. Here is how we handle that – we ask that all charges be paid to us at time of service and we will file your insurance that day. You will be directly reimbursed by your insurance company within 14 days. If you are a patient of record, you must update this information on an annual basis for us to continue to offer this service.

We know that your insurance is a contract between you, your employer and insurance company. We are not party to this agreement or the terms and conditions. We will file our estimated coverage procedures and as a courtesy to you to receive your reimbursement, knowing all charges are your responsibility from that date they are incurred.

I have read, understand and agree to comply with all the above statements. I authorize the release of my dental records for the purpose of insurance and/or compensation for services rendered by Ruth Bailey, DDS.

____

Signature of Patient or Responsible Party (if a minor, please complete the next line)

____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW TI CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

OUR LEGAL DUTY
We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you Notice about our privacy practices, our legal duties and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (04/01/2004), and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION
We use and disclose health information about you for treatment, payments, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician r other healthcare providers providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you

Healthcare Operations: We may use and disclose you health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, you general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of you incapacity or emergency circumstances, we will disclose health information based on determinations using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your

best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law as ordered.

Abuse of Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail, email, text messaging, letters, or cell phone).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (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 the Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us s letter to the address at the end of this Notice. If you request copies, we will charge you $ _____ for each page, $ _____ per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances n which we or our business associates disclosed you health information for purposes, other than treatment, payment healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12 month period, we may charge you a reasonable, cost-based fee for responding to those additional requests.

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 to alternative locations. (You must make your request(s) in writing.) Your request must specify the 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 you 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 (e-mail), you are entitled to receive this Notice in written form also, please make that request upon arrival at our office.

RECEIPT OF NOTICE OF PRIVACY PRACTICES
Written Acknowledgement Form

I ____, have read and / or received a copy of Notice of Privacy Practices from Ruth E. Bailey, D.D.S., PC

____

Signature of Patient   Date