

Welcome

Thank you for selecting our dental healthcare team!
We will strive to provide you with the best possible dental care.
To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Patient Information (CONFIDENTIAL)

Patient # _____

SS#/SIN _____

Date _____

Name _____ Birthdate _____ Home Phone _____

Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Email _____ Cell Phone _____

Check Appropriate Box: Minor Single Married Divorced Widowed Separated

If Student, Name of School/College _____ City _____ State/Prov. _____ Full Time Part Time

Patient or Parent/Guardian's Employer _____ Work Phone _____

Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Email _____ Cell Phone _____

Driver's License # _____ Birthdate _____ Financial Institution _____

Employer _____ Work Phone _____ SS#/SIN _____

Is this person currently a patient in our office? Yes No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

Cash Personal Check Credit Card VISA MasterCard I wish to discuss the office's payment policy.

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City _____ State/Prov. _____ Zip/P.C. _____

Insurance Company _____ Group # _____ Policy/ID # _____

Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes No IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City _____ State/Prov. _____ Zip/P.C. _____

Insurance Company _____ Group # _____ Policy/ID # _____

Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

Over Please

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

- | | Yes | No | | Yes | No |
|---|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 1. Are you under medical treatment now? | <input type="checkbox"/> | <input type="checkbox"/> | 10. Are you wearing contact lenses? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? | <input type="checkbox"/> | <input type="checkbox"/> | 11. Are you allergic to or have you had any reactions to the following? | | |
| If yes, please explain _____ | | | Local Anesthetics (e.g. Novocain) | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you taking any medication(s) including non-prescription medicine? | <input type="checkbox"/> | <input type="checkbox"/> | Penicillin or any other Antibiotics | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, what medication(s) are you taking? _____ | | | Sulfa Drugs | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever taken Fen-Phen/Redux? | <input type="checkbox"/> | <input type="checkbox"/> | Barbiturates | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates? | <input type="checkbox"/> | <input type="checkbox"/> | Sedatives | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours? | <input type="checkbox"/> | <input type="checkbox"/> | Iodine | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you use tobacco? | <input type="checkbox"/> | <input type="checkbox"/> | Aspirin | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you use controlled substances? | <input type="checkbox"/> | <input type="checkbox"/> | Any Metals (e.g. nickel, mercury, etc.) | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you have or have you had any of the following? | | | Latex Rubber | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Other (please list) _____ | | |
| | | | 12. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? ... | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | 13. Women Only: | | |
| | | | a) Are you pregnant or think you may be pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | b) Are you nursing? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | c) Are you taking oral contraceptives? | <input type="checkbox"/> | <input type="checkbox"/> |

- | | Yes | No | | Yes | No | | Yes | No |
|------------------------------|--------------------------|--------------------------|------------------------------------|--------------------------|--------------------------|-----------------------------|--------------------------|--------------------------|
| High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> | Chest Pains | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Attack | <input type="checkbox"/> | <input type="checkbox"/> | Cardiac Pacemaker | <input type="checkbox"/> | <input type="checkbox"/> | Easily Winded | <input type="checkbox"/> | <input type="checkbox"/> |
| Rheumatic Fever | <input type="checkbox"/> | <input type="checkbox"/> | Heart Murmur | <input type="checkbox"/> | <input type="checkbox"/> | Stroke | <input type="checkbox"/> | <input type="checkbox"/> |
| Swollen Ankles | <input type="checkbox"/> | <input type="checkbox"/> | Angina | <input type="checkbox"/> | <input type="checkbox"/> | Hay Fever / Allergies | <input type="checkbox"/> | <input type="checkbox"/> |
| Fainting / Seizures | <input type="checkbox"/> | <input type="checkbox"/> | Frequently Tired | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Anemia | <input type="checkbox"/> | <input type="checkbox"/> | Radiation Therapy | <input type="checkbox"/> | <input type="checkbox"/> |
| Low Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Emphysema | <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> |
| Epilepsy / Convulsions | <input type="checkbox"/> | <input type="checkbox"/> | Cancer | <input type="checkbox"/> | <input type="checkbox"/> | Recent Weight Loss | <input type="checkbox"/> | <input type="checkbox"/> |
| Leukemia | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Joint Replacement or Implant | <input type="checkbox"/> | <input type="checkbox"/> | Heart Trouble | <input type="checkbox"/> | <input type="checkbox"/> |
| Kidney Diseases | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis / Jaundice | <input type="checkbox"/> | <input type="checkbox"/> | Respiratory Problems | <input type="checkbox"/> | <input type="checkbox"/> |
| AIDS or HIV Infection | <input type="checkbox"/> | <input type="checkbox"/> | Sexually Transmitted Disease | <input type="checkbox"/> | <input type="checkbox"/> | Mitral Valve Prolapse | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid Problem | <input type="checkbox"/> | <input type="checkbox"/> | Stomach Troubles / Ulcers | <input type="checkbox"/> | <input type="checkbox"/> | Other | <input type="checkbox"/> | <input type="checkbox"/> |

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

- | | Yes | No | | Yes | No |
|---|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 1. Do your gums bleed while brushing or flossing? | <input type="checkbox"/> | <input type="checkbox"/> | 8. Do you have frequent headaches? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are your teeth sensitive to hot or cold liquids/foods? | <input type="checkbox"/> | <input type="checkbox"/> | 9. Do you clench or grind your teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are your teeth sensitive to sweet or sour liquids/foods? | <input type="checkbox"/> | <input type="checkbox"/> | 10. Do you bite your lips or cheeks frequently? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you feel pain to any of your teeth? | <input type="checkbox"/> | <input type="checkbox"/> | 11. Have you ever had any difficult extractions in the past? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have any sores or lumps in or near your mouth? | <input type="checkbox"/> | <input type="checkbox"/> | 12. Have you ever had any prolonged bleeding following extractions? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you had any head, neck or jaw injuries? | <input type="checkbox"/> | <input type="checkbox"/> | 13. Have you had any orthodontic treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever experienced any of the following problems in your jaw? | | | 14. Do you wear dentures or partials? | <input type="checkbox"/> | <input type="checkbox"/> |
| Clicking | <input type="checkbox"/> | <input type="checkbox"/> | If yes, date of placement _____ | | |
| Pain (joint, ear, side of face) | <input type="checkbox"/> | <input type="checkbox"/> | 15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty in opening or closing | <input type="checkbox"/> | <input type="checkbox"/> | 16. Do you like your smile? | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty in chewing | <input type="checkbox"/> | <input type="checkbox"/> | | | |

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X
Signature of patient (or parent/guardian if minor) _____ Date _____

Doctor's Comments _____
Signature _____ Date _____

POPLAR PIKE DENTAL

Dr. Douglas Dugard
Dr. Sahar Moshref
3023 Centre Oak Way
Germantown, TN 38138
901-755-7600

Office Collection Policy:

Accounts are due and payable at the time of service unless prior arrangements have been made. If you have dental insurance, our office will file your insurance but cannot guarantee any insurance payments for services rendered. Additionally, your copays are due at the date of service. You agree that you are 100% responsible for any charges incurred from services rendered, regardless of any insurance coverage. In the event that your account is placed with a collection agency, a collection fee in the amount of up to 33.3% may be added to your account and shall become part of the total amount due. You will be responsible for any and all collection fees including collection fees, reasonable attorney fees and court cost. Further, you agree that in order for us to service your account or to collect any amounts you may owe, we and our/or collection agency may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We and our collection agency may also contact you by sending text messages and/or e-mails using any e-mail you have provided us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

Patient/Responsible Party Signature

Date

HIPAA FORM

POPLAR PIKE DENTAL

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Home phone: _____ Cell Phone: _____

E-mail: _____ Social Security Number: _____

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: Judith Bidwell

Telephone: 901-755-7600

E-mail: judith0608@bellsouth.net

Address: 3023 Centre Oak Way, Germantown, TN 38138

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 this Consent.

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: _____

POPLAR PIKE DENTAL

Dr. Douglas Dugard
Dr. Sahar Moshref
3023 Centre Oak Way
Germantown, TN 38138
901-755-7600

INSURANCE WAIVER

I, _____, understand that if for any reason my insurance denies or does not cover any or all of my services received at this practice, I will be personally 100% responsible for payment, regardless of insurance coverage. I also understand that this waiver is good for any and all visits with this office now and in the future.

It is my responsibility as the patient and the insured to update this office of any insurance changes. I will provide the office with updated cards and information. This information is to help us with filing your claim with the correct insurance company.

It is your responsibility to know your insurance coverage. We cannot be responsible to know everyone's insurance policy and benefits. If you have questions in regard to your coverage, please call your insurance company's member services department for help.

Please remember you are fully responsible for all fees charged by this office regardless of your insurance coverage.

We file your insurance as a courtesy to you.

Patient's Signature or Guarantor if Minor

Date

Thank you,
Management