



Denton Dental Solutions
Greg Denton, DDS

Welcome!

It is with the greatest pleasure that we welcome you to our dental practice here in Mt. Juliet. My name is Dr. Greg Denton and I have been in general practice in the Hermitage and Mt. Juliet area for over twenty years. My wife and I were raised in the Hermitage and Mt. Juliet area and continue to live in this wonderful community with our family. My team and I are very proud to offer you the best services available in general and cosmetic dentistry. Let us know how we can help you quickly feel at home in our office.

For your convenience, we have enclosed a health questionnaire and other information. If you have any questions, please feel free to call us at 615-754-0853. Please bring the enclosed forms (filled out) with you to your scheduled appointment. If you are unable to complete your paperwork before your visit, please arrive fifteen minutes prior to your appointment.

We look forward to meeting you and serving your dental needs now and in the future.

Sincerely,

Greg Denton, D.D.S



PATIENT INFORMATION

Last Name _____ First Name _____ Middle Initial _____

Birthdate _____ Age _____ Sex Male Female I prefer to be called _____

S.S.N. / S.I.N. _____ Home Phone _____ Cell _____

Email Address _____ I prefer confirmation via Cell Email

Patient Address _____ Apt# _____

City _____ State _____ Zip _____

Marital Status Married Single Divorced Widowed

RESPONSIBLE PARTY INFORMATION *(If Not Patient)*

Last Name _____ First Name _____ Middle Initial _____

Birthdate _____ Age _____ Sex Male Female I prefer to be called _____

S.S.N. / S.I.N. _____ Home Phone _____ Cell _____

Email Address _____ I prefer confirmation via Cell Email

Patient Address _____ Apt# _____

City _____ State _____ Zip _____

Marital Status Married Single Divorced Widowed

DENTAL INSURANCE INFORMATION

Primary Policy Holder's Name _____ S.S.N. / S.I.N. _____

Birth Date _____ Employed By _____

Dental Insurance Company _____ Subscriber ID _____

Secondary Policy Holder's Name _____ S.S.N. / S.I.N. _____

Birth Date _____ Employed By _____

Dental Insurance Company _____ Subscriber ID _____



Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now? Yes No If yes, please explain _____
- Have you ever been hospitalized or had a major operation? Yes No If yes, please explain _____
- Have you ever had a serious head or neck injury? Yes No If yes, please explain _____
- Are you taking any medications, pills or drugs? Yes No If yes, please explain _____
- Do you take, or have you taken, Phen-Fen or Redux? Yes No If yes, what? _____
- Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No If yes, what? _____
- Are you on a special diet? Yes No If yes, what? _____
- Do you use tobacco? Yes No If yes, what? _____
- Do you use controlled substances? Yes No If yes, what? _____

Are you a woman who is... Pregnant/Trying to get pregnant Nursing Taking oral contraceptives

Are you allergic to any of the following?

- Aspirin Penicillin Codeine Acrylic Other _____
- Metal Latex Sulfa Drugs Local Anesthetics No Known Allergies

Do you have, or have you had any of the following?

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Herpes | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Easily Winded | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Hives or Rash | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Swelling of Limbs |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Parathyroid Disease | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Yellow Jaundice |
| <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Radiation Treatments | |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Recent Weight Loss | |
| <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Renal Dialysis | |

Have you ever had any serious illness not listed above? Yes No If yes, _____

Comments _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian _____

Date _____



This notice describes how dental information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment, or health care operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

USES OF DISCLOSURES OF PROTECTED HEALTH INFORMATION

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a dentist, to whom you have been referred, to ensure that the dentist has the necessary information to diagnose or treat you.

Payment: your protected health information will be used, as needed, to obtain payment for your healthcare services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operation: We may use or disclose, as needed, your protected health information in order to support the business activities of your dentist's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your dentist. We may also call you by name in the waiting room when your dentist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law; communicable disease; health oversight; abuse or neglect; Food and Drug Administration requirements; legal proceedings; law enforcement; coroners, funeral directors, and organ donation; research; criminal activity and national security; worker's compensation; inmates; required uses and disclosures. Under the law, we must take disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements with section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization at anytime, in writing, except to the extent that your dentist or the dentist's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.



Your dentist is not required to agree to a restriction that you may request. If the dentist believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another healthcare professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e., electronically.

You may have the right to have your dentist amend your protected health information. If we deny your request for amendment you have the right to file a state of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

COMPLAINTS

You may complain to the Secretary of Health and Human Services or us if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please speak with our HIPAA Compliance Office in person or by phone at our main phone number.

Signature below is only acknowledgment that you have received this Notice of Privacy Practices.

Signature of Patient, Parent or Guardian

Date

Print Name



Receipt of Dr. Denton's Notice of Privacy Practices & Policies

ACKNOWLEDGMENT

This is to acknowledge receipt of Dr. Denton's Private Practices and Policies notice as required by HIPAA (The Health Information Portability and Accountability Act).

By signing below, you indicate that you have read and understand our policies. This form also allows you to designate below any persons with whom you authorize us to discuss your personal information.

Signature of Patient, Parent or Guardian

Date

Print Name

DISCLOSURE

Please list designated individuals with whom you authorize Dr. Denton and staff to discuss your personal information:



In our continued commitment to provide the highest quality dental care available to all of our patients, and to have those services comfortably affordable, we are please to offer you these options for payment.

Please check one of the following:

- | | |
|-------------------------------------|---|
| <input type="checkbox"/> Visa | <input type="checkbox"/> American Express |
| <input type="checkbox"/> Discover | <input type="checkbox"/> Cash |
| <input type="checkbox"/> MasterCard | <input type="checkbox"/> Personal Check * |

*returned checks with have a \$25.00 fee.

We are pleased to offer third-party extended payment financing through CareCredit and Lending Club. Please ask a member of the staff for details and credit applications.

We are committed to support you in understanding your dental health, so that you will always be able to make the best choices.

We will, as a courtesy, process your insurance benefits in your office, which will relieve you of this time consuming and sometimes complicated task. We will always recommend treatment based upon your dental needs, not based on insurance coverage, which can be inadequate with some dental plans.

I agree that I am fully responsible for the total payment of all procedures performed in this office. This includes any treatment that is not a benefit of any dental insurance that I may have. I understand that all services are due and payable at the time services are rendered, regardless of whether or not my insurance benefits have been received. One and one-half percent (1.5%) per month interest (18% per year) will be charged on accounts 60 days from treatment date.

MISSED APPOINTMENTS

Appointment times are reserved especially for you. If you come in late, the doctor may request that you reschedule the appointment, and you may be charged a fee of \$40. If for any reason you should need to change your appointment, there will be no charge, provided you give us a 48-hour notice. Please help us serve you better by keeping your scheduled appointments. We are here to assist in any way possible. Please make your questions and concerns known to your team. Our goal is to ensure that you have an outstanding experience.

Signature of Patient, Parent or Guardian

Date

Team Member