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

Denton Dental Solutions
Greg Denton, DDS

Patient Information

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

Emergency Contact: Name: _____ Phone: _____ Referred by: _____

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 _____

Denton Dental Solutions
Greg Denton, DDS

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?

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

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

HIPAA Notice of Privacy Practices

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.

HIPAA Notice of Privacy Practices

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 out 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 HIPPA 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

Denton Dental Solutions
Greg Denton, DDS

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:

Denton Dental Solutions
Greg Denton, DDS

Consent for Services and Financial Policy

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred their care and financial responsibility on the part of each patient must be determined before treatment.

GENERAL
Thank you for choosing our practice as your Dental Care Provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to treatment. All patients must complete our Information and Insurance form before seeing the doctor.

WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER & CARE CREDIT

DENTAL INSURANCE:
Our office will gladly work with you to help get the maximum benefit available to you. Most dental insurance plans do not cover 100% of your cost of treatment. Therefore; you will be expected to pay your deductible and your **ESTIMATED** co-payment on the day services are rendered. We will gladly file your insurance claim. Many variables exist from carrier to carrier (i.e. deductibles, annual maximums, allowable fee limitations, non-covered procedures and other restrictions), therefore, we cannot guarantee any estimated charges. Because your insurance is an agreement between you and the insurance company, ultimately you are responsible for all charges. Please know that we will do everything possible to see that you receive the full benefits from your insurance company. If for some reason your insurance company has not paid their estimated portion within 60 days from the start of treatment, you are responsible for payment in full at that time. Treatment could be altered if your dental needs change. The patient will be notified of any change(s)in treatment. After a statement of accounts has been sent and a balance is left on the account after 60 days, the credit card kept on file will be charged for any balance over 60 days.

REGARDING INSURANCE PLANS WHERE WE ARE A PARTICIPATING PROVIDER
All ESTIMATED portions and deductibles are due prior to treatment. In the event YOUR insurance coverage changes to a plan where we are a non-participating provider, refer to above paragraph. You are responsible for advising this office if you have a change in your insurance coverage prior to your appointment.

USUAL AND CUSTOMARY RATES
Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

ADULT PATIENTS
Adult patients are responsible for full payment at time of service.

MINOR PATIENTS
The adult accompanying a minor and the parents(or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to be approved by Visa/MasterCard, American Express, Discover, CareCredit, or payment by cash or check at time of service has been verified.

MISSED APPOINTMENTS
We respectfully ask that you give us a minimum of 48 hours notice to cancel or reschedule your appointment. Please help us serve you better by keeping scheduled appointments.

AUTHORIZATION & RELEASE: I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered t o me or my child during the period of such dental care to third party payers and/or healthcare practitioners. I authorize and request my insurance company to pay directly to the dentist (if my insurance will allow it) or dental group insurance benefits otherwise payable to me. I understand that my 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. I authorize my personal payment information (checks or credit cards used to make payments on your account),to be kept on file, if needed,to make restitution on any balance over 60 days past due.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I agree to have any photos taken of me to be used for education, training and/or marketing.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____

Signature of Patient, Parent or Guardian