Carolina A. Wilson, D.M.D.
COSMETIC + FAMILY DENTISTRY
PERSONAL CARE SUPERIOR RESULTS

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(865)539-4494
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Welcome to our practice! We look forward to meeting you. My staff and I will work together as a team to bring you the highest quality treatment in a warm, caring setting.
We would like to share some information with you, so that we may serve you as best we can.

We will see all patients on an appointment basis so that your time will be reserved. We make every attempt to see you promptly, as we know your time is valuable. Should you be unable to keep the appointment you have set, we do require a 24-hour notice to avoid a charged fee for missed appointments. Our goal is to have an efficient office so that we may serve all of our patients better.

Our office hours are as follows:

Monday-Thursday	8:30 A.M. - 5:00 P.M.
Friday-Sunday	Closed

Should an emergency situation arise after office hours, please call (865)539-4494. Your call will be returned as promptly as possible.

Our financial policy is as follows:

PAYMENT OF FEES
Payment for your initial office visit is required at the time services are rendered. Responsibility for payment begins when treatment begins.

Payment for all dental procedures will be due at the time of treatment unless previous financial arrangements have been made.

For major treatment plans, a consultation visit will be scheduled. At this time, definite financial arrangements can be made with the office coordinator prior to initiating treatment.

Major treatment is any treatment requiring laboratory services, i.e., crowns, bridges, partials, dentures, mouthguards, etc. This type of treatment requires two equal payments: a deposit of 50% at the first appointment, and the balance due upon completion of treatment.

Payment for all dental procedures may be paid through your MasterCard, Visa, American Express, or Discover card. Please see our office coordinator for details.

Dental Registration And History

1 Patient Information

Date _____

SS# _____

Patient Name

Last Name _____

Middle Name _____

First Name _____

Address

House/Apt. No _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone _____

Spouse's Name _____

Birthdate _____

Spouse's Employer _____

Whom may we thank for referring you ?

_____

_____

2 Dental Insurance

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Company _____

Group No # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS # _____

Relationship to Patient _____

Insurance Company _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to

(Name of the Insurance Company)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____

Signature of Patient, Parent, Guardian or Personal Representative

_____

Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____

Date Relationship to Patient

3 Phone Numbers

Home _____ Work _____ Ext. _____ Cell _____

Spouse's Work _____ Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home Phone _____ Work Phone _____

4 Dental History

Reason for today's visit _____

_____

Former Dentist _____

City / State _____

Date of last dental visit _____

Date of last dental X-ray _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath	☐ Yes	☐ No	Chew on one side of mouth	☐ Yes	☐ No	Mouth breathing	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No	Cigarette, pipe, or cigar smoking	☐ Yes	☐ No	Mouth pain, brushing	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No	Clicking popping jaw	☐ Yes	☐ No	Orthodontic treatment	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No	Dry mouth	☐ Yes	☐ No	Pain around ear	☐ Yes	☐ No
			Fingernail biting	☐ Yes	☐ No	Periodontal treatment	☐ Yes	☐ No
			Food collection between the teeth	☐ Yes	☐ No	Sensitivity to cold	☐ Yes	☐ No
			Foreign objects	☐ Yes	☐ No	Sensitivity to heat	☐ Yes	☐ No
			Grinding teeth	☐ Yes	☐ No	Sensitivity to Sweets	☐ Yes	☐ No
			Gums swollen or tender	☐ Yes	☐ No	Sensitivity when biting	☐ Yes	☐ No
			Jaw pain or tiredness	☐ Yes	☐ No	Sores or growths in your mouth	☐ Yes	☐ No
			Lip or cheek bitting	☐ Yes	☐ No	How often do you floss?	_____	
			Loose teeth or broken fillings	☐ Yes	☐ No	How often do you brush	_____	

Dental Registration And History

5 Health History

Physician's Name_____ Date of last visit

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combination of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Place a mark on "Yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes	☐ No	Fainting or dizziness	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Artifical Heart Valves	☐ Yes	☐ No	Heart Attack	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Artifical Joints	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Heart Problems	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	Hepatitis Type	☐ Yes	☐ No	Skin Rash	☐ Yes	☐ No
Bleeding abnormally,			Herpes	☐ Yes	☐ No	Special Diet	☐ Yes	☐ No
with extractions or surgery	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No	Swollen Feet or Ankles	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Jaw Pain	☐ Yes	☐ No	Swollen Neck Glands	☐ Yes	☐ No
Chemical Dependancy	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Leukemia	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Congenital Heart Lesions	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Tumor or growth on head or neck	☐ Yes	☐ No
Cortisone Treatments	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No	Ulcer	☐ Yes	☐ No
Cough, persistent or bloody	☐ Yes	☐ No	Nervous Problems	☐ Yes	☐ No	Sexually Transmitted Disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Weight Loss, unexplained	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Parkinson's	☐ Yes	☐ No			
Epilepsy	☐ Yes	☐ No	Psychiartric Care	☐ Yes	☐ No			

Any other medical condition not listed _____

_____

_____

Do you wear contact lenses? ☐ Yes ☐ No

Women:

Are you pregnant? ☐ Yes ☐ No Due date _____

Are you nursing? ☐ Yes ☐ No

Take birth control pills? ☐ Yes ☐ No

6 Medications

List any medication you are currently taking and the correlating diagnosis:

_____

_____

_____

_____

_____

Pharmacy Name _____

Phone _____

7 Allergies

Aspirin	☐ Yes	☐ No
Barbiturates (Sleeping Pills)	☐ Yes	☐ No
Codeine	☐ Yes	☐ No
Iodine	☐ Yes	☐ No
Latex	☐ Yes	☐ No
Local Anesthetic	☐ Yes	☐ No
Penicillin	☐ Yes	☐ No
Sulfa	☐ Yes	☐ No
Other _____		

HIPAA - Patient Consent Form

The department of Health and Human Services has established a "Privacy Rule" to help insure that personal health information is protected for privacy. The Privacy Rule was also created to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment of health care operations.

As our patient we want you to know that we respect the privacy of your personal dental records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about your treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal dental records. We may have indirect treatment relationships with you (such as laboratories that interact with doctors and not patients), and may have to disclose personal health information for purposes of treatment, payment or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have to the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out the following: a) Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment; i.e. release of radiographs and or treatment plans to referring physicians and or dentists) b) Obtaining payment from third party payers (i.e. my insurance company) c) The day-to-day healthcare operations of your practice

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Patient Name: _____

_____ _____ _____

Parent/Guardian Signature Date

Compliance Assurance Notification for Our Patients

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule". We strive to achieve the very highest standards of ethics and integrity in performing services for out patients.

It is our policy to properly determine appropriate uses of PHI in accordance with government rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosures of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of that fact, our policy is to listen to our employees and patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problems so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.

_____

Patient

_____ _____

Date Staff

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Appointment Policy

Cancellation Policy

In order to be respectful of the dental needs of our other patients, we request that you call promptly to reschedule an appointment. We require that cancellations be made at least 24 hours in advance so that the appointment time can be reallocated to someone in need of dental care.

Failed Appointment Policy

A failed appointment is defined as:

- A patient that fails to cancel or reschedule an appointment at least 24 hours before the scheduled appointment time.

Late Arrival Policy

A patient who arrives late, 15 minutes or more, to their scheduled appointment time will be seen if the schedule allows.

Appointments are in high demand, and your prompt cancellation will give another patient access to timely dental care. An appointment policy reminder letter will be issued after the first two failed appointments. The office reserves the right to dismiss a patient after three failed appointments.

We appreciate your understanding as we navigate through the new normal Covid-19 has brought.

I have read and understand the Appointment Policy.

Signature:_____ **Date:**_____

Patient name:_____ **D.O.B:**_____