Music City Dental

Family, Cosmetic, and Implant Dentistry

Terry Spurlin, DDS • 615-953-2469

NEW PATIENT INFORMATION

(Please present your driver license and the insurance card at the front desk)

Patient Name: _____ Date of birth:_____ SS# _____

Your Preferred Name _____ Single __ Married __Other__ Divorced__ Widowed __

Address_____ Apt_____ City _____State ___ Zip _____

Cell #:_____ Work#:_____ Home #:_____

Email: _____Preferred method of contact? _____

Your Company Name: _____ Position: _____

Business name address: _____

Emergency Contact: Name: _____ Phone(s):_____

******Who may we thank for your referral to us?* _____*****

Please complete the following information regarding your dental coverage:

Family member name that provides coverage: _____

Their Birth Date: _____ SS#_____ Relationship:_____

Phone #: _____ Employer: _____

Office Financial Policy Assignment and Release

Payment in full is due at the time of services.

If you have dental insurance Music City Dental will as a courtesy file your claim. We will make every effort to present accurate co-pay information on your treatment plan but once the claim is processed you may still have a balance due. All deductibles and co-pays are due on the date of service and will be collected based on the information provided by your insurance company; however any balance not covered by insurance is your responsibility. Please sign below to allow claim payment to be made to Music City Dental and acknowledge that the all charges incurred and not covered by insurance are your responsibility.

_____ _____

Guarantor signature **Date**

____ I have read and understand the Office Financial Policy presented on the clipboard.

____ I would like a copy of the Office Financial Policy

Music City Dental
Family, Cosmetic, and Implant Dentistry

Terry Spurlin, DDS • 615-953-2469

Dental History Checklist

Welcome! So that we may provide you with the best possible care, please complete both sides of this medical/dental history form. All information is completely confidential.

What is the reason for your visit today?		
Date of last dental visit:		Name, address and phone # of Previous Dentist:
Date of last dental cleaning:		
Date of last full-mouth x-ray:		
How often do you have dental examinations?	Brush your teeth?	Floss?
What other dental aids do you use (Interplak, toothpick, etc.)		
Do you have dental problems now?	If yes, please describe:	

Are any of your teeth sensitive to:

Hot or cold?	Yes	No
Sweets?	Yes	No
Biting or Chewing?	Yes	No
Have you noticed any bad odors or tastes?	Yes	No
Do you frequently get cold sores, blisters or any other oral lesions?	Yes	No

If yes, where? _____

Do You:

Clench or grind your teeth while asleep or awake ?	Yes	No
Bite your lips or cheeks regularly?	Yes	No
Hold foreign objects with your teeth (pencils, fingernails, etc.) ?	Yes	No
Mouth breathe while awake or asleep?	Yes	No
Have tired jaws, especially in the mornings?	Yes	No
Smoke or chew tobacco?	Yes	No

Have you ever had:

Orthodontic treatment?	Yes	No
Oral surgery?	Yes	No
Periodontal treatment?	Yes	No
Your teeth ground or the bite adjusted?	Yes	No
A bite plate or mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No

If so, describe: _____

Have You Experienced:

Clicking or popping of the jaw?	Yes	No
Pain (joint, ear, side of face) ?	Yes	No
Difficulty in opening or closing the mouth?	Yes	No
Difficulty in chewing on either side of the mouth?	Yes	No
Headaches, neck aches, or shoulder aches?	Yes	No
Sore muscles (neck, shoulders) ?	Yes	No

On a scale of 1- 10 how would you rate your smile? _____

Would you like to keep all of your teeth all of your life?	Yes	No
Do you feel nervous about having dental treatment?	Yes	No

If so, what is your biggest concern?_____

_____

_____

Have you ever had an upsetting dental experience?	Yes	No

If yes, describe: _____

Is there anything else about having dental treatment that you would like us to know?	Yes	No

If yes, describe: _____

_____

Music City Dental
Family, Cosmetic, and Implant Dentistry

705 Craighead
Nashville TN 37204

Phone: (615) 953-2469
Fax: (615) 953-2937

Office Policy and Consent Form

Please remember that we are here to serve you in a comfortable and professional atmosphere. Our goal is to provide you with the very best quality of dental care. Please carefully read and initial each paragraph, then sign and date the form at the bottom.

INSURANCE AND PAYMENT POLICIES

(____) **FEES FOR SERVICE AT OUR OFFICE WILL BE REQUESTED AT THE TIME OF YOUR VISIT**. For treatment involving fees above $500, special financial arrangements may be discussed with our office administrator.

(____) For patients with Dental Insurance:
Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. As a courtesy we will file your claim for you at no charge; however, your portion is due as services are rendered. Although we gladly file dental insurance claims as a courtesy to you, any and all account balances are ultimately your responsibility. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

(____) Please note, for your convenience, we do accept VISA, MasterCard, Discover and Care Credit as well as checks and cash.

OFFICE POLICIES

(____) Your appointment time is set aside especially for you. We ask for the courtesy to the Doctor and to other patients that you keep your scheduled appointments. **If you must change or miss an appointment, we require a 48-hour notice. Cancellations, last minute rescheduling or failure to show will result in a broken appointment charge of $40**, or no reappointment. If more than one family member is scheduled and fails to make their appointment, the $40 cancellation fee will be assessed for the first individual and $40 for each family member thereafter. This policy is strictly enforced due to our high volume of patients.

(____) Our office will provide confirmation calls and postcards to you. We ask that if we are unable to reach you, that you please contact us as soon as possible to confirm your appointment. Failure to do so may result in your appointment needing to be rescheduled.

(____) We realize that many families are in a state of change. The policy in our office is that the parent who requests treatment for a child is responsible to us for all fees incurred.

(____) We will be fair in working out special finances with you, but please also be fair to us with your commitments. A 1.5 % finance charge will be assessed monthly on all overdue balances.

CONSENT

I have read and understand all the above information. I hereby authorize the Doctor to perform those diagnostic and treatment procedures, including local anesthesia and sedation, deemed necessary. If I ever have any change in my health or change in my medication(s), I will inform the Doctor at the next appointment. For insured patients, my signature below authorizes assignment of insurance benefits to the Doctor and authorizes the release of dental records to my insurance company.

Date: _____ Signature: _____ ( ) Patient ( ) Parent ( ) Guardian

Music City Dental

Family, Cosmetic, and Implant Dentistry

Terry Spurlin, DDS (615) 953-2469

MEDICAL HISTORY

>>>Patient Name<<< >>>Date of Birth<<<

1. Have you been under the care of a medical doctor during the past two years for any illness, condition or surgery? ..... YES NO

   If yes, for what? _____

   _____

   Physician's Name Physician's Phone

2. Please list all prescriptions and over-the-counter medications that you take regularly. List name and dosage.

   _____ _____

   _____ _____

   _____ _____

   _____ _____

3. Are you aware of having an allergic (or adverse reaction) to any medication or substance? ..... YES NO

   If yes, please list: _____

4. Has your physician told you to take antibiotics before dental appointments? ..... YES NO

5. Indicate which of the following you have had, or have at present.

Heart (Surgery, Disease, Attack)	Yes	No	Ulcers	Yes	No	Hepatitis A (infectious) B (serum)	Yes	No
Chest Pain	Yes	No	Diabetes	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disease	Yes	No	Thyroid Problems	Yes	No	A.I.D.S.	Yes	No
Heart Murmur	Yes	No	Glaucoma	Yes	No	H.I.V. Positive	Yes	No
High Blood Pressure	Yes	No	Contact Lenses	Yes	No	Cold Sores/Fever Blisters	Yes	No
Mitral Valve Prolapse	Yes	No	Emphysema	Yes	No	Blood Transfusion	Yes	No
Artificial Heart Valve	Yes	No	Reflux	Yes	No	Hemophilia	Yes	No
Heart Pacemaker	Yes	No	Tuberculosis	Yes	No	Sickle Cell Disease	Yes	No
Rheumatic Fever	Yes	No	Asthma	Yes	No	Bruise Easily	Yes	No
Arthritis/Rheumatism	Yes	No	Hay Fever	Yes	No	Liver Disease	Yes	No
Cortisone Medicine	Yes	No	Latex Sensitivity	Yes	No	Osteoporosis	Yes	No
Sleep Apnea	Yes	No	Allergies or Hives	Yes	No	Neurological Disorders	Yes	No
Stroke	Yes	No	Sinus Trouble	Yes	No	Epilepsy or Seizures	Yes	No
Diet (Special/Restricted)	Yes	No	Radiation Therapy	Yes	No	Fainting or Dizzy Spells	Yes	No
Artificial Joints (Hip, Knee, etc.)	Yes	No	Chemotherapy	Yes	No	Nervous/Anxious	Yes	No
Kidney Disease	Yes	No	Tumors	Yes	No	Psychiatric/Psychological Care	Yes	No

6. Do you have or have had any disease, condition, or problem not listed? ..... YES NO

   If yes, please list: _____

7. **Women:** Are you: **Pregnant?** Yes, _____ months No **Nursing?** Yes No

   Taking Birth Control Pills? Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner, I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature _____ *Date* _____

We appreciate the opportunity to serve you and others whom you may refer as a result of your experience here. You will find us to be very open and straightforward regarding fees and treatment. Our desire is to provide you with the highest quality care available in a setting we believe is comfortable and technologically advanced. Modern dentistry can be a very pleasant experience!

Insurance

Our Policy
Regarding Dental Insurance

You are fortunate to have dental insurance, whether you have purchased it or your employer has provided it for you. Though your dental insurance is your responsibility we can help! We will go the extra mile to help you maximize your benefits. As a courtesy, we will help by filing your insurance forms, which will save you considerable time and trouble. We accept payments from most insurance companies, which reduces your immediate out-of-pocket expense.

Regardless of what we may calculate your insurance company to pay, it is only an estimate. Our estimate is based on limited information obtained from your insurance company. You must understand, we cannot forecast what they will pay.

We must stress that you are responsible for the total treatment fee. Your dental insurance is not designed to pay the entire cost of your treatment, but it is intended to help cover a certain portion of the cost. Better terms for dental insurance may be "dental assistance" or "dental benefits."

Please remember, however, the financial obligation for dental treatment is between you and this office, and is not between this office and your insurance company.

In order for us to obtain your insurance information for submiting your claim and/or discuss your situation directly with your insurance please complete the "Insurance Information Release Form" (attached) and return.

I have read and understand the above.

Print Patient Name	Patient Signature	Date

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

_____ _____

Please ***print*** name of Patient Please ***sign*** for Patient / Guardian of Patient

_____ _____

Legal Representative / Guardian Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents: _____

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

☐ First Name Only ☐ Proper Surname ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

□ Phone Message
□ Text Message
□ Email
☐ **Any of the Above**
☐ **None of the above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment ____
I could not communicate with the patient ____
The patient refused to sign ____
The patient was unable to sign because ____
Other (please describe) ___

_____
Signature of Privacy Officer