

NEW PATIENT INFORMATION

Last Name _____ First _____ Middle _____ Goes By _____
 Spouse Last _____ First _____ Middle _____ Goes By _____
 Social Security Number _____ Birthdate _____ Age _____
 Address _____ Apt # _____
 City _____ State _____ Zip _____
 Employer _____ Spouse Employer _____
 Home Phone _____ Preferred contact number: Cell Home Work
 Work Phone _____ Email _____
 Cell Phone _____ May we confirm your appointment by email? Yes No
 Sex: Male Female
 Marital Status: Single Married Divorced Separated Widowed
 Whom can we thank for referring you to us today? _____

RESPONSIBLE PARTY

If Patient is a Child, complete this section. Otherwise, skip to "Dental Insurance."

Relationship to Patient: Mother Father Grandparent Other: _____
 Last Name _____ First _____ Middle _____ Goes By _____
 Spouse Last _____ First _____ Middle _____ Goes By _____
 Social Security Number _____ Birthdate _____ Age _____
 Address _____ Apt # _____
 City _____ State _____ Zip _____
 Employer _____ Spouse Employer _____
 Cell Phone _____ Preferred contact number: Cell Home Work
 Home Phone _____ Email _____
 Work Phone _____ May we confirm your appointment by email? Yes No

DENTAL INSURANCE

Primary

Secondary

Name of Subscriber:	_____	_____
Relationship to Patient:	_____	_____
Subscriber SSN or ID#:	_____	_____
Subscriber Date of Birth:	_____	_____
Insurance Company:	_____	_____
Group & Policy Holder ID #:	_____	_____
Employer:	_____	_____

Do we have permission to contact your insurance company? Yes No

PAYMENT TODAY: Cash Check Visa/MC Care Credit Other:

By signing below, I acknowledge that the foregoing information I have provided is true and accurate. I agree that I will notify Southern Tennessee Endodontics at subsequent appointments if there are any changes in my information; for example, a change in phone number, address, or insurance.

Signature of **PATIENT** or **GUARDIAN** _____ DATE ____ / ____ / ____



MEDICAL HISTORY

Patient Name _____ Date of Birth ____/____/____

Although endodontic 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 are taking, could have an important interrelationship with the dental care you will receive. Thank you for answering the following questions to the best of your knowledge.

- 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: _____
Do you take, or have you taken, Phen-Fen or Redux? Yes No.....If yes, please explain: _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No.....If yes, please explain: _____
Are you on a special diet? Yes No.....If yes, please explain: _____
Do you use tobacco? Yes No.....If yes, type/frequency: _____
Do you use controlled substances? Yes No.....If yes, please explain: _____

Women Only Are you: Pregnant/Trying to Become Pregnant? Nursing Taking Oral Contraceptives?

Please mark all for which you have an ALLERGY: Penicillin Codeine Acrylic Metal Latex Aspirin
 Local Anesthetics Sulfa Drugs Other: _____

Do you now have, or have you ever had, any of the following? Please mark an X in the box of all that apply:
 AIDS/HIV Positive Chest Pains Frequent Headaches Irregular Heartbeat Scarlet Fever
 Alzheimer's Disease Cold Sores/Fever Blisters Genital Herpes Kidney Problems Shingles
 Anaphylaxis Congenital Heart Disorder Glaucoma Leukemia Sickle Cell Disease
 Anemia Convulsions Hay Fever Liver Disease Sinus Trouble
 Angina Cortisone Medicine Heart Attack/Failure Low Blood Pressure Spina Bifida
 Arthritis/Gout Diabetes Heart Murmur Lung Disease Stomach/intestinal Disease
 Artificial Heart Valve Drug Addiction Heart Pace Maker Mitral Valve Prolapsed Stroke
 Artificial Joint Easily Winded Heart Trouble/Disease Pain in Jaw Joints Swelling of Limbs
 Asthma Emphysema Hemophilia Parathyroid Disease Thyroid Disease
 Blood Disease Epilepsy or Seizures Hepatitis A Psychiatric Care Tonsillitis
 Blood Transfusion Excessive Bleeding Hepatitis B or C Radiation Treatments Tuberculosis
 Breathing Problem Excessive Thirst Herpes Recent Weight Loss Tumors or Growths
 Bruise Easily Fainting Spells/Dizziness High Blood Pressure Renal Dialysis Ulcers
 Cancer Frequent Cough Hives or Rash Rheumatic Fever Venereal Disease
 Chemotherapy Frequent Diarrhea Hypoglycemia Rheumatism Yellow Jaundice
Have you ever had any serious illness(es) not listed above? If yes, please explain: _____

Table with 2 columns: Current Medications (please list all) and Dosage and Frequency. Multiple empty rows for data entry.

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 or GUARDIAN _____ DATE ____/____/____



2130 N. Jackson St.
Tullahoma, TN 37388
T: 931.222.4222
F: 931.222.4223
www.southernendo.com

Cancelation and Rescheduling Policy

Thank you for choosing Southern Tennessee Endodontics for your dental care. We strive to provide the best service to all of our patients, and as such, we ask that all patients kindly provide us with a minimum of 24 hours notice to cancel or reschedule an appointment. We understand that emergencies occur, and we ask that if you cannot come to your appointment to please call us at 931-222-4222 to inform us so that we can accommodate another patient in need of endodontic treatment.

If we do receive a short notice cancelation less than 24 hours before the appointed time, we will require prepayment for any necessary treatment BEFORE scheduling another appointment. If an additional appointment is broken or rescheduled without adequate notice, a cancelation fee of \$50 will be applied to your account and the remainder of the pre-paid fee will be refunded by check to your home address. In addition, we will ask that you seek dental care elsewhere.

This policy is in place to protect our patients and to ensure that each patient receives his or her endodontic care in a timely manner. If you have any questions regarding this policy, please ask any of our staff prior to signing this form. If you require additional information or wish to file a complaint, you can find the information on how to do so below. Thank you.

Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your dental care, you may contact the Privacy Officer at:

Southern Tennessee Endodontics
Joshua Puckett, DMD
2130 N. Jackson St.
Tullahoma, TN 37388
T: 931.222.4222
F: 931.222.4223
www.southernendo.com

Your signature below is an acknowledgment that you have received and reviewed this Cancelation and Rescheduling Policy.

Signature: _____ Date: ____/____/____

Print Name: _____



Joshua Puckett, DMD

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Tullahoma, TN 37388
T: 931.222.4222
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www.southerntnendo.com

Financial Agreement

Thank you for choosing *Southern Tennessee Endodontics* for your dental needs. We provide a variety of payment options to help you receive the dental care you deserve. The purpose of this financial policy is to eliminate any confusion concerning financial arrangements offered by our office. We communicate this policy to each patient.

For our patients with insurance benefits, *Southern Tennessee Endodontics* is more than happy to prepare and submit dental insurance claims and/or assist in making insurance collections on the patient's behalf. For your convenience, we can submit your insurance claim and accept the assignments of benefits directly in our office. Because dental insurance companies will not divulge a patient's personal insurance arrangements, *Southern Tennessee Endodontics* can only **estimate** benefits to be paid *and does not guarantee payment*. **Any remaining balance not covered by the insurance company will be due within 30 days of service.** If you have questions regarding your dental benefits, please contact your insurance company directly.

The full cost of treatment is expected at the time of service. Treatment will continue only after financial arrangements have been made. The patient is responsible for all charges for dental services.

Payment options include **Cash, Check, Visa, MasterCard, Discover, and Care Credit.**

If financing is necessary for any portion of my balance, the Doctor offers Care Credit. It is my responsibility to arrange financing thru Care Credit, my bank, or other financial institution prior to treatment. The Doctor does not provide in-house financing.

My signature acknowledges that I have read, understand and agree to the account payment and collection policies of Southern Tennessee Endodontics covered in this Financial Agreement.

My signature also authorizes my dental insurance company to pay the Doctor directly on all insurance submissions made on my behalf. I understand that any remaining balance after insurance has paid will be due and payable within 30 days of service. In the event of a default, I agree to pay legal interest on the indebtedness, together with such collection costs, collection agency fees, and reasonable attorney fees as may be required to effect collection of any balance due.

Signature: _____ Date: ____/____/____

Print Name: _____



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Consent for Endodontic (Root Canal) Therapy

1. The purpose of root canal therapy is to retain a tooth that would otherwise require extraction.
2. Treatment will require the use of anesthetics, a series of diagnostic radiographs (x-rays), and may require multiple visits/appointments. *Please Note: Dr. Puckett will not be responsible for complications resulting from incomplete treatment if the patient fails to have treatment completed within two months of treatment start date.
3. In most cases, there is only a mild discomfort after treatment. This discomfort can usually be controlled with Tylenol®, Motrin®, or other prescribed medications.
4. Endodontic Treatment has a high degree of success (approx. 90-95%), but as with any medical or dental treatment, there is no guarantee of success or outcome. Occasionally, a tooth which has had root canal therapy may require retreatment, surgery, or even extraction.
5. Accurate and complete disclosure of medical history and information is necessary for proper diagnosis, and to help prevent unnecessary complications during treatment.
6. The most common complications with root canal therapy include, but are not limited to:
 - Continued infection requiring endodontic surgery or extraction of the tooth.
 - Calcified (narrowed) canals or canals blocked by separated instruments requiring root canal surgery or extraction of the tooth.
 - Pain requiring the use of medications.
 - Side effects and possible reactions to medications.
 - Fracture of the root or crown of the tooth during or after treatment. It is recommended that all posterior (back) teeth be crowned after root canal treatment. If the tooth already has a crown, there is a chance it will need to be replaced due to decay or loss of structural support. Also, porcelain crowns are subject to breakage.
 - Tenderness of the tooth following treatment; due to possible complications with root canal treatment, gum disease, physical stress from chewing, or the degree of healing your body exhibits
7. Other treatment choices include: no treatment, waiting for definite development of symptoms, or a tooth extraction. Risks involved with these choices may include: pain, infection, swelling, loss of teeth, and possible infection in other areas.
8. If you have any questions please ask prior to signing this form or proceeding with your treatment.

I have read and understand the above information, understand the possible risks involved, and hereby consent to treatment.

Signature: _____ Date: ____/____/____

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Southern Tennessee Endodontics is required by law to maintain the privacy of your protected health information (PHI) and to provide individuals with notice of its legal duties and privacy practices currently in effect with respect to PHI. This Notice describes how we may use and disclose your PHI for treatment, payment, and for health care operations as well as for other purposes that are permitted or required by law. 45 CFR § 164.520.

Southern Tennessee Endodontics reserves the right to change the terms of this Notice and make the new notice provisions effective for all the PHI we maintain. If Practice makes a material change to this Notice, we will post the changes promptly. A paper copy of this Notice is available upon request.

Effective Date

This Notice of Privacy Practices became effective on April 14, 2003 and was amended on September 21st, 2011.

Types of Uses and Disclosures of your PHI

"Treatment" - We will use and disclose your PHI to provide, coordinate or manage your dental health care and any related services. We will also disclose PHI to other providers who may be treating you such as a specialist.

"Payment" - We will use your PHI to obtain payment for the dental health care services provided. For example, we may provide information to a health insurance company or business associate to obtain payment for the treatment provided for you.

"Healthcare Operations" - We will use your PHI to support the management of our dental office. For example, we may use information about you to conduct quality performance reviews regarding our services or the performance of our staff. Additionally, we may obtain services from business associates such as training programs, legal services and insurance.

HITECH Amendments

HITECH Act Breach Notification Requirements: The HITECH Act requires us to notify each individual whose unsecured PHI has been, or is reasonably believed to have been accessed, acquired or disclosed due to a breach. The HITECH Act imposes a similar requirement on Business Associates. "Unsecured PHI" refers to PHI that is not secured through the use of technologies or methodologies that render the PHI unusable, unreadable, or indecipherable to unauthorized individuals.

Restriction of Disclosure: The HITECH Acts restricts us from refusing an individual's request not to use or disclose the individual's PHI in instances where the patient's services were paid out of pocket to prevent the information from flowing to the health plan since no claim is being made against the third party payer.

Access to Electronic Health Records (EHRs): The HITECH Act expands the right of records access. Individuals have the right to access their EHR in an electronic format and to direct us to send the e-record directly to a third party. We may only charge for the labor costs to transfer this information.

Expansion of Accounting of Disclosures: The HITECH Act removed the accounting of disclosures exception of PHI to carry out treatment, payment and healthcare operations. All such disclosures must be accounted for if the disclosure is made through an EHR. We also will provide the individual with a list and contact information for all relevant business associates to obtain an accounting of disclosures of PHI.

Prohibition on Sale of PHI: The HITECH Act prohibits covered entities and business associates from receiving indirect or direct remuneration in exchange for PHI without obtain an authorization from the individual unless such an exchange meets one of the exceptions listed by the government.

Southern Tennessee Endodontics Responsibilities

Certain Uses or Disclosures: We will use and disclose your PHI when required to by federal, state or local law.

Appointment Reminders: We may contact you to provide appointment reminders via telephone or post cards. We may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Revocation: Other uses and disclosures will be made only with your written authorization and you may revoke such authorization.

Public Health & Safety: We will use and disclose your PHI to public health authorities permitted to collect or receive information for the purpose of controlling disease, injury or disability.

Individual Rights

Request Restriction of Disclosures: You have the right to request restrictions on certain uses and disclosures of PHI and under HIPAA, Southern Tennessee Endodontics is not required to agree to the restriction unless as clarified by defined by the HITECH Act.

Right to Receive Confidential Communications: You have the right to receive confidential communications. Please specify your preference of communication in writing to us such as your home telephone, work telephone, mobile telephone, and / or email. We may provide relevant portions of your PHI to a family member, relative, close friend or any other person you identify as being involved in your dental care or payment.

Right to PHI: You have the right to inspect and copy the PHI that we maintain about you in our designated record set for as long as we maintain the information. We may charge a fee for the costs of copying, mailing or other supplies used in fulfilling your request. Please contact the Privacy Officer to inspect your record or receive a copy.

Right to Amend: You have the right to request that we amend your health information if you feel it is incomplete or inaccurate. You must make the request in writing to our Privacy Officer stating the reasoning that supports your request. We may deny the request if the information was not created by our office or if the person who created it is no longer available to make this amendment.

Right to Accounting: You have the right to receive an accounting of disclosures of your health information as required by law. Please submit a written request to our Privacy Officer.

Right to Paper Copy: You have a right to obtain a paper copy of the Notice of Privacy Practices.

Request Information or File a Complaint

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Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our Practice. You may also file a complaint with the Secretary of Health and Human Services at:

U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, SW
Room 515 FHHH Building
Washington, D.C. 20201
www.hhs.gov/ocr

Your signature below is an acknowledgment that you have received and reviewed this Notice of our Privacy Practices.

Signature: _____ Date: ____/____/____

Print Name: _____