COMPREHENSIVE DENTISTRY, PLLC

Patient's Name: _____
Last, First, M.I. (Preferred Name)

Home Address: _____
Street Apartment # City State Zip Code

Date of Birth:____/____/____ Social Security #:_____-____-_____ Home Phone: _____

Mobile Phone: _____ E-mail: _____

Gender: ❑ Male ❑ Female Family Status: ❑ Single ❑ Married ❑ Child ❑ Other: _____

Employment or School Info.

Current Employer Name: _____ Employer's Phone: _____

Employer's address: _____

Job Title: _____

Whom may we contact in case of an emergency? _____ Phone: _____

Emergency contact's relationship to patient? _____ Alternate Phone: _____

Whom may we thank for referring you to our practice? _____

If the patient listed above is under the age of 18 please provide responsible parent or guardian information in this area.

Responsible Parent or Guardian Name: _____
Last, First, M.I. (Preferred Name)

Home Address: _____
Street Apartment # City State Zip Code

Date of Birth:____/____/____ Social Security #:_____-____-_____ Home Phone: _____

Mobile Phone: _____ E-mail: _____

Please sign

I certify that all of the preceding answers and information provided are true and correct. If I ever have any change in my personal information, I will inform the office at the next appointment without fail.

Signature in full: _____ Today's Date:____/____/____

If signed by a personal representative on behalf of the patient, complete the following:
Personal representative's name: _____
Relationship to patient: _____

Continued on the Other Side...

COMPREHENSIVE DENTISTRY, PLLC

Patient Account Agreement

One of our goals is to help you understand all aspects of your treatment, including your financial responsibilities. Please take a moment to familiarize yourself with our *Financial Policies*.

SECTION A: FINANCIAL POLICIES

PAYMENT:

Please select your method(s) of payment:

- ❑ Cash, Check, or Debit Card
- ❑ Credit Card
- ❑ Insurance (*Additional Form Required*)
- ❑ CareCredit

COLLECTIONS:

An outside collections agency is contracted for delinquent accounts. Accounts over 90 days past due and slow-pay accounts are considered delinquent, however, an account can be turned over to collections at any time. You are responsible for any service charges, collection fees, attorney fees, or court costs related to the collections process.

Full name of the person responsible for this account: _____

Broken appointments creates scheduling problems for our other patients. If you need to change your appointment, you must call two business days in advance. There is a fee for short-notice changes to appointments, cancellations, and no-shows. _____ (*initial*)

➢ I understand treatment plans and fee estimates for dental care can only be extended for six months.

➢ I grant permission to you or your assignee to contact me at home or at my work to discuss matters related to my treatment or account status.

➢ I understand I will be charged and agreed to pay a fee up to $50.^{00}$ on any returned checks.

➢ I understand I will be charged and agreed to pay a 1.5% monthly service charge on any balance exceeding 30 days.

SECTION B: ACKNOWLEDGMENT AND ACCEPTANCE OF FINANCIAL POLICIES

I have read and understand the all of the above information and agree to their content. I also understand that I am ultimately responsible for payment of my account.

Signature in full: _____ Date: _____

printed name: _____

Patient's Name: _____

COMPREHENSIVE DENTISTRY, PLLC

Date of Birth: ____/____/____

DENTAL HISTORY

Reason for this visit: _____ How often do you brush? _____
When was your last dental visit? _____ How often do you floss? _____
What texture toothbrush do you use? ❑ HARD ❑ MEDIUM ❑ SOFT ❑ EXTRA-SOFT
How much soda do you drink on an average day? _____

Do your gums bleed while brushing or flossing?	Yes ❑ No ❑	Have you ever had any head, neck or jaw injuries?----------	Yes ❑ No ❑
Are your teeth sensitive to hot or cold?----------	Yes ❑ No ❑	Do you clinch or grind your teeth?----------	Yes ❑ No ❑
Are your teeth sensitive to sweet?----------	Yes ❑ No ❑	Have you ever had: Orthodontic treatment?----------	Yes ❑ No ❑
Do you have any loose teeth?----------	Yes ❑ No ❑	Oral surgery?----------	Yes ❑ No ❑
Do you have any sores or lumps in or	Yes ❑ No ❑	Gum treatment?----------	Yes ❑ No ❑
around your mouth?----------	Yes ❑ No ❑		
Have you ever experienced: Jaw pain?----------	Yes ❑ No ❑	Do you wear a denture or retainer?----------	Yes ❑ No ❑
Clicking in your jaw?----------	Yes ❑ No ❑	Are you satisfied with the appearance of your smile?-------	Yes ❑ No ❑
Difficulty opening or closing?----------	Yes ❑ No ❑	Have you ever had a bad experience in a dental office?----	Yes ❑ No ❑
		Do you have any concerns you would like us to address?--	Yes ❑ No ❑

MEDICAL HISTORY

Have you been hospitalized within the past 2 years?---------- Yes ❑ No ❑
Do you use tobacco?---------- Yes ❑ No ❑
Are you allergic or have reactions to:
Local aesthetics(i.e., Novocain)?---------- Yes ❑ No ❑
Penicillin or other antibiotics?---------- Yes ❑ No ❑
Sulfa drugs?---------- Yes ❑ No ❑
Latex?---------- Yes ❑ No ❑
Other: _____ Yes ❑ No ❑

Do you have a condition that requires pre-medication of antibiotics before dental treatment:---------- Yes ❑ No ❑
If yes, please explain:
_____

Do you have any disease, condition, problem or concern not listed on this form that need further clarification?---------- Yes ❑ No ❑
If yes, please explain: _____
_____
_____

Do you have any of the following? or ever had

Acid Reflux	Yes ❑ No ❑	Hepatitis------	Yes ❑ No ❑	Kidney Disease----	Yes ❑ No ❑
AIDS/HIV----	Yes ❑ No ❑	High Blood		Liver Disease------	Yes ❑ No ❑
Allergies------	Yes ❑ No ❑	Pressure-------	Yes ❑ No ❑	Mental Disorder---	Yes ❑ No ❑
Anemia--------	Yes ❑ No ❑	Hearing		Migraines----------	Yes ❑ No ❑
Arthritis-------	Yes ❑ No ❑	Impaired------	Yes ❑ No ❑	Nervous Disorder-	Yes ❑ No ❑
Artificial Joints	Yes ❑ No ❑			Radiation/Chemo	
Asthma--------	Yes ❑ No ❑			Treatment-------	Yes ❑ No ❑
Cancer---------	Yes ❑ No ❑			Respiratory	
Diabetes-------	Yes ❑ No ❑			Problems--------	Yes ❑ No ❑
Dizziness------	Yes ❑ No ❑			Scarlet/Rheumatic	
Epilepsy-------	Yes ❑ No ❑			Fever----------	Yes ❑ No ❑
Heart Disease	Yes ❑ No ❑			Seizures----------	Yes ❑ No ❑
Heart Murmur	Yes ❑ No ❑			Sinus Problems----	Yes ❑ No ❑
				Stomach Problems	Yes ❑ No ❑
				Stroke----------	Yes ❑ No ❑
				Vision impairment--	Yes ❑ No ❑
				For women:	
				Are you or do you think you may be pregnant?----------	Yes ❑ No ❑

List all medicines you have taken in the past 30 days and *what the medication is for* (include non-prescription drugs and vitamins) _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct.
If I ever have any change in my health, I will inform the office at the next appointment without fail.

Signature in full: _____ Today's Date: _____

Continued on the Other Side

COMPREHENSIVE DENTISTRY, PLLC

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Full Name: _____

Date of Birth: _____ Last 4 digits of Social Security Number: _____

SECTION B: TO THE PATIENT - PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:
Contact Person: Dr. Johnna Shockley E-mail: office@drjohnna.com
Phone: (865)947-9890 Fax: (865)947-9895 Address: 1340 E. Emory Rd, Knoxville, TN 37938

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SECTION C: SIGNATURE

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature in full: _____ Today's Date: ____/____/____

If signed by a personal representative on behalf of the patient, complete the following:

Personal representative's name: _____

Relationship to patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

COMPREHENSIVE DENTISTRY, PLLC

To better serve our patients with dental insurance, we accept *Assignment of Benefits* to cover charges to your account if the Insured completely fill out this form.

A NOTE ABOUT YOUR DENTAL INSURANCE

Please note, the practice of Dr. Johnna JC Shockley is structured to focus on patient care, not insurance contracts. Please remember that you are ultimately responsible for your account. We urge you to read your Dental Policy so that you are fully aware of any coverage limitations or exclusions.

Most often, your dental plan is provided to you through a contract between your employer and an insurance company. These two companies negotiate the terms of your policy. Your employer chooses how much coverage you have and the type of covered services, co-pay percentages, deductibles, and the maximum annual benefit.

Our top priority is to give you the highest possible quality of care that you choose; however, your dental plan may not cover some procedures. Treatment exclusions are a part of every dental plan. We try to help you understand your treatment and use your dental coverage. As a courtesy, we generate all claim forms and submit them electronically to ensure the fastest turnaround possible. Upon your request, we can submit a *Pre-Treatment Estimate* to specify your co-payments for any proposed treatment.

Dental Insurance Information for the ***PRIMARY POLICY HOLDER*****:**

Full Name: _____ Social Security #: _____

Home Address: _____ Date of Birth: _____

Employer: _____ Insurance Company: _____

Member/Subscriber # _____ Group #: _____

Covered Dependents:	*Date of Birth:*	*Relationship to Insured:*
_____	_____	❑ Self ❑ Spouse ❑ Child ❑ Other
_____	_____	❑ Self ❑ Spouse ❑ Child ❑ Other
_____	_____	❑ Self ❑ Spouse ❑ Child ❑ Other
_____	_____	❑ Self ❑ Spouse ❑ Child ❑ Other

TERMS AND CONDITIONS

_____ Co-pays and deductibles must be paid in full on the day of service.

_____ *Pre-Treatment Estimates* are recommended for treatment plans in excess of $300.

_____ You are responsible for all fees. This includes, but is not limited to deductibles, co-payments and non-covered services.

***As of March 18, 2016 our office is only In-Network with Delta Dental, Cigna DPPO Radius network, Principal PPO and the following Blue Cross Blue Shield of Tennessee plans--BlueChoice HMO, Preferred Dental LP and BlueCarePlus.

However, with so many plans available today we may not participate in every one. If we are not a participating provider on your plan and you choose to be seen in our office, your benefits may be reduced or eliminated completely.

I certify that all of the preceding information is true and correct. If I ever have any change in my personal, employment or insurance information, I will inform the office at the next appointment without fail. I hereby authorize Comprehensive Dentistry, PLLC to submit any necessary insurance claims for me and to directly accept payment of benefits.

Signature in full: _____ Date: _____

Printed name: _____

COMPREHENSIVE DENTISTRY, PLLC

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate

or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. Request must be made in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may request that we provide copies in a format other than photocopies and we will use the format you request unless we cannot practicably do so. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. We charge you a reasonable cost-based fee for expenses such as copies and staff time. If you request copies, we charge you *$1.50* for each page, *$10.00* for each x-ray, *$25.00* per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. Your request for additional restrictions must be in writing. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. {You must make your request in writing.} Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Dr. Johnna J.C. Shockley
Telephone: (865) 947-9890 Fax: (865) 947-9895
E-mail: office@drjohnna.com
Address: 1340 E. Emory Road, Knoxville, TN 37938