7518 Hwy 70 S, Ste B
Nashville, TN 37221
(615) 669-2780

7186 Nolensville Rd., Ste B
Nolensville, TN 37135
(615) 669-5485

Patient Registration Form

Name: ______________________________ Home Phone: __________________ Cell Phone: __________________

Address: ____________________________ City: ___________________ State: ____ Zip: ____________________

Social Security: ______________________ Birthdate: _______________ Email: _____________________________

Employer: ____ Work Phone: _____________________________

Check One: Minor Single Married Other

Patient Emergency Contact Information

Name ______________________________ Relationship: ____________________ Phone: ___________________

Responsible Party (If under the age of 18)

Name: ____________________________________ Relationship to Patient: _________________________

Address:___________________________________ Birthdate: ____________________________________

Phone: _______________________________ Employer: ____________________________________

Office Payment Policy

As a courtesy we will submit dental insurance, but we cannot accept the responsibility for collecting insurance payments or for negotiating a dispute claim. Insurance is a contract between the patient and the insurance carrier. Even though you may be covered by dental insurance, there will be a co-pay due on the day of your visit. You can expect either an overpayment refund or a bill for the uncovered portion of the insurance payment after our office has received it, since it is not possible to predict the exact amount of the insurance payment prior to the initiation of treatment. Please initial here that you have read and understand this policy _____________

The best doctor-patient relationships are maintained when there is complete understanding of the treatment rendered and the fee. Please initial here that you have read and understand this policy _____________

For convenience we offer the following methods of payment: Please check your intended method of payment:

Credit/Debit Card Personal Check Cash GreenSky *subject to approval*

DENTAL INSURANCE (Please inform the front desk if you have secondary dental insurance)

Subscriber Name : _______________________________________ Relationship to patient:______________________

Date of Birth: _______________________________________ Social Security Number: ________________________

Name of Employer: _________________________________ Work Phone: _________________________________

Insurance Company: ________________________________ Phone Number: _______________________________

Group Number : _________________________________ Subscriber ID Number: ______________________________

Insurance Company Address:____

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Release of Information

I authorize release of any information relating to this insurance claim. I understand that my dental insurance may pay less than the actual bill for services. I agree to be responsible for the payment of all services rendered on my behalf or my dependents. I authorize and request my dental insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.

Consent for Use and Disclosure of Health Information: We take our patients' health information privacy seriously, and we will make every effort to protect that information. It is our policy that we only disclose patient health information about treatment, payment, and healthcare operations. Any other disclosure of healthcare information would require a written authorization except for communication to the referring general dentist or other medical/dental specialist directly involved in your treatment.

____ _____________________

Signature of Patient, Parent, or Guardian Date

You may refuse to sign this acknowledgment

May we leave a voicemail message for you on your personal phone with information regarding billing, treatment estimates, and upcoming appointments? Yes / No

May we leave messages concerning your appointment/treatment with a co-worker or receptionist? Yes / No

Please list family/friends below that we may discuss your appointment/treatment with:

Name: _________________________________ Relationship: ______________________________
Name: _________________________________ Relationship: ______________________________

____ _____________________

Signature of Patient, Parent, or Guardian Date

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Patient Medical History

Date: _______________ Referring Dentist: ____

Patient Name: ____

Date of Birth: ___________________________ Age: _________________ Gender: Male / Female

List All Current Medications (Prescribed and OTC): ____

____

List All Drug Allergies (Medications, Environmental, Foods): ____

____

Are you allergic or sensitive to latex or rubber gloves? . . . . YES NO

Have you ever had an adverse reaction to local anesthetic? . . . . YES NO

Have you ever had any excessive bleeding requiring special treatment? . . . . YES NO

Circle any of the following, which you have had or currently have:

AIDs	Cold Sores	Heart Attack	Mitral Valve Prolapse
Allergies or Hives	Colitis	Heart Murmur	Pain in Jaw
Anemia	Cortisone Medications	Hemophilia Dru	Psychiatric Treatment
Angina Pectoris	Diabetes Type I	Drug Addiction	Radiation Therapy
Arthritis	Diabetes Type II	Hepatitis – Type___	Rheumatic Fever
Artificial Joint	Emphysema	High Blood Pressure	Sinus Troubles
Asthma	Epilepsy or Seizures	HIV	Stroke
Blood Transfusion	Fainting or Dizzy Spells	Kidney Issues	Thyroid Disease
Cancer	Glaucoma	Liver Disease	Ulcers
Chemotherapy	Hay Fever	Migraines	Venereal Disease

Do you have any disease or condition not listed? ____

WOMEN: Are you pregnant: YES NO If so, how many weeks? _______________________

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the office without fail.

____ ____________________

Signature of Patient, Parent, or Guardian Date

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Patient HIPAA Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Information Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you, Elite Endodontics, to use and disclose my protected health information to carry out the following:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payer (e.g. my insurance company);
- The day-to-day healthcare operations of Elite Endodontics healthcare practice

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operation, and that you are then bound to comply with this restriction.

I understand that I may revoke this consent in writing, at any time. However, any use of disclosure that occurred prior to the date I revoke this consent is not affected.

Patient/ Legal Guardian Printed Name: ____

Patient/ Legal Guardian Signature: ____

Relationship to Patient: ____________________________ Date: _________________

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Financial Policy

Thank you for considering Elite Endodontics for your treatment. We pride ourselves in patient-centered care. In our continuing efforts to provide comprehensive dentistry to you, our valued patients, we ask that you become acquainted with our financial policy. If at any time you have any questions, please feel free to ask one of our team members, so that we may better serve you. All recommended treatments are in the best interest of our patients. We will assist you in your payment options to help you receive the highest quality of dental care treatment that is necessary for your needs.

Dental Insurance

We accept assignment of estimated insurance benefits as a courtesy to our patients. Please note that your dental insurance is a contract between you and the insurance company. Our usual and customary fees, which are based on geographical area, are a reflection of our commitment to excellence. All estimated co-pays and deductibles are due at the time of service. Balances remaining after 60 days will begin to accrue a finance charge of 1.5% from the date of service on the unpaid balance of your account. In the event that insurance does not cover your treatment or is cancelled/terminated for any reason, or cannot be verified for any reason, the patient or responsible party will be responsible for the entire fee amount including the insurance portion.

Emergency Patients

Please note that our policy required verification of insurance. In the event that we are not able to verify your insurance information, payment will be due at the time of service. We will assist you in submitting a claim to your insurance company, so that the insurance company will reimburse you directly for your treatment. If the insurance payment is sent to our dental center, any applicable credit will be refunded to the patient.

Appointments Cancellation Policy

We reserve appointment times especially for you and your dental care needs. We strive to give each patient a courtesy call one to two days in advance of their scheduled visit. However, you are expected to keep your appointment time with or without our courtesy call. Therefore, we ask kindly ask that you give 24-hour notice if you are unable to keep your appointment. **Please note that if 24-hour notice is not given, there may be a $75 broken appointment fee**. A broken appointment is a loss to yourself, your dentist, and to another patient who could have had that appointment time. **We reserve the right to terminate your relationship with our office after 2 (two) or more broken appointments without 24-hour notice.**

Patient Identification

We require a **picture** I.D. for all patients over the age of 18. We also require permission for treatment for patient's guardian if under 18 years of age.

See Next Page →

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Method of Payment

For your convenience we accept Cash, ATM/Check cards and all Major Credit Cards (American Express, MasterCard, Visa, Discover), and Checks (with proper I.D.). There will be a fifty dollar ($50) returned check fee applied to your account in the event your check is denied by the bank. Payment will be expected within 48 hours of notice from the bank, in cash or by credit card. As an added courtesy, we also offer a revolving line of credit through a third party (upon credit approval). This line of credit allows you to start treatment today and spread payments over a comfortable period of time.

*Our fees are explained and disclosed prior to receiving any treatment plan or services. Our fees are reasonable and commensurate with the knowledge, skill, experience and service provided by our dentist and staff.

Deposit

We may require a deposit to be made to hold any appointment time.

Refund Policy

1. Once Services are performed, refunds cannot be made for those services.
2. All electronic payments will be refunded within **ten (10) business days**.
3. All cash and check payments will be refunded, by company check, within **thirty (30) business days**.
4. A "Release of Claims" form must be singed before refunds are issued.

Agreement to pay

In the event there is a default of payment on any balance due, Elite Endodontics will make all necessary collection efforts to secure the balance due. This may include reporting a delinquency to a credit report agency and taking legal action. Any additional costs incurred will be charged to the patient or responsible party.

By signing for, and accepting this policy, I understand that I am entering into a contractual relationship with Elite Endodontics for professional care and that I am ultimately responsible for all fees incurred for my treatment regardless of payment or denial of my insurance claims(s) by my insurance company.

I have read, understand, and agree to all stated within the Financial Agreement.

Patient Printed Name: ____

Patient Signature: ____ Date: ____________________