Gealon A Thomas, DDS, PLLC
Thomas Family Dentistry
111 Peacock Court, Seymour, TN 37865
(865) 573-0274

DATE: _____

ABOUT YOU

_____ _____ _____ _____
Patient Last Name | Patient First Name | MI | Preferred Name

Date of Birth: ____/____/____ Age: _____ SSN: ____-____-____ Male ◯ Female ◯

Mailing Address: _____ _____ _____ _____
Street Name/Number | City | State | Zip Code

Phone Number: _____ _____ _____ _____
Home | Cell | Work | Email Address

Employer: _____ How Long: _____

Status: Minor ◯ Single ◯ Married ◯ Divorced ◯ Separated ◯ Widowed ◯

Spouses Name: _____ Number of Children: _____

EMERGENCY CONTACT INFORMATION

Whom should we contact: _____ Relation: _____
Phone Number(s): _____ _____
Name of Medical Doctor: _____ Phone Number: _____

ACCOUNT INFORMATION

Person Responsible for Account:
Name: _____ Relationship to Patient: _____
Billing Address: _____ _____ _____ _____
Street Name and Number | City | State | Zip Code

SSN: _____-_____-_____ Driver's License Number: _____ Issuing State: _____

_____ ***I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company/provider***

INSURANCE INFORMATION

Primary Dental Insurance:
Company Name: _____ Phone Number: _____
Address: _____ _____ _____ _____
Street Name and Number | City | State | Zip Code

Insured's Name: _____ ID Number/SSN: _____ Date of Birth: _____
Employer: _____ Group Number: _____ Relationship to Patient:_____

Secondary Dental Insurance:
Company Name: _____ Phone Number: _____
Address: _____ _____ _____ _____
Street Name and Number | City | State | Zip Code
Insured's Name: _____ ID Number/SSN: _____ Group Number_____

GEALON A THOMAS, DDS, PLLC

Medical History

Patient Name: _____ Date of Birth: _____ Date: _____

Although dental personnel primarily treat the area in and around the mouth, the mouth is a part of the entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯Yes ◯No If yes
Have you ever been hospitalized or had a major surgery? ◯Yes ◯No If yes
Have you ever had a serious neck injury? ◯Yes ◯No If yes
Are you taking any medications, pills or drugs? ◯Yes ◯No If yes

Do you take, or have you taken, Phen-Fen or Redux? ◯Yes ◯No
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯Yes ◯No If yes, when? _____
Are you currently on a special diet? ◯Yes ◯No If yes, please explain: _____
Do you use tobacco products? ◯Yes ◯No

WOMAN: Are you: ◯ Pregnant or trying to get pregnant? ◯ Nursing?

Are you allergic to any of the following:

◯ Aspirin ◯ Penicillin ◯ Codeine ◯ Acrylic ◯ Metal ◯ Latex ◯ Sulfa Drugs
◯ Local Anesthetics ◯ Other - Please Explain: _____

Do you use controlled substances? ◯ Yes ◯ No If yes, please explain: _____

Do you have or have you had any of the following:

AIDS/HIV Positive	◯Yes ◯No	Emphysema	◯Yes ◯No	Hypoglocemia	◯Yes ◯No	Spina Bifida	◯Yes ◯No
Alzheimer's Disease	◯Yes ◯No	Epilepsy or Seizures	◯Yes ◯No	Irregular Heartbeat	◯Yes ◯No	Stomach/Intestinal	
Anaphylaxis	◯Yes ◯No	Excessive Bleeding	◯Yes ◯No	Kidney Problems	◯Yes ◯No	Disease	◯Yes ◯No
Anemia	◯Yes ◯No	Excessive Thirst	◯Yes ◯No	Leukemia	◯Yes ◯No	Stroke	◯Yes ◯No
Arthritis/Gout	◯Yes ◯No	Fainting/Dizziness	◯Yes ◯No	Liver Disease	◯Yes ◯No	Swelling of	
Artificial Heart Valve	◯Yes ◯No	Frequent Diarrhea	◯Yes ◯No	Low Blood Pressure	◯Yes ◯No	Limbs	◯Yes ◯No
Artificial Joint	◯Yes ◯No	Frequent Headaches	◯Yes ◯No	Lung Disease	◯Yes ◯No	Thyroid	
Blood Disease	◯Yes ◯No	Genital Herpes	◯Yes ◯No	Mitral Valve Prolapse	◯Yes ◯No	Disease	◯Yes ◯No
Blood Transfusion	◯Yes ◯No	Glaucoma	◯Yes ◯No	Osteoporasis	◯Yes ◯No	Tonsillitis	◯Yes ◯No
Breathing Problems	◯Yes ◯No	Hay Fever	◯Yes ◯No	Pain in Jaw Joints	◯Yes ◯No	Tuberculosis	◯Yes ◯No
Bruise Easily	◯Yes ◯No	Heart Attack/Failure	◯Yes ◯No	Parathyroid Disease	◯Yes ◯No	Tumors or	
Cancer	◯Yes ◯No	Heart Murmur	◯Yes ◯No	Psychiatric Care	◯Yes ◯No	Growths	◯Yes ◯No
Chemotherapy	◯Yes ◯No	Heart Pacemaker	◯Yes ◯No	Radiation Treatments	◯Yes ◯No	Ulcers	◯Yes ◯No
Chest Pains	◯Yes ◯No	Heart Trouble	◯Yes ◯No	Recent Weight Loss	◯Yes ◯No	Venereal	
Cold Sores/Fever Blisters	◯Yes ◯No	Hemophilia	◯Yes ◯No	Renal Dialysis	◯Yes ◯No	Disease	◯Yes ◯No
Congenital Heart Disorder	◯Yes ◯No	Hepatitis A	◯Yes ◯No	Rheumatic Fever	◯Yes ◯No	Yellow	
Convulsions	◯Yes ◯No	Hepatitis B or C	◯Yes ◯No	Rheumatism	◯Yes ◯No	Jaundice	◯Yes ◯No
Cortisone Medicine	◯Yes ◯No	Herpes	◯Yes ◯No	Scarlet Fever	◯Yes ◯No		
Diabetes	◯Yes ◯No	High Blood Pressure	◯Yes ◯No	Shingles	◯Yes ◯No		
Drug Addiction	◯Yes ◯No	High Cholesterol	◯Yes ◯No	Sickle Cell Disease	◯Yes ◯No		
Easily Winded	◯Yes ◯No	Hives or Rash	◯Yes ◯No	Sinus Trouble	◯Yes ◯No		

Have you ever had a serious illness not listed above: ◯ Yes ◯ No If yes, please explain: _____
Comments:

_____

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.

X _____
PATIENT SIGNATURE

RELATIONSHIP TO PATIENT: ◯ Self ◯ Parent ◯ Guardian ◯ Legal Representative

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____ SSN: _____-_____-_____ Date: ____/____/_____

TO THE PATIENT – PLEASE READ THE FOLLOWING:

PURPOSE OF CONSENT: I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). By signing this consent, I am authorizing you 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);
- Obtain payment from third party payers (ie: my insurance company);
- Day-to-day healthcare operations of your practice.

NOTICE OF PRIVACY PRACTICES: You have the right to read our ***Notice of Privacy Practices*** prior to signing this consent. Our notice provides a description of our treatment, payment activities, healthcare operations, the uses and disclosures we may make of your protected health information and the other important matters concerning your protected health information. A copy of our privacy practices is provided with this consent. We reserve the right to change our privacy practices as described in our *Notice of Privacy Practices*. Should we change our privacy practices, we will issue a revised notice which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

ACKNOWLEDGEMENT OF CONSENT AND RECEIPT:

I have had full opportunity to read and consider the contents of this consent. I understand that, by signing this form, I am granting my consent to your use and disclosure of my protected health information. I also understand that I may revoke my consent to disclose my protected health information at any time and that such request should be sent in writing to the office of Gealon A Thomas, DDS PLLC/Thomas Family Dentistry.

I wish to obtain a hard copy of this office's ***Notice of Privacy Practices*** ◯ **Yes** ◯ **No**

X _____

PATIENT SIGNATURE

RELATIONSHIP TO PATIENT: ◯ Self ◯ Parent ◯ Guardian ◯ Legal Representative

GEALON A THOMAS, DDS, PLLC
FINANCIAL POLICY

Gealon A Thomas, DDS, PLLC/Thomas Family Dentistry is referred to as "We", "Us", "Our"

Thank you for choosing Gealon A Thomas, DDS, PLLC/Thomas Family Dentistry as your dental provider. We are committed to your treatment being successful. Please understand that payment for services is considered part of your treatment. The following is a statement of our Financial Policy which we require you to read and sign prior to treatment.

Payment is expected at the time services are rendered. We accept Visa, Mastercard, American Express, Discover, Checks and Cash. We also offer the Care Credit Program with approved credit.

INSURANCE

As a courtesy to you, we will file most all dental insurance claims for you; however, your insurance is a contract between you and your insurance carrier. We are not a party of that contract. In order to file an insurance claim, the following information is required: Copy of insurance card containing the full name of the policy holder, date of birth, social security number, member/subscriber identification number, place of employment, telephone number and mailing address.

All copays and deductibles are to be paid at the time of service. If insurance has not paid your claim within 45 (forty five) days, you will be responsible for the balance at that time. Please be aware that some or possibly all of the services may be considered not reasonable and necessary by your insurance plan and therefore be considered a non-covered service. Our office will try to provide a treatment estimate for you; however, the estimate is **not** a guarantee of payment and in no way holds us responsible for the amount(s) unpaid by your insurance carrier. You are responsible for all charges not covered/paid by your insurance provider.

In regards to insurance companies of which we are considered an "in network" or "participating" provider, all copays and deductibles are due at the time services are rendered. Should your insurance company/provider change to a plan in which we do not participate, please refer to the above paragraph.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment of all charges regardless of any insurance company's arbitrary determination of *usual and customary* rates.

MINOR PATIENTS

The parent, guardian or legal representative of the minor, is responsible for full payment of services rendered. We must also have the office required patient paperwork completed and signed by the parent, guardian or legal representative of the minor prior to any treatment. We must have verification of authorized payment prior to any treatment or service(s) rendered. Please Note: In circumstances where the parents of the minor child(ren)are divorced, we are not a party of any divorce settlement or any court order(s) as to whom will be responsible for the payment of charges. All payment is expected due and payable at the time services are rendered.

MISSED APPOINTMENTS

Unless canceled at least 24 hours prior to your scheduled appointment, our policy is to charge an office visit fee for the missed appointment. Please Note: Our answering service is not authorized to accept cancellations.

BILLING FEE

After the first treatment for service(s) is rendered, an initial billing statement will be processed and mailed to you or the person of which you have identified as the responsible party for payment of your account. A billing fee in the amount of $2.00 will be assessed to all subsequent statements that are processed and mailed.

COLLECTION SERVICES

In the event your account balance is unpaid after a period of 90 or more days, the account will be turned over to a collection/recovery agency. A fee in the amount of 40% of the outstanding account balance, will be added to the account to cover collection agency fees. Please Note: You will also be responsible for any and all court costs related to the collection of an unpaid account balance.

Thank you for your understanding of our Financial Policy. Should you have any questions or concerns, we will be happy to discuss those with you. I have read, understand and agree to this Financial Policy

X _____

PATIENT SIGNATURE DATE

RELATIONSHIP TO PATIENT: ○ Self ○ Parent/Guardian ○ Legal Representative

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION.

Gealon A Thomas, DDS PLLC/Thomas Family Dentistry referred to as, "We", "Us", "Our"

Under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), all medical records and other individually identifiable health information of which we have knowledge must be kept confidential. All personal health information used by us or disclosed by us is covered by this Act regardless if this personal health information is in electronic, oral or paper form. Several new rights are granted to patients under this Act, allowing control over how your personal health information is used, how you can access it and, in some cases, amend it.

We are required by law to maintain the privacy of your personal health information and to provide you with notice of our legal duties and privacy practices with respect to your personal health information.

We may be assessed a penalty for any misuse or unauthorized disclosures of your personal health information as regulated by HIPAA.

This ***Notice of Privacy Practices*** is effective as of April, 2003.

We are bound to abide by the terms of this notice and reserve the right to make revisions to this policy. Should revisions be made, you will be notified in writing, and a copy of the revised policy will be made available at your request.

You will be asked to sign a consent form authorizing us to use and disclose your personal health information for the following purposes, as defined under the Act:

- Treatment means the provision, coordination, or management of healthcare and related services by one or more healthcare providers, including the coordination or management of healthcare by third party; consultation between healthcare providers relating to a patient; or the referral of a patient for health care from one healthcare provider to another. (ie:) Referral to an orthodontist.
- Payment means obtaining reimbursement for the provision of health care; determinations of eligibility or coverage; billing; claims management; collection activities; justification of charges; and disclosure to consumer reporting agencies; protected health information relating to the collection of reimbursements (only certain information may be disclosed). (ie:) Submitting your bill for health care services to your insurance company.
- Healthcare Operations are any activities related to covered functions in which we participate in the function of our offices, such as conducting quality assessment activities; protocol development; case management and care coordination; auditing functions; business management and general administrative activities, including implementation of this regulation; customer service evaluations; resolution of grievance; fundraising, and marketing for which an authorization is not required. (ie:) Evaluation of customer service given to patients.

We may, without prior consent use or disclose your personal health information to carry out treatment, payment of healthcare operations:

- Directly to you at your request;
- In an emergency treatment situation, if we attempt to obtain such consent as soon as reasonable practicable after the delivery of such treatment, if we are required by law to treat you and attempts to obtain consent are unsuccessful, or if we attempt to obtain consent but we are unable, due to barriers of communication, but we determine in our professional opinion that treatment is clearly inferred from the circumstances;
- Pursuant to and in compliance with an authorization signed by you; and
- Provided that you are informed in advance of the use and disclosure and have the opportunity to agree to or prohibit or restrict the use or disclosure. This may be an oral agreement between us and may include a directory maintained at our facility containing specific information allowed by this Act.

We may de-identify your personal health information by using codes or removing all individually identifiable health information.

All other uses and disclosures will be made only upon securing a written authorization form signed by you. You have the right to revoke this authorization at any time upon written notice sent to the office of Gealon A Thomas, DDS, PLLC/Thomas Family Dentistry, and we will abide by that request; however, exceptions would be any actions already taken, relying on your authorization prior to the receipt of the written revocation notice.

We may contact you to provide appointment reminders, or to inform you about treatment alternatives or other health related benefits or services that may be of interest to you.

Under **HIPAA**, you have the following rights with respect to your protected health information:

- Request restrictions on certain uses and disclosures of protected health information including restrictions placed upon disclosure to family members, close personal friends, or any other person you may identify. We are; however, not required to agree with a requested restriction;
- Receive confidential communications of your protected health information either directly from us or by alternative means or from alternative locations;
- Inspect and copy your protected health information;
- Amend your protected health information; however, this request may be denied under certain circumstances;
- Receive an accounting of disclosures of your protected health information made by us within the 6 (six) years prior to the date of the accounting request;
- Obtain a paper copy of this notice from us even if you have already agreed to receive the notice electronically

If you feel your privacy rights or the provisions of this notice of privacy policies has been violated, you have the right to file a formal written complaint.