Jesse Pollom, DDS
Lee Ann Lenz, DDS

HIXSON DENTAL GROUP

1605 Williams Road
Hixson, TN 37343
Phone: 423-843-0418

We sincerely thank you for choosing our practice for your dental needs, Our goal is for every dental visit to be the best it can possibly be, We are always accepting new patients, and we look forward to seeing any friends or family you refer to our office.

Please, let us know if you need assistance completing this form. Email this form back to us at info@hixsondentalgroup.com

Patient Information

Date: _____ Name: (Last) _____ (First) _____ (Middle) _____

Date of Birth: _____ Sex: _____ Marital Status: _____ Nickname: _____

Age: _____ Social Security Number: _____ Driver's License No: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Address: Street _____ City _____ State: _____ Zip: _____

Employer Name: _____ Occupation: _____ Employer Phone: _____

How did you hear about our office? _____ Email Address (required): _____

How would you like to be contacted? ☐ Home ☐ Work ☐ Cell ☐ Email

Emergency Contact Name and Phone Number: _____

Billing Information (If Different from Patient Information)

If patient is a minor, list parent or guardian's information here

Date: _____ Name: (Last) _____ (First) _____ (Middle) _____

Social Security Number: _____ Driver's License No: _____ Marital Status: _____

Address: Street _____ City _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer Name: _____ Employer Phone: _____

Employer Address: _____

Email Address: _____

Primary Dental Insurance

Insured's Full Name: _____ Date of Birth: _____ Marital Status: _____

Address: Street _____ City _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Insured's ID, or Social Security Number: _____ Relationship to Patient: _____

Employer Name: _____ Full Time ☐ Part Time ☐ Retired ☐

Insurance Company Name: _____ Group Number: _____

Insurance Company Phone Number: _____

Insurance Company Address: _____

Does Patient have Secondary Dental Insurance Coverage: Yes ☐ No ☐

If yes, please notify patient coordinator upon completion of this form.

Please continue on back of this page

HIXSON DENTAL GROUP

Financial Agreement

Please read the following

Payment for services rendered by Hixson Dental Group is the sole responsibility of the patient or legal guardian. Payment is due upon receipt of services. All charges not covered by Insurance are the responsibility of the patient /guardian. We no longer accept assignment of secondary dental insurance towards payment. We will fill out the forms to allow reimbursement to the patient. If there is any default in payment for services, the patient or guardian agrees to be responsible for any costs necessary to collect this debt. (Court Costs, Collection Fees, Attorney Fees, etc.).

Initial:_____

Dental Insurance

If you have dental insurance

As a courtesy, we accept payment from most insurance companies and will file your dental claim on your behalf. We will estimate your deductible, and any portion not covered by your insurance, and that amount is due at the time services are rendered. Our estimates may differ from your insurance company's calculations. I understand that insurance estimates are not a guarantee of coverage. Any amounts not paid by insurance, are the guarantor's responsibility.

By signing below, I acknowledge that all services rendered will be charged directly to me and I am ultimately responsible for my account regardless of my insurance coverage.

Initial:_____

Assignment and Release

I hereby authorize payment directly to Hixson Dental Group for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered to me, or my dependants.

I authorize the above doctor and/or provider or supplier of the services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Initial:_____

Photography Release

I _____, hereby authorize Hixson Dental Group to take photographs, slides, and/or videos of my face, jaws, mouth, and teeth for my records and patient care.

On occasion photographs, slides, and or videos are used in publications, or as part of a demonstration. My name or other identifying informations will be kept confidential.
I do not expect compensation, financial or otherwise, for these photographs.

Initial:_____

Printed Name of Responsible Party:_____

Signature of Responsible Party:_____ **Date:**_____

Today's Date: _____ Patient Name: _____ Age: _____ Date of Birth: _____

Health History Information

Have you ever used bone loss prevention drugs (biphosphonates) such as Fosomax, Actonel, or Boniva?
Yes ☐ No ☐ List: _____

Are you currently taking any blood thinners, including aspirin:
Yes ☐ No ☐ List: _____

Have you had any joint replacement surgery?
Yes ☐ No ☐ List: _____

Have you had any stints placed in your body?
Yes ☐ No ☐ List: _____

Do you have any orthopedic pins, plates, or screws in any part of your body?
Yes ☐ No ☐ List: _____

Have you ever been told that you need to pre-medicate with antibiotics for dental treatment? Yes ☐ No ☐
If yes, what has been prescribed? _____

Do you currently, or have you previously smoked or used tobacco products? Yes ☐ No ☐
If yes, how long ago? _____

Do you currently, or have you previously used recreational drugs? Yes ☐ No ☐
If yes, how long ago? _____

If female are you pregnant? Yes ☐ No ☐ Nursing? Yes ☐ No ☐ On birth control? Yes ☐ No ☐

Dental History

Name of previous dentist: _____

Date of last cleaning or exam: _____

Have you ever had orthodontics, periodontal surgery or other major dental sugery? Yes ☐ No ☐

Explain: _____

_____

Do you have any areas where food impacts around your teeth? Yes ☐ No ☐

Do your gums tend to bleed easily, feel irritated, or feel tender? Yes ☐ No ☐

Are you sensitive to hot, cold, pressures, or sweets? Yes ☐ No ☐

Do you have popping, clicking, or other noises in your jaw joints? Yes ☐ No ☐

Are you aware of grinding or clenching your teeth? Yes ☐ No ☐

Have you ever had any negative reactions to a dental injection or nitrous oxide? Yes ☐ No ☐

Are you anxious or nervous about dental treatment? Yes ☐ No ☐

Is there anything, not listed on this form, that you feel we should know about your medical or dental history?

_____

_____

_____

List any items you wish to discuss with your dentist today

_____

_____

Please continue on back of this Page

Complete The Followinq

y	N	Conditions
☐	☐	Anemia
☐	☐	Arthritis, Rheumatism
☐	☐	Artificial Joints
☐	☐	Asthma
☐	☐	Back Problems
☐	☐	Bleeding Abnormally W/Extractions
☐	☐	Blood Disease
☐	☐	Cancer Type_____
☐	☐	Chemical Dependency
☐	☐	Chemotherapy
☐	☐	Chronic Fatigue Syndrome
☐	☐	Circulatory Problems
☐	☐	Congenital Heart Lesions
☐	☐	Cortisone Treatments
☐	☐	Cough: Persistent or Bloody
☐	☐	Diabetes Type
☐	☐	Drug Abuse
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Fainting Spells or Dizziness
☐	☐	Glaucoma
☐	☐	HIV+AIDS

y	N	Conditions
☐	☐	Headaches
☐	☐	Heart Murmur
☐	☐	Hepatitis A
☐	☐	Hepatitis B
☐	☐	Hepatitis C
☐	☐	Herpes
☐	☐	High Blood Pressure
☐	☐	Jaw Pain
☐	☐	Joint Replacement
☐	☐	Kidney Disease
☐	☐	Latex Sensitivity
☐	☐	Liver Disease
☐	☐	Low Blood Pressure
☐	☐	Mitral Valve Prolapse
☐	☐	Pace Maker
☐	☐	PsychiatricCare
☐	☐	Radiation Treatment
☐	☐	Respiratory Disease
☐	☐	Stroke
☐	☐	Swollen Neck
☐	☐	Thyroid Problems

y	N	Conditions
☐	☐	Tonsillitis
☐	☐	Tuberculosis
☐	☐	Tumor or Growth on Head/neck
☐	☐	Ulcers
☐	☐	Venereal Disease
☐	☐	Osteoporosis Med (IV/Oral} Fosomax

y	N	Allergies
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicilin
☐	☐	Tetracycline

Other: _____

Medications

List all medications here. Include all prescriptions, over the counter medications, vitamins, and herbs.

_____

_____

_____

_____

_____

✱ Printed name: _____ Signature: _____ Date: _____

Office Use Only

_____

_____

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_____

HIXSON DENTAL GROUP

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this notice carefully.

Your medical record may contain personal information about your health. This information may identify you and relate to your past, present or future physical or mental health condition and related health care services and is called Protected Health Information (PHI). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI. We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHL We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

How we may use and disclose health care information about you:

For Care or Treatment: Your PHI may be used and disclosed to those who are involved in your care for the purpose of providing, coordinating, or managing your services. This includes consultation with clinical supervisors or other team members. Your authorization is required to disclose PHI to any other care provider not currently involved in your care.
Example: *If another dentist referred you to us, we may contact that dentist to discuss your care. Likewise, if we refer you to another dentist, we may contact that dentist to discuss your care or they may contact us.*

For Payment: Your PHI may be used and disclosed to any parties that are involved in payment for care or treatment. If you pay for your care or treatment completely out of pocket with no use of any insurance, you may restrict the disclosure of your PHI for payment. ***Example:*** *Your payer may require copies of your PHI during the course of a medical record request, chart audit or review.*

For Business Operations: We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. We may also disclose PHI in the course of providing you with appointment reminders or leaving messages on your phone or at your home about questions you asked or test results. ***Example:*** *We may share your PHI with third parties that perform various business activities (e.g., Council on Accreditation or other regulatory or licensing bodies) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI.*

Required by Law: Under the law, we must make disclosures of your PHI available to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule, if so required.

Without Authorization: Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. Examples of some of the types of uses and disclosures that may be made without your authorization are those that are:

Required by Law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the health department)

Required by Court Order

Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission: We may use or disclose your information to family members that are directly involved in your receipt of services with your verbal permission

With Authorization: Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked. Your explicit authorization is required to release psychotherapy notes and PHI for the purposes of marketing, subsidized treatment communication and for the sale of such information.

Your rights regarding your PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer:

Right of Access to Inspect and Copy. You have the right, which may be restricted only in exceptional circumstances or with documents released to us, to inspect and copy PHI that may be used to make decisions about service provided.

Right to Amend. If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend th information although we are not required to agree to the amendment.

Right to an Accounting of Disclosures. You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.

Right to Request Restrictions. You have the right to request a restriction or limitation on the use or disclosure of your PHI for services, payment, or business operations. We are not required to agree to your request.

Right to Request Confidential Communication. You have the right to request that we communicate with you about PHI matters in a specific manner (e.g. telephone, email, postal mail, etc.)

Right to a copy of this Notice. You have the right to a copy of this notice.

Website Privacy

Any personal information you provide us with via our website, including your e-mail address, will never be sold or rented to any third party without your express permission. If you provide us with any personal or contact information in order to receive anything from us, we may collect and store that personal data. We do not automatically collect your personal e-mail address simply because you visit our site. In some instances, we may partner with a third party to provide services such as newsletters, surveys to improve our services, health or company updates, and in such case, we may need to provide your contact information to said third parties. This information, however, will only be provided to these third-party partners specifically for these communications, and the third party will not use your information for any other reason. While we may track the volume of visitors on specific pages of our website and download information from specific pages, these numbers are only used in aggregate and without any personal information. This demographic information may be shared with our partners but it is not linked to any personal information that can identify you or any visitor to our site.

Our site may contain links to other outside websites. We cannot take responsibility for the privacy policies or practices of these sites and we encourage you to check the privacy practices of all internet sites you visit. While we make every effort to ensure that all the information provided on our website is correct and accurate, we make no warranty, express or implied, as to the accuracy, completeness or timeliness, of the information available on our site. We are not liable to anyone for any loss, claim or damages caused in whole or in part, by any of the information provided on our site. By using our website, you consent to the collection and use of personal information as detailed herein. Any changes to this Privacy Policy will be made public on this site so you will know what information we collect and how we use it.

Breaches:

You will be notified immediately if we receive information that there has been a breach involving your PHI.

Complaints:

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer at Hixson Dental Group. If you have questions and would like additional information, you may contact us at 423-843-0418.

_____

Print Name

_____ _____

Signature **Date**

PATIENT CONSENT- ADULT

Clinical

I authorize Hixson Dental Group to perform all recommended treatment, including but not limited to:

a. All recommended treatment

b. Radiographs, study models, photos, and other diagnostic aids or materials (collectively, ("Diagnostic Material") as needed to make a thorough diagnosis;

c. The use of anesthetics, sedatives, and other medications, as needed, and am fully aware that using anesthetics agents involves certain risks, including but not limited to redness and swelling of tissues, pain, itching, vomiting, dizziness, miscarriage, cardiac arrest, drowsiness, and/or lack of coordination.

HIPAA Acknowledgment

I authorize the Practice to release to staff, hospitals, health care service plans, insurance companies, self-insurers or their Adult representatives, specialty dentists involved in my care, any and all information, records, and other diagnostic material about my medical history, services rendered, or recommended treatment.

I acknowledge receipt of the Notice of Privacy Practices.

| authorize sharing my protected health information with the following individuals who may be involved in my care and I understand am responsible to notify the Practice of any changes:

Name (Please Print): _____ Relationship: _____
Name (Please Print): _____ Relationship: _____
Name (Please Print): _____ Relationship: _____

Printed Name of Patient/Legal Guardian: _____

Signature of Patient/Legal Guardian: _____ **Date:** _____

PATIENT CONSENT - MINOR CHILD
(Effective until age 18 - Tennessee)

The parent or legal guardian must complete this form for a minor, provide consent for dental treatment, and accompany the child during each dental visit. Treatment will not be provided for unattended minors unless it is an emergency. If you wish to designate another adult to be a decision-maker in your child's dental care, please complete the Limited Power of Attorney. If you authorize sharing protected health information, complete the HIPPA Acknowledgement section below. **Your Child(ren)'s Names:**

Patient's/Child's Name (Please Print): _____ Date of Birth: _____
Patient's/Child's Name (Please Print): _____ Date of Birth: _____
Patient's/Child's Name (Please Print): _____ Date of Birth: _____

Clinical

As the parent legal guardian of the child(ren) listed above, I authorize **Hixson Dental Group** to perform all recommended treatment on the patient, including but not limited to:

a. All recommended treatment;

b. Radiographs, study models, photos, and other diagnostic aids or materials (collectively, ("Diagnostic Material") as needed to make a thorough diagnosis;

c.The use of anesthetics, sedatives, and other medications, as needed, and am fully aware that using anesthetics agents involves certain risks, including but not limited to redness and swelling of tissues, pain, itching, vomiting, dizziness, miscarriage cardiac arrest, drowsiness, and/or lack of coordination.

HIPAA Acknowledgment

I authorize the Practice to release to staff, hospitals, health care service plans, insurance companies, self-insurers or their representatives, specialty dentists involved in my child's care, any and all information, records, and other diagnostic material about my child's medical history, services rendered, or recommended treatment.

Children

I acknowledge receipt of the Notice of Privacy Practices.

I authorize sharing my child's protected health information with the following individuals who may be involved in my child's care and I understand I am responsible to notify the Practice of any changes:

Name (Please Print): _____ Relationship: _____
Name (Please Print): _____ Relationship: _____
Name (Please Print): _____ Relationship: _____

Printed Name of Parent/Legal Guardian: _____

Signature of Parent Legal Guardian: _____ **Date:** _____