Hunter Oral & Implant Surgery

Patient Registration and HIPAA Acknowledgment Form

Dentist _____ Referred by _____

PATIENT INFORMATION

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Male ☐ Female

First Name _____ MI _____ Last Name _____ Nickname _____

Address _____ Apt. _____ City_____ State _____ Zip _____

DOB _____ /_____/_____ Age _____ SS# _____ Employer _____

Home Phone (_____)_____ Cell Phone (_____)_____ Work Phone (_____)_____Ext._____

Email _____

FINANCIALLY RESPONSIBLE PARTY ***Statements and refunds will be issued to this person.****

Relationship to Patient_____

First Name _____ MI _____ Last Name _____

Address _____ Apt. _____ City_____ State _____ Zip _____

DOB ____ /_____/_____ Age _____ SS# _____ Employer _____

Home Phone (_____)_____ Cell Phone (_____)_____ Work Phone (_____)_____Ext._____

Email _____

HIPAA Acknowledgment

- I authorize the Practice to release to staff, hospitals, health care service plans, insurance companies, self-insurers or their representatives, and dentists, any and all information, records, and other diagnostic material about medical history, services rendered, or recommended treatment.
- I have been given the opportunity to review the Notice of Privacy Practices.
- I authorize sharing of patient's protected health information with the following individuals:
  - Name _____ Relationship_____ Phone _____
  - Name _____ Relationship_____ Phone _____
  - Name _____ Relationship_____ Phone _____
- I authorize the following means of communication:
  - Home Phone_____ to include a message
  - Cell Phone _____ to include a text message or voice message
  - Email _____ Other _____
- To the best of my knowledge, the information on these forms has been accurately answered, and it is my responsibility to inform Hunter Oral & Implant Surgery of any changes.

Today's Date_____/_____/_____

Patient (over 18) or Parent/Legal Guardian Signature _____

Print Name and Relationship to Patient _____

PATIENT HEALTH HISTORY

Patient Full Name _____ (_____) Age _____
Name you go by

Dentist _____ Referred by _____ Primary Care Doctor _____

X-rays with you or mailed to us? Yes ❑ No ❑ How did you hear about us? _____

HAVE YOU EVER HAD:

Yes ❑ No ❑ 1. Glaucoma
Yes ❑ No ❑ 2. A. Heart Attack
Yes ❑ No ❑ B. By-Pass Surgery
Yes ❑ No ❑ C. Congestive Heart Failure
Yes ❑ No ❑ D. Valve Replacement
Yes ❑ No ❑ E. Murmur
Yes ❑ No ❑ F. Stents
Yes ❑ No ❑ 3. Rheumatic Fever
Yes ❑ No ❑ 4. Stroke
5. Are you on:
Yes ❑ No ❑ A. Plavix
Yes ❑ No ❑ B. Coumadin (Warfarin)
Yes ❑ No ❑ C. Aspirin
Yes ❑ No ❑ D. Other blood thinner _____
Yes ❑ No ❑ 7. Lung disease or emphysema
Yes ❑ No ❑ 8. Asthma
Medication: _____
Yes ❑ No ❑ 9. High Blood Pressure
Medication: _____
Yes ❑ No ❑ 10. Diabetes
Medication: _____
Yes ❑ No ❑ 11. Kidney Disease
Yes ❑ No ❑ 12. Liver Disease
Yes ❑ No ❑ 13. Hepatitis
Type: _____
Yes ❑ No ❑ 14. Tuberculosis (TB)
Yes ❑ No ❑ 15. Seizures
Medication: _____
Yes ❑ No ❑ 16. Have you been treated for osteoporosis?
Medication: _____
Yes ❑ No ❑ 17. Have you ever been given Zometa or Aredia?
Yes ❑ No ❑ 18. Arthritis
Medication: _____
Yes ❑ No ❑ 19. Joint Replacement
When? _____
Yes ❑ No ❑ 20. Are you being treated for anemia?
Yes ❑ No ❑ 21. Are you immuno-suppressed?
Yes ❑ No ❑ 22. Stomach or Intestinal Ulcers
Yes ❑ No ❑ 23. Cancer
Yes ❑ No ❑ 24. Have you ever had popping, clicking, or pain in your jaw joints?
Yes ❑ No ❑ 25. Are you/do you think you may be pregnant?
Yes ❑ No ❑ 26. Do you breast feed?
Yes ❑ No ❑ 27. Do you smoke or vape?
Yes ❑ No ❑ 28. Do you dip or chew tobacco?
Yes ❑ No ❑ 29. Do you have sleep apnea?
Yes ❑ No ❑ 30. Are you taking the diet medication Phentermine?
Yes ❑ No ❑ 31. Are you allergic to latex?
Yes ❑ No ❑ 32. Special Needs _____

32. List Drug Allergies: _____

_____

33. Complications following oral surgery or with general anesthesia? What? _____

34. Other serious illness? What? _____

35. List prescription or over-the-counter medications, including any diet medications: _____

_____

_____

_____

TO THE BEST OF MY KNOWLEDGE, THE QUESTIONS ON THIS FORM HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS. IT IS MY RESPONSIBILITY TO INFORM DR. HUNTER OF ANY CHANGES.

_____ _____
Signature of Patient, Parent, or Legal Guardian Date

FOR OFFICE USE ONLY: _____

_____

_____

Hunter Oral & Implant Surgery
Insurance Information

YOU MUST PROVIDE INSURANCE CARD(S) OR PROOF OF INSURANCE AT TIME OF TREATMENT OR PAYMENT IN FULL WILL BE REQUIRED. WE DO NOT TAKE MEDICARE OR MEDICARE ADVANTAGE PLANS. I UNDERSTAND I WILL HAVE TO PAY OUT OF POCKET IF I HAVE ONE OF THESE PLANS.

Patient's Name _____ **Date** _____

PRIMARY DENTAL INSURANCE

Insurance Company _____

ID# _____

Group # _____

Claims Address _____

City _____ State _____ Zip _____

Insurance Phone (_____) _____

Subscriber's Information:

Relationship to Patient: ☐Self ☐Spouse ☐Parent ☐Other

Last Name _____

First Name _____

DOB_____ ☐Male ☐Female

SS# _____

Address _____
(If different than patient)

Phone (_____) _____ Employer_____

SECONDARY DENTAL INSURANCE

Insurance Company _____

ID# _____

Group # _____

Claims Address _____

City _____ State _____ Zip _____

Insurance Phone (_____) _____

Subscriber's Information:

Relationship to Patient: ☐Self ☐Spouse ☐Parent ☐Other

Last Name _____

First Name _____

DOB_____ ☐Male ☐Female

SS# _____

Address _____
(If different than patient)

Phone (_____) _____ Employer_____

PRIMARY MEDICAL INSURANCE

Insurance Company _____

ID# _____

Group # _____

Claims Address _____

City _____ State _____ Zip _____

Insurance Phone (_____) _____

Subscriber's Information:

Relationship to Patient: ☐Self ☐Spouse ☐Parent ☐Other

Last Name _____

First Name _____

DOB_____ ☐Male ☐Female

SS# _____

Address _____
(If different than patient)

Phone (_____) _____ Employer_____

SECONDARY MEDICAL INSURANCE

Insurance Company _____

ID# _____

Group # _____

Claims Address _____

City _____ State _____ Zip _____

Insurance Phone (_____) _____

Subscriber's Information:

Relationship to Patient: ☐Self ☐Spouse ☐Parent ☐Other

Last Name _____

First Name _____

DOB_____ ☐Male ☐Female

SS# _____

Address _____
(If different than patient)

Phone (_____) _____ Employer_____

Hunter Oral & Implant Surgery

Insurance and Financial Acknowledgment

- **I understand I must provide insurance card(s) or proof of insurance at time of treatment or payment in full is required. Estimated insurance co-pays are due at time of service.**
- The Practice does NOT take Medicare or any Medicare Advantage Plans. I understand I will have to pay out of pocket if I have one of these plans.
- A patient's insurance policy is a contract between the patient and their insurance carrier. We are happy to file insurance as a courtesy to our patients. Tennessee State Law requires payment of insurance claims within 30 days. **If you have not received notification of payment within 30 days, it is your responsibility to contact the insurance carrier. The account balance must be paid within 90 days from the date of service regardless of insurance status.**
- I hereby authorize Hunter Oral & Implant Surgery to furnish information to insurance carriers or any other agencies concerning my illness and treatments that are necessary to process my claim. I hereby assign to Hunter Oral & Implant Surgery all payments for services rendered to my dependent or myself. **I understand that I am responsible for any amount not paid by insurance.**
- **I understand this account must be fully paid within 90 days from the time of treatment or a service charge of 1.5% per month (18% APR) will be applied.**
- **I also understand should this account be considered past due, I will be responsible for 40% collection cost that will be added to the original balance plus attorney fees and court/legal fees.**
- I accept responsibility for all charges incurred by this patient. To the best of my knowledge, the information on these forms has been accurately answered, and it is my responsibility to inform Hunter Oral & Implant Surgery of any changes.

Patient Name_____ **Date**_____

Patient (over 18) or Parent/Legal Guardian Signature _____

Print Name and Relationship to Patient _____

COVID-19 ACKNOWLEDGEMENT OF RISK AND HEALTH SCREENING FORM

_____ _____

Patient's Name Date of Birth

Our practice wants to ensure you are aware of the relative risks of exposure to COVID-19 associated with receiving treatment. This practice follows the applicable state and federal regulations and recommendations regarding infection control, sterilization, disinfection, and the use of PPE (personal protective equipment). We also work to protect our patients and office staff from virus spread by promoting frequent hand washing and office cleaning, using PPE for patient encounters, and adding additional environmental controls in the treatment areas.

Although we are using enhanced infection control measures in our practice, due to the nature of the procedures we provide, it is not possible to maintain social distancing during treatment or for you to wear a mask during treatment. This means that the risk of exposure to COVID-19 remains when receiving treatment during the pandemic.

COVID Health History

Have you ever been diagnosed with COVID-19?	YES	NO	If yes, when? _____
Have you ever been hospitalized for COVID-19 treatment?	YES	NO	If yes, when? _____
Are you fully vaccinated or in the course of being vaccinated for COVID-19?	YES	NO	
Have you been tested for COVID-19 and are awaiting results?	YES	NO	
In the last 14 days, have you been in contact with any confirmed cases of COVID-19?	YES	NO	

Symptoms – Today, or in the last 14 days:

Have you had a fever or felt hot or feverish?	YES	NO
Have you had any shortness of breath or other breathing difficulties?	YES	NO
Have you had a cough?	YES	NO
Have you had any other flu-like symptoms, such as an upset stomach, headache, or fatigue?	YES	NO
Have you had a loss of taste or smell?	YES	NO
Have you otherwise felt unwell?	YES	NO

Patient Acknowledgement - By signing this document, I acknowledge that I have read the Patient Acknowledgment and that I understand and accept that there is a risk of COVID-19 exposure with treatment. I also acknowledge that the Health History and Health Screening answers I have provided are true and accurate. I will contact Hunter Oral & Implant Surgery within 2 days after my procedure if I develop COVID symptoms.

_____ _____

Patient or Legal Representative Signature Date

_____

Print Patient or Legal Representative Name/Relationship

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge I have received a copy of the Hunter Oral & Implant Surgery Notice of Privacy Practices. I understand this notice explains how my protected health information is used and disclosed by the practice, and my rights regarding my protected health information.

I understand I should keep the Notice and refer to it if I have questions. I also understand I should contact the Compliance at compliance@sdbmail.com if I have a question or concern about my privacy rights.

_____

Printed Name of Patient

_____ _____

(If applicable) Printed Name of Patient's Legal Representative **Relationship to Patient**

_____ _____

Signature of Patient or Patient's Legal Representative **Date**

FOR OFFICE USE ONLY IF ACKNOWLEDGEMENT IS NOT SIGNED

The following attempt(s) were made to obtain a written Acknowledgement of Receipt:

□ NPP given to the patient who refused to sign.

□ NPP was mailed to the patient's home address as stated in record.

□ NPP was mailed to an alternate address at the patient's request.

□ NPP was faxed or e-mailed to the patient at their request.

Other reason(s) why written acknowledgement was not obtained: _____

_____

_____

_____