Dr. Gaylan Brown   Dr. Benjamin Cannon

WWW.Easthillsdentalcenter.com

102 Highway 70 E Suite 2
Dickson, TN 37055
P:(615)446-4644 F:(615)446-4660

210 East Main Street
Waverly, TN 37185
P:*(931)296-3882 F:(931)296-3856*

It is a pleasure to welcome you to our dental office. We are so pleased you have selected East Hills Dental Center for your dental care needs. Our goal is to determine what dental treatment you want and need and deliver that to you with courtesy and clinical excellence. From your initial examination appointment, we will prepare a treatment plan that meets your dental care needs as well as your dental budget.

We offer different payment options to meet your financial needs. Your options include: Cash, Check, all major credit cards, Electronic Draft, and CareCredit Financing. Unless otherwise discussed, payment is expected in full at the time of treatment. To schedule an appointment with a doctor or hygienist that exceeds one hour of chair time our office collects a 10% or $50 deposit (whichever is greater) at the time of scheduling to reserve this time especially for you. This deposit amount will be deducted from your total due at the time services are rendered. In the event the appointment is failed or cancelled with less than 48-hour business notice the deposit will be forfeited.

Office hours are by appointment. Unless an unexpected dental emergency arises, we try to ensure patients are seen at their scheduled appointment time. When appropriate, we prefer to schedule longer appointments and complete as much dental treatment in one visit as we can. This allows for the least disruption in your daily schedule as possible.

When you enter our office, you can expect to receive the best dental care and customer service we can provide. We know how important it is to have a dental care provider you can rely on and trust. You can rest assured that as one of our patients you will never be treated as a client or customer. Simply put, our patients are our family. Whether we are sorting through the tangle of information that can be dental insurance, explaining a complex procedure, or scheduling an appointment, our staff is here to help you.

Please sign below that you have read and understand our office policies.

____

Signature of Patient (or Responsible Party)   Date

PATIENT REGISTRATION

Patient Information: **Referred By:** ______________________________

First Name:______________________ **Last Name:**______________________ **Middle Initial:** ________

Preferred Name: ______________________________ **Patient is:** Responsible Party Policy Holder

Address: ______________________________ **City, State, Zip:**______________________

Home Phone: ( ) - ________ **Work Phone:** ( ) - ________ **Cell Phone:** ( ) - ________

Date of Birth:________________ **SSN:**______________________ **Drivers Lic#:**________________

E-mail: ______________________________ **Marital Status:** Married Single Divorced Separated Widowed

Employment Status: Full-Time Part-Time Self Employed Retired Unemployed **Student Status:** Full-Time Part-Time

Responsible Party: (if someone other than the patient):

First Name:______________________ **Last Name:**______________________ **Middle Initial:** ________

Preferred Name: ______________________________ **Patient is:** Responsible Party Policy Holder

Address: ______________________________ **City, State, Zip:**______________________

Home Phone: ( ) - ________ **Work Phone:** ( ) - ________ **Cell Phone:** ( ) - ________

Date of Birth:________________ **SSN:**______________________ **Drivers Lic#:**________________

E-mail: ______________________________ **Marital Status:** Married Single Divorced Separated Widowed

Employment Status: Full-Time Part-Time Self Employed Retired Unemployed

Primary Insurance Information:

Name of Insured: ______________________________ **Relationship to patient: Self Spouse Child Other**

Insured SSN: ______________________________ **Insured Date of Birth:** ________________

Employer: ______________________________ **Subscriber ID:** ________________

Insurance Company: ____

Address: ______________________________ **City, State, Zip:** ________________

Secondary Insurance Information:

Name of Insured: ______________________________ **Relationship to patient: Self Spouse Child Other**

Insured SSN: ______________________________ **Insured Date of Birth:** ________________

Employer: ______________________________ **Subscriber ID:** ________________

Insurance Company: ____

Address: ______________________________ **City, State, Zip:** ________________

____

Signature of Patient (or Responsible Party) **Date**

Dental and Medical History

Patient Name: Birth Date: Date Created:

MEDICAL HISTORY

Question	Answer	
Are you currently under the care of a physician?	Yes No	If yes
Have you ever been hospitalized due to a surgery or illness?	Yes No	If yes
Have you ever had serious injury to the jaw, face, neck or head?	Yes No	If yes
Are you taking any medications or vitamins?	Yes No	If yes
Have you ever used bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Bonvia.	Yes No	
Have you ever taken any of the group of drugs collectively referred to as Phen-Fen? These include combinations of	Yes No	
Do you use controlled substances?	Yes No	
Do you wear contact lenses?	Yes No	
Do you use tobacco, in any form?	Yes No	

WOMEN

Please check the box below if any of the following apply to you:

- [ ] Pregnant or trying to get pregnant
- [ ] Nursing
- [ ] Taking oral contraceptives

ALLERGIES

Please check the box below if you are allergic to any of the following:

- [ ] Acrylic
- [ ] Aspirin
- [ ] Codeine
- [ ] Latex
- [ ] Local Anesthetics
- [ ] Metal
- [ ] Penicillin
- [ ] Sulfa Drugs
- [ ] Other

CONDITIONS

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

Condition		Condition		Condition		Condition	
AIDS/HIV	Yes No	Alzheimer's Disease	Yes No	Anaphylaxis	Yes No	Anemia	Yes No
Angina	Yes No	Arthritis, Rheumatism, Gout	Yes No	Artificial Heart Valves	Yes No	Artificial Joints	Yes No
Asthma	Yes No	Back Problems	Yes No	Bleeding Abnormally	Yes No	Blood Disease	Yes No
Breathing Problems	Yes No	Bruise Easily	Yes No	Cancer	Yes No	Chemical Dependency	Yes No
Chemotherapy	Yes No	Chest Pains	Yes No	Circulatory Problems	Yes No	Cold Sores or Fever Blisters	Yes No
Congenital Heart Disorder	Yes No	Cortisone Treatments	Yes No	Diabetes	Yes No	Drug Addiction	Yes No
Emphysema	Yes No	Epilepsy or Seizures	Yes No	Fainting or Dizziness	Yes No	Glaucoma	Yes No
Headaches	Yes No	Heart Murmur	Yes No	Heart Problems	Yes No	Hepatitis	Yes No
Herpes	Yes No	High Blood Pressure	Yes No	High Cholesterol	Yes No	Hypoglycemia	Yes No
Irregular Heartbeat	Yes No	Jaundice	Yes No	Jaw Pain or Tiredness	Yes No	Kidney Disease	Yes No
Liver Disease	Yes No	Low Blood Pressure	Yes No	Lung Disease	Yes No	Mitral Valve Prolapse	Yes No
Nervous Problems	Yes No	Osteoporosis	Yes No	Pacemaker	Yes No	Psychiatric Care	Yes No
Radiation Treatment	Yes No	Respratory Disease	Yes No	Rheumatic Fever	Yes No	Scarlet Fever	Yes No
Shortness of Breath	Yes No	Sinus Trouble	Yes No	Skin Rash or Hives	Yes No	Stroke	Yes No
Swollen Feet or Ankles	Yes No	Swollen Neck Glands	Yes No	Thyroid Problems	Yes No	Tonsilitis	Yes No
Tuberculosis	Yes No	Tumor or growth on head or neck	Yes No	Ulcer	Yes No	Unexplained Weight Loss	Yes No
Venereal Disease	Yes No	Other	Yes No				

DENTAL HISTORY

Date of last dental visit and previous dentist: Comment

Please mark yes or no to indicate if you have had any of the following:

Item		Item		Item		Item	
Bad breath	Yes No	Bleeding gums	Yes No	Blisters on lips or mouth	Yes No	Burning sensation on tongue	Yes No
Chew on one side of mouth	Yes No	Clicking or popping jaw	Yes No	Dry mouth	Yes No	Fingernail biting	Yes No
Food collection between teeth	Yes No	Grinding teeth	Yes No	Gums swollen or tender	Yes No	Lip or cheek biting	Yes No
Loose teeth or broken fillings	Yes No	Mouth breathing	Yes No	Mouth pain	Yes No	Orthodontic treatment	Yes No
Pain around ear	Yes No	Periodontal disease	Yes No	Sensitivity to cold	Yes No	Sensitivity to hot	Yes No
Sensitivity to pressure	Yes No	Sensitivity to sweets	Yes No				

CONSENT FOR TREATMENT

I hereby authorize East Hills Dental Center to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by the dental team to make a thorough diagnosis of any dental needs. I also authorize the dentist to perform any and all forms of dental treatment, medication and therapy that may be indicated. I understand the use of aesthetic agents embodies a certain risk.

I give East Hills Dental Center permission to file dental insurance on my behalf. I assign all insurance payments to be mailed and payable directly to East Hills Dental Center. I understand that the estimates I am given after my dental benefit are only estimates and I am ultimately responsible for full payment any dental services rendered.

Payment is due and payable at the time services are rendered unless financial agreements have been made prior to date of service. I further understand that a finance charge of 1.5% per month will be added to any balance greater that 60 days past due. If for any reason my account is turned over for third party collection efforts, I understand I will be responsible for any and all fees incurred.

Patient Name: ____

Responsible Party Name: ____

____

Signature of Patient (or Responsible Party) Date

East Hills Dental Center Gaylan W. Brown DDS Ben Cannon DDS

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we usually will not ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;

- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours. If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this Notice.
- ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of

time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

- get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of the Notice of Privacy Practices.

Signature: ____