Patient Information

*First Name*_____ *Last Name*_____ *Preferred Name*_____

*Mailing Address*_____ *City, State, Zip*_____

*Home Phone*_____ *Cell Phone*_____ *Work Phone*_____

*Birth Date*_____ *Gender M / F* *Social Security #*_____ *Drivers License #*_____

*Email*_____ *Marital Status (circle): Single Married Divorced Widowed*

Responsible Party (if other than patient)

*First Name*_____ *Last Name*_____ *Preferred Name*_____

*Address*_____ *City, State, Zip*_____

*Home Phone*_____ *Cell Phone*_____ *Work Phone*_____

*Birth Date*_____ *Social Security #*_____ *Drivers License #*_____

*Relationship to Patient (circle) Mother Father Grandparent Legal Guardian Other:*_____

*****Please note that the person bringing dependent children to their appointment will be responsible for co-pays and payment at time of service*****

Primary Insurance Information

Insured Name_____ Employer_____

Social Sec #_____ Birth Date_____ Insurance Member ID#_____

Ins. Company_____ Group Number_____

Ins Co. Address_____

Insured Relationship to Patient (circle)- self spouse child Other:_____

Secondary Insurance Information

Insured Name_____ Employer_____

Social Sec #_____ Birth Date_____ Insurance Member ID#_____

Ins. Company_____ Group Number_____

Ins Co. Address_____

Insured Relationship to Patient (circle)- self spouse child Other:_____

Rocky Top Dentistry PLLC

2025 MEDICAL HX

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or 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	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco/chewing tobacco/or vape?	◯ Yes ◯ No	
Do you use controlled substances?	◯ Yes ◯ No	If yes

Women: Are you...

☐ Pregnant? Weeks_____ ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Other? ☐ If yes

Do you have, or have you had, any of the following?

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

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

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.

Signature of Patient, Parent or Guardian:

X Date:_____

Rocky Top Dentistry

Acknowledgement of Receipt of HIPAA Documents

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

I acknowledge that I have received a copy of ***Rocky Top Dentistry's Notice of Privacy Practices,*** which describes how my protected health information (PHI) may be used and disclosed and explains my rights regarding that information under the Health Insurance Portability and Accountability Act (HIPAA).

I understand that Rocky Top Dentistry reserves the right to change is privacy practices and the terms of its Notice of Privacy Practices at any time, and that updated notices will be made available in accordance with federal law.

I understand that I may request a paper copy of the Notice of Privacy Practices at any time, even if I have agreed to receive it electronically.

Printed Name: _____

Signature: _____

Relationship to Patient (if applicable): _____

Date: _____

FOR OFFICE USE ONLY: If acknowledgment was not obtained, please document the reason:

___ Patient refused to sign ____Patient unable to sign ____ Other (explain)

_____

_____

Staff Member Name:_____ Date: _____

Staff Signature: _____

Appointment Cancellation & No-Show Policy

At Rocky Top Dentistry, we value your time and strive to provide the highest quality care to all our patients. To do so, we reserve appointment times specifically for you.

We kindly request a minimum ***of 48 hours' notice*** for any appointment changes, cancellations, or rescheduling. This allows us the opportunity to offer the reserved time to another patient who may need care.

Appointments that are canceled with less than 48 hours' notice, or missed without notice, will be considered broken appointments and may result in the following fees:

- $50 broken appointment fee for a one-hour appointment
- $150 broken appointment fee for a two-hour or more appointment

Broken appointment fees are not covered by insurance and are the responsibility of the patient.

We understand that emergencies can occur and will review such situations on a case-by-case basis. Thank you for your courtesy, understanding, and cooperation in helping us provide timely care to all our patients.

I have read and understand the Appointment Cancellation & No-Show Policy of Rocky Top Dentistry and agree to comply with its terms.

Patient Name (Print) : _____ Patient Signature : _____

Contact and Information Release Form

Please provide us with the information listed below to allow us to comply with HIPAA regulations about contacting you and releasing protected health information (PHI) to others. This will include but not limited to appointment reminders, treatment, conditions, financial records, referrals and billing.

Please ***initial*** the contact below that you wish to be used. You can choose more than one option.

_____ Home Phone _____ Cell Phone _____Text Messages

Email: _____ (provide email address)

Emergency Contact Name and Phone #:

_____

The following person(s) listed below may be contacted regarding my Personal Health Information (PHI) as listed above:

_____

_____

By signing below, you agree to allow Rocky Top Dentistry and its employees to contact you and release your PHI as listed above. Any changes must be submitted in writing to our office. Rocky Top Dentistry and its representatives *will not* be held liable for information released in error due to changes not received in writing.

Name: _____ Date: _____

Signature: _____

Rocky Top Dentistry

Financial Responsibility Agreement

Patient Name: _____ Date of Birth: _____

Guarantor (if different) _____ Phone Number: _____

Rocky Top Dentistry is committed to providing quality dental care. To maintain this standard, patients are required to understand and agree to the following financial policies:

1. **Payment at Time of Service- Payment** is due in full at time services are rendered unless prior arrangements have been made. This includes co-payments, deductibles, and any portion not expected to be covered by insurance. We accept cash, checks, debit, HSA and all major credit cards. (There is a 3% surcharge on all major credit cards. This does not apply to debit or HSA cards.)
2. **Insurance Responsibility-** As a courtesy, Rocky Top Dentistry will submit insurance claims on behalf of the patient. Insurance coverage is a contract between the patient and the insurance carrier. The patient is fully responsible for all charges not paid by insurance, including denied claims, deductibles, co-insurance, and non-covered services. Any remaining balance after insurance payment is due immediately. By signing below, I give Rocky Top Dentistry permission to file my dental insurance for services rendered.
3. **Credit Card on File Authorization-**A valid credit card may be required to be kept on file. By signing this agreement, the patient authorizes Rocky Top Dentistry to charge the card on file for any outstanding balance remaining after insurance has paid or after billing statements have been issued.
4. **Past-Due Accounts & Collection Policy-** Accounts with balances outstanding for 90 days or more may be subject to collection proceedings. A monthly financial/billing charge may be applied to balances carried on after the 90-day period. Accounts may be turned over to a collection agency, and the patient or responsible party agrees to pay all costs of collection, including reasonable attorney fees, as permitted by law.
5. **Returned or Declined Payments-** Returned checks or declined payments may result in additional fees and require future payments to be made by cash or credit card.
6. **Responsibility for Dependents-** Parents or legal guardians are financially responsible for the dental care of their dependents. This includes all charges not covered by insurance. The parent or legal guardian bringing dependent patients to the office for care will be the party responsible for payment.
7. **Divorce, Alimony, or Custody Agreements-** Rocky Top Dentistry is not responsible for financial arrangements outlined in divorce decrees, custody agreements, or alimony arrangements. The individual signing this agreement remains fully responsible for all charges incurred, regardless of any external legal or financial agreements.

Acknowledgment and Agreement

I have read and understand the financial responsibility policies of Rocky Top Dentistry and agree to be financially responsible for all charges incurred for services provided to me or my dependents.

Patient/Guarantor Signature: _____

Date: _____