Spring Hill Smiles, Larrabee Family Dentistry & Orthodontics
4873 Port Royal Rd, Spring Hill, TN 37174
(931) 486-3232
www.springhillsmiles.com/

NEW PATIENT FORM

Basic Information

Name:		Gender:	
Preferred Name:		DOB:	
SSN #:		Marital status:	
Referral source:		Employer:	
Referred by:		Occupation:	

Contact Information

Mobile phone:	
Home phone:	
Email:	

Address Information

Street address:	
City:	
State:	
ZIP:	

Emergency Contact

Full Name:	
Phone number:	
Relation:	

Work Information

Street address:	
City:	
State:	
ZIP:	

Patient's signature:

Date:

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PRIVACY POLICY CONSENT

CLIENT RIGHTS AND HIPAA AUTHORIZATIONS

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time (HIPAA).

1. Tell your provider if you do not understand this authorization, and the provider will explain it to you.

2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to the provider at the following address: 4873 Port Royal Rd, Spring Hill, TN 37174:

3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, payment, enrollment or your eligibility for benefits. However, you may be required to complete this authorization form before receiving treatment if you have authorized your provider to disclose information about you to a third party. If you refuse to sign this authorization, and you have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a patient in their practice.

4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA. If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.

5. You may inspect or copy the protected dental information to be used or disclosed under this authorization. You do not have the right of access to the following protected dental information: psychotherapy notes, information compiled for legal proceedings, laboratory results to which the Clinical Laboratory Improvement Act (CLIA) prohibits access or information held by certain research laboratories. In addition, our provider may deny access if the provider reasonably believes access could cause harm to you or another individual. If access is denied, you may request to have a licensed health care professional for a second opinion at your expense.

6. If this office initiated this authorization, you must receive a copy of the signed authorization.

7. Special Instructions for completing this authorization for the use and disclosure of Psychotherapy Notes. HIPAA provides special protections to certain medical records known as Psychotherapy Notes. All Psychotherapy Notes recorded on any medium by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separately from the rest of the clients medical records to maintain a higher standard of protection. Psychotherapy Notes are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separate from the rest of the individuals medical records. Excluded from the Psychotherapy Notes definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. Except for limited circumstances set forth in HIPAA, in order for a medical provider to release Psychotherapy Notes to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other dental records.

8. You have a right to an accounting of the disclosures of your protected dental information by the provider or its business associates. The maximum disclosure accounting period is the six years immediately preceding the accounting request. The provider is not required to provide an accounting for disclosures: (a) for treatment, payment, or dental care operations; (b) to you or your personal representative; (c) for notification of or to persons involved in an individuals dental care or payment for dental care, for disaster relief, or for facility directories; (d) pursuant to an authorization; (e) of a limited data set; (f) for national security or intelligence purposes; (g) to correctional institutions or law enforcement officials for certain purposes regarding inmates or individuals in lawful custody; or (h) incident to otherwise permitted or required uses or disclosures. Accounting for disclosures to dental oversight agencies and law enforcement officials must be temporarily suspended on their written representation that an accounting would likely impede their activities.

Patient's signature: Date:

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FINANCIAL POLICY

FINANCIAL POLICY

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require that you read and sign prior to any treatment. It is our hope that this policy will facilitate open communication between us and help avoid potential misunderstandings, allowing you to always make the best choices related to your care.

INSURANCE:

Please remember your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy to you, our office provides certain services, including a pre-treatment estimate which we send to the insurance company at your request. It is physically impossible for us to have the knowledge and keep track of every aspect of your insurance. It is up to you to contact your insurance company and inquire as to what benefits your employer has purchased for you. If you have any questions concerning the pre-treatment estimate and/or fees for service, it is your responsibility to have these answered prior to treatment to minimize any confusion on your behalf.

Please be aware some or perhaps all of the services provided may or may not be covered by your insurance policy. Any balance is your responsibility whether or not your insurance company pays any portion.

PAYMENT:

Understand that regardless of any insurance status, you are responsible for the balance due on your account. You are responsible for any and all professional services rendered. This includes but is not limited to: dental fees, surgical procedures, tests, office procedures, medications and also any other services not directly provided by the dentist.

FULL PAYMENT is due at the time of service. If insurance benefits apply, ESTIMATED PATIENT CO-PAYMENTS and DEDUCTIBLES are due at the time of service, unless other arrangements are made.

UNPAID BALANCE over 90 days old will be subject to a monthly interest of 1.0% (APR 12%). If payment is delinquent, the patient will be responsible for payment of collection, attorneys fees, and court costs associated with the recovery of the monies due on the account.

MISSED APPOINTMENTS:

Unless we receive notice of cancellation 48 hours in advance, you will be charged $50. Please help us maintain the highest quality of care by keeping scheduled appointments.

I have read, understand and agree to the terms and conditions of this Financial Agreement.

Patient's signature: Date:

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COMMUNICATION CONSENTS

EMAIL CONSENT FORM

PURPOSE: This form is used to obtain your consent to communicate with you by email regarding your Protected Health Information. Spring Hill Smiles, Larrabee Family Dentistry & Orthodontics offers patients the opportunity to communicate by email. Transmitting patient information by email has a number of risks that patients should consider before granting consent to use email for these purposes. Spring Hill Smiles, Larrabee Family Dentistry & Orthodontics will use reasonable means to protect the security and confidentiality of email information sent and received. However, Spring Hill Smiles, Larrabee Family Dentistry & Orthodontics cannot guarantee the security and confidentiality of email communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication of email between Spring Hill Smiles, Larrabee Family Dentistry & Orthodontics and myself, and consent to the conditions outlined herein. Any questions I may have, been answered by Spring Hill Smiles, Larrabee Family Dentistry & Orthodontics.

Patient's signature: Date:

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TEXT MESSAGE TO MOBILE CONSENT FORM

PURPOSE: This form is used to obtain your consent to communicate with you by mobile text messaging regarding your Protected Health Information. Spring Hill Smiles, Larrabee Family Dentistry & Orthodontics, offers patients the opportunity to communicate by mobile text messaging. Transmitting patient information by mobile text messaging has a number of risks that patients should consider before granting consent to use mobile text messaging for these purposes. Spring Hill Smiles, Larrabee Family Dentistry & Orthodontics will use reasonable means to protect the security and confidentiality of mobile text messaging information sent and received. However, Spring Hill Smiles, Larrabee Family Dentistry & Orthodontics cannot guarantee the security and confidentiality of mobile text messaging communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of mobile text messaging between Spring Hill Smiles, Larrabee Family Dentistry & Orthodontics and myself, and consent to the conditions outlined herein. Any questions I may have, been answered by Spring Hill Smiles, Larrabee Family Dentistry & Orthodontics.

Patient's signature: Date:

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DENTAL INSURANCE INFORMATION

| DOB:

Created at: **07/16/2024 7:25:43 AM**

Primary Insurance Information

Do you have a dental insurance?	
Would you please upload dental insurance card photo?	
Patient's relationship to the Insurance Holder	
Policy Holder's Name	
Policy Holder's Date of Birth	
Policy Holder's SSN	
Policy Holder's Address	
Policy Holder's City	
Policy Holder's State	
Policy Holder's ZIP	
Policy Holder's Phone Number	
Policy Holder's Employer	
Dental Insurance Company	
ID Number	
Group Number	
Phone number on the back of your insurance card	
Address on the back of your insurance card	

Secondary Insurance Information

Do you have a secondary dental insurance?	
That's all! If you would like to add secondary insurance, you need to provide primary insurance first.	
Would you like to upload dental insurance card photo?	
Patient's relationship to the Insurance Holder	
Policy Holder's Name	
Policy Holder's Date of Birth	
Policy Holder's SSN	
Policy Holder's Address	
Policy Holder's City	
Policy Holder's State	
Policy Holder's ZIP	
Policy Holder's Phone Number	
Policy Holder's Employer	
Dental Insurance Company	
ID Number	
Group Number	

Phone number on the back of your insurance card	
Address on the back of your insurance card	

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DENTAL HISTORY

| DOB:

General Information

Who was your previous Dentist and how long were you a patient there?	
Date of your last dental exam	
Date of your last cleaning	
Do you have any immediate concerns you'd like us to address?	

Office Relationship

What do you value most in your dental visits?	
Is there anything you prefer during your visits to make you more comfortable during your time with us?	
On a scale from 1-5, 5 being most terrified, are you fearful of dental treatment?	

Personal History

Please answer the following questions	
Are you concerned about the appearance of your teeth?	
Are you interested in improving your smile?	
Have you had any cavities within the past 2 years?	
Are any teeth currently sensitive to biting, sweets, hot, or cold?	
Do you avoid or have difficulty chewing or biting heavily any hard foods?	
Do you have any problems sleeping, wake up with a headache or with sore or sensitive teeth?	
Do you clench your teeth in the daytime?	
Do you wear, or have you ever worn a bite appliance? Either for clenching at night (a night guard) or for sleep apnea?	
Do you bite your nails, chew gum or on pens, hold nails with your teeth, or any other oral habits?	
Does the amount of saliva in your mouth seem too little or do you find yourself with a dry mouth often?	
Have you ever noticed a consistently unpleasant taste or odor in your mouth?	

Dental Structural History

Please answer the following questions	
Do your gums bleed when brushing or flossing?	
Is brushing or flossing typically painful?	
Have you ever experienced or been told you have gum recession?	
Have you ever been treated for or been told you have gum disease?	
Have you had any teeth removed for braces or otherwise?	
Do you know of any missing teeth or teeth that have never developed?	
Have you ever had braces, orthodontic treatment or spacers, or had a "bite adjustment?"	

Are your teeth becoming more crowded, overlapped, or "crooked?"	
Are your teeth developing spaces?	
Do you frequently get food caught between any teeth?	
Have you noticed your teeth becoming shorter, thinner, or flatter over the years?	
Do you have problems with your jaw joint? (TMD, popping, clicking, deviating from side to side when opening or closing?)	
Is it often difficult to open wide?	
Do you have more than one bite? Or do you notice shifting your jaw around to make your teeth fit together?	

Patient's signature: Date:

Doctor's signature: Date:

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HEALTH HISTORY

| DOB:

Summary

Medical Conditions	**none listed**
Allergies	**none listed**
Medications	**none listed**

Medical History

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, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

General Health Information	
Are you under a physician's care now?	
Have you ever been hospitalized or had a major operation?	
Have you ever had a serious head or neck injury?	
Are you taking any medications, pills, or drugs?	
Any history of bisphosphonate? (i.e Fosamax, Boniva, Actonel usually for osteoporosis treatment)	
Have you had an joint replacement surgery?	
Does your physican require you to premedicate with antibiotics for dental treatment?	
Are you wearing removable dental appliances?	
Chief dental complaint?	
Do you have history of tobacco use? If yes, please specify type, quantity and length of use	
Have you been diagnosed with sleep apnea?	
Are you currently being treated for, or ever been treated for sleep apnea?	
Have you been told you snore?	
Do you feel unrested?	
Do you have a history of substance abuse?	
Current or history of Cancer, Radiation treatment, or Chemotherapy?	
Women: Are you?	
Pregnant/Trying to get pregnant?	
Taking oral contraceptives?	
Nursing?	
It is important that you understand antibiotics (and some other medication) may interfere with the effectiveness of oral contraceptives.	
Are you allergic to any of the following?	
Aspirin	
Penicillin or other antibiotics	
Codeine	

Acrylic	
Metal	
Latex	
Sulfa Drugs	
Local Anesthetics	
Alcohol	
Barbiturates, sedatives or sleeping pill	
Iodine	
Narcotics	
Other?	
Do you use controlled substances?	
Have you ever had any serious illness not listed above?	
Do you have, or have you had, any of the following?	
AIDS/HIV Positive	
Alzheimer's Disease	
Anaphylaxis	
Anemia	
Angina (Chest pains)	
Arthritis/Gout	
Artificial Heart Valve	
Artificial Joint	
Asthma	
Blood Disease	
Blood Transfusion	
Breathing Problems	
Bruise Easily	
Cancer	
Chemotherapy	
Cold Sores/Fever Blisters	
Congenital Heart Disease	
Convulsions	
Cortisone Medicine	
Diabetes Type I	
Grind/Clench teeth	
Bleeding Disorder	
Dialysis	
Diabetes Type II	
Drug Addiction	
Easily Winded	
Emphysema	
Epilepsy or Seizures	
Excessive Bleeding	

Excessive Thirst	
Fainting/Dizzy Spells	
Frequent Cough	
Frequent Diarrhea	
Frequent Headaches	
Glaucoma	
Hay Fever	
Heart Attack/Failure	
Heart Murmur	
Heart Pacemaker	
Heart Trouble/Disease	
Hemophilia	
Hepatitis A or B	
Thyroid Disease	
COPD	
ADD/ADHD	
Heptatitis C	
Herpes	
High Blood Pressure	
High Cholesterol	
Hives/Rash	
Hyperthyroid Problems	
Hypothyroid Problems	
Hypoglycemia	
Irregular Heartbeat	
Kidney Problems	
Leukemia	
Liver Disease	
Low Blood Pressure	
Lung Disease	
Mitral Valve Prolapse	
Osteoporosis	
Pain in Jaw Joints	
Parathyroid Disease	
Psychiatric Care	
Difficulty Opening mouth	
Reoccurring Mouth Sores	
Autism Spectrum Disorder	
Radiation Treatments	
Recent Weight Loss	
Renal Dialysis	
Rheumatic Fever	

Rheumatism	
Scarlet Fever	
Shingles	
Sickle Cell Disease	
Sinus Trouble	
Spina Bifida	
Stomach/Intestinal Disease	
Stroke	
Swelling of Limbs	
Tonsillitis	
Tuberculosis	
Tumors/Growths	
Ulcers	
Venereal Disease	
Yellow Jaundice	
Depression/Anxiety	
Bronchitis	
Migraines	

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.

Patient's signature: Date:

Doctor's signature: Date: