Haley E. Schmitt, D.D.S
5120 Virginia Way, Ste B-12. Brentwood, TN 37027
(615) 373-0883

WELCOME

Patient Information (Confidential)

Name: _____ Birthdate: _____ SSN: ___ ___ _____

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

Email: _____ May we confirm your appointment via email? _____

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

Check appropriate status: Minor___ Single ____Married ____Divorced____ Widowed ____Separated ____

Patient's or Patient/Guardian Employed: _____ Work Phone: _____

Business Address: _____ City: _____ State: _____ Zip: _____

Spouse or Parent's Name: _____ Employer: _____ Work Phone: _____

If patient is a student, name of School/College: _____ City: _____State: _____

Whom may we thank for referring you? _____

Emergency Contact: _____ Phone Number: _____

Responsible Party

Person responsible for this account: _____ Relationship to patient: _____

Address: _____ Home Phone: _____

SSN: ____ __ _____ Birthdate: _____ Employer: _____

Work Phone: _____ Is this person currently a patient in our office? _____

Insurance Information (Please provide insurance card)

Name of Insured: _____ Relationship to Patient: _____

Birthdate: _____ SSN: ___ ___ _____ Home Phone: _____

Name of Employer: _____ Work Phone: _____

Address of Employer: _____ City: _____ State: _____ Zip: _____

Insurance Company: _____ ID: _____ Group Number: _____

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? ☐Excellent ☐Good ☐Fair ☐Poor

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1. hospitalization for illness or injury _____	☐	☐
2. an allergic reaction to _____	☐	☐
☐ aspirin, ibuprofen, acetaminophen, codeine		
☐ penicillin		
☐ erythromycin		
☐ tetracycline		
☐ sulfa		
☐ local anesthetic		
☐ fluoride		
☐ metals (nickel, gold, silver, _____)		
☐ latex		
☐ other _____		
3. heart problems, or cardiac stent within the last six months __	☐	☐
4. history of infective endocarditis _____	☐	☐
5. artificial heart valve, repaired heart defect (PFO) _____	☐	☐
6. pacemaker or implantable defibrillator _____	☐	☐
7. orthopedic implant (joint replacement) _____	☐	☐
8. rheumatic or scarlet fever _____	☐	☐
9. high or low blood pressure _____	☐	☐
10. a stroke (taking blood thinners) _____	☐	☐
11. anemia or other blood disorder _____	☐	☐
12. prolonged bleeding due to a slight cut (INR > 3.5) _____	☐	☐
13. emphysema, shortness of breath, sarcoidosis _____	☐	☐
14. tuberculosis, measles, chicken pox _____	☐	☐
15. asthma _____	☐	☐
16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus)	☐	☐
17. kidney disease _____	☐	☐
18. liver disease _____	☐	☐
19. jaundice _____	☐	☐
20. thyroid, parathyroid disease, or calcium deficiency _____	☐	☐
21. hormone deficiency _____	☐	☐
22. high cholesterol or taking statin drugs _____	☐	☐
23. diabetes (HbA1c = _____) _____	☐	☐
24. stomach or duodenal ulcer _____	☐	☐
25. digestive disorders (i.e. celiac disease, gastric reflux) _____	☐	☐
26. osteoporosis/osteopenia (i.e. taking bisphosphonates) _____	☐	☐
27. arthritis _____	☐	☐
28. autoimmune disease _____	☐	☐
(i.e. rheumatoid arthritis, lupus, scleroderma)		
29. glaucoma _____	☐	☐
30. contact lenses _____	☐	☐
31. head or neck injuries _____	☐	☐
32. epilepsy, convulsions (seizures) _____	☐	☐
33. neurologic disorders (ADD/ADHD, prion disease) _____	☐	☐
34. viral infections and cold sores _____	☐	☐
35. any lumps or swelling in the mouth _____	☐	☐
36. hives, skin rash, hay fever _____	☐	☐
37. STI / STD / HPV _____	☐	☐
38. hepatitis (type ___) _____	☐	☐
39. HIV / AIDS _____	☐	☐
40. tumor, abnormal growth _____	☐	☐
41. radiation therapy _____	☐	☐
42. chemotherapy, immunosuppressive medication _____	☐	☐
43. emotional difficulties _____	☐	☐
44. psychiatric treatment _____	☐	☐
45. antidepressant medication _____	☐	☐
46. alcohol / recreational drug use _____	☐	☐
ARE YOU:		
47. presently being treated for any other illness _____	☐	☐
48. aware of a change in your health in the last 24 hours		
(i.e. fever, chills, new cough, or diarrhea) _____	☐	☐
49. taking medication for weight management _____	☐	☐
50. taking dietary supplements _____	☐	☐
51. often exhausted or fatigued _____	☐	☐
52. experiencing frequent headaches _____	☐	☐
53. a smoker, smoked previously or use smokeless tobacco _	☐	☐
54. considered a touchy / sensitive person _____	☐	☐
55. often unhappy or depressed _____	☐	☐
56. taking birth control pills _____	☐	☐
57. currently pregnant _____	☐	☐
58. prostate disorders _____	☐	☐

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)

_____

List all medications, supplements, and or vitamins taken within the last two years.

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

DENTAL HISTORY

Name_____ Nickname_____ Age_____
Referred by_____How would you rate the condition of your mouth? ☐Excellent ☐Good ☐Fair ☐Poor
Previous Dentist _____How long have you been a patient?_____Months/Years☐
Date of most recent dental exam _____/_____/_____ Date of most recent x-rays _____/_____/_____
Date of most recent treatment (other than a cleaning) _____/_____/_____
I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING: **YES** **NO**

PERSONAL HISTORY

1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [___] _____ ☐ ☐
2. Have you had an unfavorable dental experience? _____ ☐ ☐
3. Have you ever had complications from past dental treatment? _____ ☐ ☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____ ☐ ☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? _____ ☐ ☐
6. Have you had any teeth removed or missing teeth that never developed? _____ ☐ ☐

GUM AND BONE

7. Do your gums bleed or are they painful when brushing or flossing? _____ ☐ ☐
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____ ☐ ☐
9. Have you ever noticed an unpleasant taste or odor in your mouth? _____ ☐ ☐
10. Is there anyone with a history of periodontal disease in your family? _____ ☐ ☐
11. Have you ever experienced gum recession? _____ ☐ ☐
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____ ☐ ☐
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth? _____ ☐ ☐

TOOTH STRUCTURE

14. Have you had any cavities within the past 3 years? _____ ☐ ☐
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____ ☐ ☐
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____ ☐ ☐
17. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? _____ ☐ ☐
18. Do you have grooves or notches on your teeth near the gum line? _____ ☐ ☐
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____ ☐ ☐
20. Do you frequently get food caught between any teeth? _____ ☐ ☐

BITE AND JAW JOINT

21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____ ☐ ☐
22. Do you feel like your lower jaw is being pushed back when you bite your teeth together? _____ ☐ ☐
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? _____ ☐ ☐
24. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____ ☐ ☐
25. Are your teeth becoming more crooked, crowded, or overlapped? _____ ☐ ☐
26. Are your teeth developing spaces or becoming more loose? _____ ☐ ☐
27. Do you have more than one bite, squeeze, or shift your jaw to make your teeth fit together? _____ ☐ ☐
28. Do you place your tongue between your teeth or close your teeth against your tongue? _____ ☐ ☐
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____ ☐ ☐
30. Do you clench your teeth in the daytime or make them sore? _____ ☐ ☐
31. Do you have any problems with sleep (i.e. restlessness), wake up with a headache or an awareness of your teeth? _____ ☐ ☐
32. Do you wear or have you ever worn a bite appliance? _____ ☐ ☐

SMILE CHARACTERISTICS

33. Is there anything about the appearance of your teeth that you would like to change? _____ ☐ ☐
34. Have you ever whitened (bleached) your teeth? _____ ☐ ☐
35. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____ ☐ ☐
36. Have you been disappointed with the appearance of previous dental work? _____ ☐ ☐

Patient's Signature _____ Date_____
Doctor's Signature _____ Date _____

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I, _____, **HAVE RECEIVED A COPY OF PRINT THIS OFFICE'S NOTICE OF PRIVACY PRACTICES.**

_____

PLEASE PRINT PATIENT'S NAME (IF DIFFERENT FROM ABOVE)

_____

PATIENT'S SIGNATURE (PARENT/GUARDIAN SIGNATURE IF PATIENT IS A MINOR)

_____

DATE

I understand that due to HIPAA regulations, patient information may NOT be released to ANY family member or friend without written authorization completed on the HIPAA disclosure form. There are disclosure exceptions if the patient is a minor or when Power of Attorney has been established.

IF SOMEONE OTHER THAN YOURSELF WILL NEED TO PICK UP PRESCRIPTIONS, REQUEST DENTAL RECORDS OR SCHEDULE APPOINTMENTS, PLEASE COMPLETE THE "AUTHORIZATION FOR USE OR DISCLOSURE OF INFORMATION" BELOW.

Please list the names of those you wish to give permission for our office to speak with on your behalf.

1._____RELATIONSHIP TO PATIENT: _____

2._____RELATIONSHIP TO PATIENT: _____

Financial Agreement

1. At your appointment, your services will be filed with your insurance as a courtesy and your *ESTIMATED* portion is collected. **Payment is due in full** the day of the appointment as services are rendered. Each dental insurance policy is different, and it is your responsibility to know and understand your individual benefits. Please note, we are unable to know exactly how much your insurance company will cover until we receive payment on the submitted services. If your insurance company does not cover a portion of the treatment performed, you will be responsible for the balance. For your convenience, we accept all major credit cards. There will be a $24 returned check fee assessed to your account if a payment is returned to us for any reason.

2. **Dental Insurance: Haley E. Schmitt DDS** strives to provide our patients with the best quality of care available and base our treatment recommendations on what we feel is best for your oral health not what your insurance company does or does not pay for. Please review the following regarding dental insurance coverage:

    a. As a dental care provider, our relationship is with you the patient and not your dental insurance company. Your dental insurance is a contract between you and your insurance company.
    b. As a courtesy, we will file your insurance claim for you at the time services are rendered. Please note, any amount that is not paid by your insurance company is the patient's responsibility. This may include deductibles, co-payments, frequencies, and procedures not covered by your dental insurance.
    c. Some insurance companies downgrade services. They determine if they will pay for a less costly service than the covered service performed by the dentist. For example, composite fillings and porcelain crows may be downgraded to amalgam fillings and full metal crowns. The difference between the services performed and the less costly service is the patient's responsibility. Any co-payment that is collected at the time of visit is an ESTIMATE. Please understand that it is ultimately your responsibility to find out if your insurance is in or out of network with us.

3. **Confirmation/Cancellation Policy:** In order to accommodate our patient's needs, we require <u>all</u> appointments to be confirmed <u>48 hours prior</u> to the scheduled date. If your appointment is not confirmed this can delay your treatment. We require a minimum of 48 hour notice prior if unable to keep your appointment. If notice is not given there will be a $50 charge notated on your account.

    By signing below, I have read and understand my financial obligation and agree to abide by this policy.

_____ _____

Signature Date

Photo and Testimonial Release

I,_____ hereby grant permission to Haley E. Schmitt DDS Cosmetic & Family Dentistry to use my photograph and any testimonial or review I give regarding the dental care I have received in any print and electronic form including, but not limited to, marketing, contests, advertising and educational materials used to advertise the dental practice. This may include use on our dental website and social media pages. I acknowledge the right of Haley E. Schmitt DDS to crop or otherwise edit any photograph, testimonial or review at their discretion. I also acknowledge that Haley E. Schmitt DDS may choose not to use my photograph, testimonial or review at this time but may do so at their discretion at a later date.

I understand the policy that Haley E. Schmitt DDS is only to use first name and last initial when labeling photographs, reviews and testimonials.

_____ _____

Patient/ Legal Guardian Name (Print) **Patient/Legal Guardian Signature**

_____

Date

Patient Rights

Access: You have the right to look at our obtain copies of your health information, with limited exceptions. Access to health information must be requested in writing. You may obtain a form to request access by using the contact information listed at the end of this notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also obtain access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you $18.00 to copy your dental information and x rays, and postage if you would like the copies mailed to you. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before March 25, 2022. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions, but if we do, we will abide by our agreement (except for in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means of location and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information show be amended). We may deny your request under certain circumstances.

Electronic Notice: If you receive this notice on our website or by electronic mail (e-mail), you are entitled to receive this notice in written form.

Questions and Complaints

If you would lie more information about our privacy practices or have questions or concerns, please contact us.
If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may voice your complaint to us using the contact information listed at the end of this notice. You also may submit a written complaint to the U.S. department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.
We support your right to privacy of your health information. We will not retaliate in any way you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Lynn McPhail, Office Manager
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