PATIENT

PATIENT LAST NAME FIRST MIDDLE	PREFERRED NAME TO BE CALLED	TODAY'S DATE	□ MALE □ FEMALE

BIRTH DATE M. D YR	SOCIAL SECURITY NUMBER	HOME PHONE □ NONE MESSAGE PHONE	MARITAL STATUS □S □M □W □D □SEP

MAILING ADDRESS	CELL PHONE	CITY	STATE	ZIP CODE
EMAIL ADDRESS		CITY	STATE	ZIP CODE

NEAREST FRIEND OR RELATIVE NOT LIVING WITH YOU	RELATIONSHIP	PHONE ( )	ADDRESS

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?	RELATIONSHIP

SELF IF MALE, HUSBAND, OR FATHER OF PATIENT IF APPLICABLE (PLEASE FILL OUT COMPLETELY) FINANCIAL RESPONSIBILITY

PERSON RESPONSIBLE LAST NAME FIRST MIDDLE	RELATIONSHIP

HOME PHONE □SAME	SOCIAL SECURITY NUMBER	DRIVER'S LICENSE NUMBER	STATE

HOME ADDRESS □SAME AS ABOVE	CITY	STATE	ZIP CODE

EMPLOYER □SELF □NONE □RET	EMPLOYER	BUS. PHONE	OCCUPATION

SELF IF FEMALE, WIFE, OR MOTHER OF PATIENT IF APPLICABLE (PLEASE FILL OUT COMPLETELY) FINANCIAL RESPONSIBILITY

PERSON RESPONSIBLE LAST NAME FIRST MIDDLE	RELATIONSHIP

HOME PHONE □SAME	SOCIAL SECURITY NUMBER	DRIVER'S LICENSE NUMBER	STATE

HOME ADDRESS □SAME AS ABOVE	CITY	STATE	ZIP CODE

EMPLOYER □SELF □NONE □RET	EMPLOYER	BUS. PHONE	OCCUPATION

IF PATIENT IS UNDER AGE 21

FULL TIME STUDENT □YES □NO	SCHOOL ATTENDING	CITY	GRADE

BOTH PARENTS NAMES	MARITAL STATUS □S □M □W □D □SEP	IF PARENTS ARE DIVORCED, WHO HAS: LEGAL CUSTODY? □Mo □Fa FINANCIAL CUSTODY? □Mo □Fa

PRIMARY DENTAL INSURANCE □NONE □PA, MEDICAID, WELFARE (If None or PA, Turn Page Over)

INSURANCE COMPANY NAME	INSURANCE COMPANY ADDRESS	CITY	STATE	ZIP CODE

INSURANCE CO. PHONE NO.	SUBSCRIBER'S LAST NAME FIRST MIDDLE	SUBSCRIBER'S BIRTH DATE

POLICY OR SOC. SEC. NO.	GROUP NO.	GROUP NAME	RELATIONSHIP OF PATIENT TO SUBSCRIBER □SELF □SPOUSE □CHILD □OTHER

SECONDARY DENTAL INSURANCE □NONE (If, Turn Page Over)

INSURANCE COMPANY NAME	INSURANCE COMPANY ADDRESS	CITY	STATE	ZIP CODE

INSURANCE CO. PHONE NO.	SUBSCRIBER'S LAST NAME FIRST MIDDLE	SUBSCRIBER'S BIRTH DATE

POLICY OR SOC. SEC. NO.	GROUP NO.	GROUP NAME	RELATIONSHIP OF PATIENT TO SUBSCRIBER □SELF □SPOUSE □CHILD □OTHER

Financial Information

Kote Family Dentistry
610 Smithview Dr
Maryville, TN 37803
865.984.6193

Our goal is to provide the highest quality of dental care possible and to have clear communication of our financial policy.

ALL ACCOUNTS ARE DUE AND PAYABLE AT TIME OF SERVICE. If a procedure requires multiple appointments, payment is required in full at the first appointment unless other arrangements are made prior to appointment with the office.

Payment options:
1. Cash
2. Check
3. Accepted Credit cards
4. Care Credit

Patient with insurance: The PATIENT is responsible for the ESTIMATED non-covered portion, procedures and/or deductibles at the time of the service. If the insurance company does not pay after 60 days, we will bill you directly for the balance.

Parents not accompanying their child to an appointment must make PRIOR arrangements for payment (cash, check or credit card authorization).

Parents accompanying their children are financially responsible for payment.

A minimal **interest** is charged for any unpaid balance over $5.00.

There is a $25.00 processing charge for **non-sufficient funds** or returned checks.

Records can be viewed at any time. There may be a nominal charge for release or copies of records.

Because instruments, chairs, and personnel are reserved exclusively for your appointment, there may be a **CHARGE FOR CHANGED OR BROKEN APPOINTMENTS LESS THAN 48 HOURS IN ADVANCE**.

I, _____ , agree to these financial terms.

Signature _____ Date_____

HIPAA Release of information AUTHORIZATION FORM

I, _____, hereby authorize Kote Family Dentistry and its affiliates, its employees and agents, to release my personal health information maintained by Kote Family Dentistry (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) except the following information about me:

_____[DESCRIBE INFORMATION NOT TO BE DISCLOSED, IF ANY] for the purpose of helping us to resolve claims and health benefit coverage issues. I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we disclose your information for treatment purposes are: setting up appointments, examining your teeth, prescribing medications, referring you to another doctor for health care services, getting copies of your health information from another professional that you may have seen. Examples of how we use your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment, preparing and sending claims, and collecting unpaid amounts.

I understand that I have a right to revoke this authorization by providing written notice to Kote Family Dentistry. However, this authorization may not be revoked if Kote Family Dentistry, it's employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

Name of Patient: _____

Signature of Patient: _____ Date:_____

If applicable, Legal Representatives sign below:
By signing this form, I represent that I am the legal representative of the patient identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the patient's behalf with respect to this authorization form.

Name of Legal Representative: _____

Signature of Legal Representative: _____ Date: _____

Name of Witness: _____

Signature of Witness: _____

Medical Information Release Form
(HIPAA Release Form)

Name: _____Date of Birth: _____/____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:_____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (day)_____ between (time)_____

Signed: _____ Date: ____/____/_____

Witness:_____ Date: ___/____/_____

Kote Family Dentistry
610 Smithview Drive
Maryville, TN 37803

General Consent for Treatment and Local Anesthesia

Although the use of local anesthetics to control pain is a safe, well-established procedure, adverse reactions can occur. These reactions include, but are not limited to, the following:

* Swelling, discomfort or light bleeding at site of injection
* Infection at site of injection
* Prolonged numbness and tingling sensation in oral cavity. These sensations are usually temporary, but can be permanent
* Loss of taste temporarily
* Jaw muscle cramps and spasms
* Jaw joint discomfort or pain radiating to head, neck and ear
* Nausea, dizziness and vomiting
* Allergic reaction
* Rapid or irregular heartbeat
* Biting of the cheek, lip and tongue after treatment resulting in swelling and discomfort

To decrease your risk of a potentially serious drug reaction, please provide us with the knowledge of any past drug allergies or adverse reactions such as:

* Allergic reaction - itching, swelling, difficulty breathing
* Adverse reaction - nausea, vomiting, headache, drowsiness

Depending on the procedure, minor to moderate sensitivity of the teeth or soreness of the gums in the area that was treated is completely normal. If you have any questions or concerns after care, please do not hesitate to call our office.

I have read and understand this form and give general informed consent for dental treatment.

_____ _____

Patient's signature or legal guardian Date

Time 11:27 AM | Dr. Arthur Kote | Date 9/25/2017

Eaglesoft Medical History

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?	◯ Yes ◯ No	
Do you use controlled substances?	◯ Yes ◯ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ 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
Angina ◯ 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:_____