**Joshua M. Hethcox Periodontics, P.C.** Date: _____

## PATIENT INFORMATION

Name: _____ Birthdate: _____

How do you prefer to be addressed: _____ SSN: _____

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

Email Address: _____

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

Employer: _____ Occupation: _____

Employer's Address: _____ City: _____ State: _____ Zip: _____

Whom may we thank for this referral? _____

Your Dentist: _____ Date of last visit: _____

Emergency Contact: _____

Emergency Contact Phone #: _____ Relationship to you: _____

Your Pharmacy: _____ Pharmacy Phone: _____

### Primary Insurance Information (Dental)

Policy Holder's Name: _____ Relationship to patient: _____

Birthdate: _____ SSN: _____ Employer: _____

Employer's Address: _____ City: _____ State: _____ Zip: _____

Insurance Company _____

Insurance Co. Address: _____

Subscriber #: _____ Group #: _____

### Secondary Insurance Information (Dental)

Policy Holder's Name: _____ Relationship to patient: _____

Birthdate: _____ SSN: _____ Employer: _____

Employer's Address: _____ City: _____ State: _____ Zip: _____

Insurance Company _____

Insurance Co. Address: _____

Subscriber #: _____ Group #: _____

**Please Read and Sign Back Page**

# -H-

## Joshua M. Hethcox Periodontics, P.C.

### OUR PROMISE TO YOU

It is the desire of Dr. Hethcox and his staff to provide you with a personalized, honest, and caring experience. Dr. Hethcox strives to use the most current technology and treatment methods to provide you with the best possible treatment and outcome for your dental health. We recognize that you have entrusted to us your dental health. We are honored that you have chosen to do so and will do our best to provide you with the best possible care.

### INSURANCE BENEFITS

With the many changes that are occurring in the insurance industry, our office has adopted the following policy: As a courtesy to the patient, this office will file your claim with your insurance company in order that *you* receive *direct reimbursement* for the amount covered by insurance. This office will not be responsible for tracking the status of the claim after the insurance company has accepted it. Any precedent to recovery or administrative appeals required by the policy shall be the sole responsibility of the patient/guarantor, and not Dr. Hethcox.

### FINANCIAL AGREEMENT

I understand I am financially responsible to Dr. Hethcox for all charges associated with services received and that *payment is due in full at the time such services are rendered* unless other arrangements have been made. Dr. Hethcox does not want finances to be a barrier to receiving treatment. He & his office staff would be more than willing to make a financial arrangement prior to services being rendered if circumstances warrant the need. The undersigned hereby obligates himself/herself to pay Dr. Hethcox for treatment rendered to the patient in accordance with regular rates and terms of this dental office, whether he/she signs as patient or representative of patient. Should accounts be referred to an attorney or collection agency for collection, the undersigned shall pay actual attorney's fees and collection expense. In the event a patient does not show for an appointment for scheduled treatment this office reserves the right to assess a charge up to $50.

I certify that I have read and understand the above information. I authorize Dr. Hethcox and his staff to submit any such insurance claims on my behalf for patient reimbursement. I agree to be responsible for payment of all services at the time that such services are rendered.

Signature:_____ Date: _____

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PERIODONTICS

# PATIENT HEALTH HISTORY

**Patient Name**_____
**Birthdate**_____
**Date**_____

**SECTION A**

Primary Physician_____
Primary Physician phone number_____

Y N 1. Has there been a change in your health in the past year?
Y N 2. Are you under a physician's care for a particular problem?
Y N 3. Have you ever had any serious illnesses or hospitalizations?
Y N 4. Have you ever had a serious head or neck injury?

**SECTION B: Do you have or have you ever had the following?**

Y N 1. Rheumatic fever
Y N 2. Congenital heart disease
Y N 3. High blood pressure
Y N 4. Artificial heart valve or pacemaker
Y N 5. Cardiovascular disease (heart attack, heart murmur, coronary artery disease, angina, heart trouble)
Y N 6. Stroke
Y N 7. Seizures, convulsions, epilepsy, fainting, dizziness
Y N 8. Asthma
Y N 9. Lung disease (COPD, emphysema, bronchitis, pneumonia, TB)
Y N 10. Bleeding disorder, anemia, do you bleed easily?
Y N 11. Liver disease (hepatitits)
Y N 12. Kidney disease
Y N 13. Diabetes--Type 1 or Type 2 (HbA1c=_____)
Y N 14. Thyroid disease (hypothyroidism)
Y N 15. Arthritis
Y N 16. High cholesterol
Y N 17. Osteoporosis / osteopenia
Y N 18. Artificial joints or implants (hip, knee, etc)
Y N 19. Cancer treatment (radiation, chemotherapy)
Y N 20. Sinus or nasal problems
Y N 21. Sexually transmitted disease, HIV, AIDS

**SECTION C: Are you allergic to any of the following?**

Y N 1. Penicillin or other antibiotics
Y N 2. Codeine or other pain killers
Y N 3. Latex or any metal products
Y N 4. Other allergies please

**SECTION D: Are you using any of the following?**

Y N 1. Antibiotics
Y N 2. Anticoagulants (blood thinners)
Y N 3. Aspirin
Y N 4. Narcotics
Y N 5. Bisphosphonates (such as Fosamax, Actonel, Boniva, Aredia, Zometa)
Y N 6. Steroids
Y N 7. Medications for sleeping
Y N 8. Chronic pain medicine
Y N 9. Do you smoke or chew tobacco?
How much per day?_____

**SECTION E: FOR WOMEN ONLY**

Y N 1. Are you pregnant, or is there any chance you might be pregnant?
Y N 2. Are you nursing?
Y N 3. Are you using oral contraceptives?
*It is important that you understand that antibiotics may interfere with the effectiveness of oral contraceptives. Please consult your physician for further guidance.*

**MEDICATIONS**

1. Please list all prescription medications

_____
_____
_____
_____
_____
_____

2. Please list all over-the-counter medications and herbal treatments.

_____
_____
_____

**I understand the importance of a truthful Health History to assist the doctor in providing optimal care, so I have answered these questions to the best of my ability.**

*Signature*_____ *Date*_____ *Doctor's Initials*_____

**Medical Update:** I have read my health history and confirm it states past and present conditions accurately.

Date_____ Patient signature_____ Doctor/Hygienist initials_____

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## DENTAL HISTORY

**Patient Name**_____
**Birthdate**_____
**Date**_____

**Please answer the following questions.**

Y N Do your gums or teeth hurt now?
Y N Have you had an abscess within the past 3 months?
Y N Have you had a toothache within the past 3 months?
Y N Are you sensitive to hot or cold?
Y N Do you clench or grind your teeth?
Y N Do you wear a nightguard?
Y N Have you ever had periodontal (gum) treatment?
If yes, when and what treatment was done?_____
_____

How often do you brush your teeth?_____
How often do you floss between your teeth?_____
When were your teeth last "cleaned" at a dental office?_____
How many times have your teeth been "cleaned" at a dental office in the past 3 years?_____
Is there anything you dislike about your smile? If yes, what?_____

### CONSENT FOR DENTAL TREATMENT

I (print name), _____, grant permission to Joshua M. Hethcox, DDS, MS and his dental office to perform the following dental procedures: a complete periodontal examination, diagnosis of oral conditions, order and take radiographs as needed for diagnosis and treatment, periodontal maintenance, cleaning teeth (scaling and root planing, prophylaxis), and administer local anesthetic when necessary.

Signature_____ Date_____

### CONSENT FOR DENTAL TREATMENT OF A MINOR

I (print name), _____, the parent and/or legal guardian of (print name) _____, a minor, whose date of birth is _____, grant permission to Joshua M. Hethcox, DDS, MS and his dental office to perform the following dental procedures: a complete periodontal examination, diagnosis of oral conditions, order and take radiographs as needed for diagnosis and treatment, periodontal maintenance, cleaning teeth (scaling and root planing, prophylaxis), and administer local anesthetic when necessary.

Signature of parent/guardian_____ Date_____

**Joshua M. Hethcox, DDS, MS**
**Notice of Information Practices**

## HIPAA PRIVACY POLICY

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

*Dr. Hethcox & his staff understand that medical information about you & your health is personal, & is committed to protecting your medical information. Individually identifiable information about your past, present or future health or condition, the provision of health care to you, or payment of such health care is considered "Protected Health Information".*

We are required to provide this Notice to you by the Health Insurance Portability and Accountability Act (**"HIPAA"**). For additional information regarding our HIPAA Medical Information Privacy Policy or our general privacy policies, we are required by law to:

- Maintain the privacy of your Personal Health Information;
- Provide you this notice of our legal duties & privacy practices with respect to your Personal Health Information; &
- Follow the terms of this notice.

We **protect** your Personal Health Information from inappropriate use or disclosure. Our employees are required to comply with our requirements that protect the confidentiality of Personal Health Information. They may look at your personal health Information only when there is an appropriate reason to do so, such as to administer our products or services.

We will **not disclose** your Personal Health Information to any other company for their use in marketing their products to you. However, as described below, we will use & disclose Personal Health Information about you for business purposes relating to your Dental Insurance coverage.

We use & disclose health information about you for treatment, payment, & healthcare operations. For example:

- **For Treatment:** We may use or disclose your health information to a dentist, physician, or other healthcare provider providing treatment to you.
- **For Payment:** We may use & disclose your health information to assist you in obtaining reimbursement from your dental insurance company for services we provide to you.
- **Healthcare Operations:** We may use & disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment & improvement activities, reviewing the competence or qualifications or healthcare professionals, evaluating practitioner & provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.
- **Required By Law:** We may disclose your health information when we are required to do so by law.
- **To Avert a Serious Threat to Health or Safety:** We may disclose Personal Health Information to avert a serious threat to someone's health or safety. We may also disclose Personal Health Information to federal, state or local agencies engaged in disaster relief.
- **To Your Family/Friends:** We may disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to assist you with your healthcare, but only if you agree that we may do so.
- **Persons Involved in Care:** We may use or disclose health information to notify, or assist in the notification of a family member or representative responsible for your care. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment, disclosing only health information that is directly relevant to the person's involvement in your healthcare.
- **For Law Enforcement or Specific Government Functions:** We may disclose Personal Health Information in response to a request by a law enforcement official made through a court order, subpoena, warrant, summons or similar process. We may disclose Personal Health Information about you to federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
- **When Requested as Part of a Regulatory or Legal Proceeding:** If you or your estate are involved in a lawsuit or a dispute, we may disclose Personal Health Information about you in response to a court or administrative order. We may disclose Personal Health Information to any governmental agency or regulator with whom you have filed a complaint or as part of a regulatory agency examination.
- **Other Uses of Personal Health Information:** Other uses & disclosures of Personal Health Information not covered by this notice & permitted by the laws that apply to us will be made only with your written authorization or that of your legal representative. If we are authorized to use or disclose Personal Health Information about you, you or your legally authorized representative may revoke that authorization, in writing, at any time, except to the extent that we have taken action relying on the authorization. You should understand that we would not be able to take back any disclosures we have already made with authorization.

**If you wish to inspect your records or correct information in your record, or if you have any questions or complaints you may contact us at:**

**Dr. Joshua M. Hethcox, Periodontics**
**101 Sherlake Lane, Suite 103**
**Knoxville, TN 37922**
**865-247-6250**

***Please Sign Back***

**Joshua M. Hethcox, DDS, MS**

You may refuse to sign this acknowledgement.

I, _____, have received and reviewed a copy of the Notice of
(Please Print Name)

Privacy Practices of Dr. Joshua M. Hethcox.

_____
Please Print Name

_____ _____
Signature Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, as required by law, but acknowledgement could not be obtained because:

_____ Individual refused to sign

_____ Communication barriers prohibited obtaining the acknowledgment

_____ An emergency situation prevented us from obtaining the acknowledgment

_____ Other (please specify):

_____