TIME 02:30 PM DATE 12/21/2018

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

Emergency Contact __

Emerg. Contact #____

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Time 2:31 PM | Mission Dental | Date 12/21/2018

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

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:_____

Makeya Jenkins, DDS
2120 Murfreesboro Pike
Nashville, TN 37217

RESERVATION POLICY

It is our goal to render excellent dental care to our patients. To be consistent with this, we have a **Reservation Policy** that allows us to maintain integrity in seeing our patients in a timely manner. When chair-time is reserved, we set aside a specific amount of time to give our patients our undivided attention. Therefore, when a patient is late, that time is then limited, and forces our team to squeeze in as much as we can, to be on time for our next scheduled reservation. If a reservation is canceled 24 hours or less, it does not provide us ample amount of time to schedule another patient in that reserved chair. With this said, **our policy is as follows:**

We require that you give our office **48-hour** notice if you need to reschedule your reservation. This allows for other patients to reserve that chair, if needed. If you miss a reservation without contacting our office within the required time, this is considered a missed reservation. As a courtesy, the first missed reservation will only be a reminder that the next missed reservation will incur a fee of $75.00. This fee cannot be billed to your insurance
company. Unfortunately, no future reservations can be scheduled, nor can records be transferred without payment of this fee.
Additionally, patients more than 15 minutes late without notice, will be considered a missed reservation and will incur the same fee of $75.00 after the first courtesy.
If you have any questions regarding this policy, please do not hesitate to ask our team!
We thank you for your patronage.

I have read and understand the Reservation Cancellation Policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

I, _____ (print name), have received a copy of **Mission Dental's** Reservation Cancellation Policy.

_____ _____
Signature Date

Makeya Jenkins, DDS
2120 Murfreesboro Pike
Nashville, TN 37217

INSURANCE POLICY

Our practice is committed to providing the best treatment possible for our patients! Mission Dental accepts many insurance policies and are in network with most companies.
So, what does this mean for you? As a patient who participates in an insurance plan through your place of employment or the Marketplace, it is important to know and understand that your insurance plan is a contract between the insurance company, your employer, and you.

Because we are honored to have you as a patient, we are committed to doing the hard part for you! It is our policy to VERIFY your coverage and **ESTIMATE** your out-of-pocket expenses before treating you. Please be mindful that these are just estimates. There are times your insurance company may pay LESS than promised, and times they may pay more than promised. Your insurance company ultimately gets to decide what they will or will not pay once the claim is submitted.

As a courtesy, our team will submit a single claim, up to two times for you. If payment from your insurance company is not received within 60 days of treatment, you are then responsible for the remaining balance.

All **ESTIMATED** out-of-pocket investments are due at the time of your reservation. I understand and agree that I will be responsible for any patient portion or account balance that remains unpaid by either me, or my insurance carrier after 60 days. In the case of default of payment, I promise to pay all accrued finance charges, interest, and administrative fees on the balance due, together with any collection costs and attorney's fees incurred in order to collect on this account.

I, _____ (print name), have received a copy of Mission Dental's Insurance Policy.

_____ _____
Signature Date

Makeya Jenkins, DDS
2120 Murfreesboro Pike
Nashville, TN 37217

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

You may refuse to sign this acknowledgement

I, _____ , have received a copy of this offices Notice of Privacy Practices.

_____
(Please Print Patient Name)

_____
(Signature of Patient or Guardian)

_____
(Date)

AUTHORIZATION OF RELEASE OF INFORMATION

Purpose: This form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself.

I, _____ , authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

_____ _____
(Please Print Name) (Relationship)

_____ _____
(Please Print Name) (Relationship)

_____ _____
(Please Print Name) (Relationship)