Cornerstone
FAMILY DENTISTRY

Confidential Patient Information		
First Name:	Middle:	Last Name:
Social Security Number:	Birth Date:	
Address:		Apt. No.
City:	State:	ZIP Code:
Phone:	Cell:	
Email:		Sex: □ Male □ Female
Emergency Contact Person:	Emergency Contact Phone:	
How Did You Hear About Us?	Whom May We Thank for Referring You?	

Guardian or Responsible Party (if patient us under 18 or disabled)		
First Name:	Middle:	Last Name:
Social Security Number:	Birth Date:	
Address (if different from patient):		Apt. No.
City:	State:	ZIP Code:
Phone:	Cell:	Email:
Signature:		**Date:**

Dental Insurance Information	
Primary Insurance	**Secondary Insurance**
Subscriber Name:	Subscriber Name:
Subscriber SSN:	Subscriber SSN:
Date of Birth:	Date of Birth:
Relationship to Subscriber: □ Self □ Spouse □ Child	Relationship to Subscriber: □ Self □ Spouse □ Child
Employer Name:	Employer Name:
Employer Phone:	Employer Phone:
Insurance Company:	Insurance Company:
Insurance Group #:	Insurance Group #:
Insurance Phone #:	Insurance Phone #:

*** Please present your insurance card and ID card to our patient services representative to be photocopied ***

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Dental and Medical Information

Reason for Today's Visit:		
Previous Dentist:		Phone:
Date of Last Dental Visit:	Date of Last Dental X-rays:	Date of Last Dental Cleaning:

Have you ever been treated for periodontal (gum) disease? □ Yes □ No

Have you ever had Novocaine or other local anesthetic? □ Yes □ No

Are you taking or have taken any steroid/cortisone therapy in the last 2 years? □ Yes □ No

Are you taking or have taken Oral Bisphosphonates (e.g. FOSAMAX, ACTONEL, BONIVA, or IV Bisphosphonates)? □ Yes □ No

Have you taken antibiotics prior to dental procedures in the past? □ Yes □ No

Have you ever received the HPV vaccination Gardasil? □ Yes □ No

Have you ever had an adverse reaction or become ill after taking penicillin, aspirin, codeine, local anesthetics, latex, metals, or any other medication? □ Yes □ No

List any medications you are allergic to: 1. _____ 2. _____ 3. _____

List any medications you are taking, including non-prescription drugs and herbals/vitamins:

1. _____ 2. _____ 3. _____ 4. _____

Do you have a history of:

	Y	N		Y	N		Y	N		Y	N
Rheumatic Fever			Asthma			Thyroid Disease			Alcoholism		
Heart Murmur			Allergies or Hives			Epilepsy or Seizures			Psychiatric Treatment		
Mitral Valve Prolapse			Anemia			Fainting or Dizzy Spells			Mouth Sores/Growths		
Diabetes			Teeth Grinding/Clenching			Pace Maker/Heart Surgery			Aspirin Therapy		
Venereal Disease			Arthritis			Pain in Your Jaw (TMJ)			Ulcers/Stomach Problems		
High Blood Pressure			HIV Positive/AIDS			Latex Allergy			Any type of Implant		
Low Blood Pressure			Blood Transfusion			Sinus Problems			Cancer (Type:)		
Any type of Transplant			Heart Problem			Excessive Bleeding			Any Artificial Joint		
Drug Use/Addiction			Dialysis			Stroke			Eating Disorder		
Hepatitis (Type:)			Chemotherapy			Lung Disease			Other Disease or Illness:		
Liver Disease			Radiation Treatment			Breathing Problems					
Kidney Disease			Use of Tobacco Products			Tuberculosis (TB)					

Women Patients	Y	N		Y	N
Is there a possibility of pregnancy?			Are you nursing?		
Estimated Delivery Date:			Are you taking any birth control prescriptions?		

I certify that I have read and understand the above questions and acknowledge that questions have been answered to the best of my knowledge. I hereby give my consent to the dentist to perform an examination and diagnose my condition. I also give my consent for any preventive or basic restorative procedures, which may be necessary. I understand that this consent will remain in effect until treatment is terminated either by the dentist or me.

Patient Signature: _____ **Date:** _____

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Financial Policy

At Cornerstone Family Dentistry, we are committed to giving you exceptional service and providing treatment that addresses both your short-term and long-term needs. We make it easier for you to get the care you need by providing low prices, flexible financing options, and no surprises. We also accept a variety of payment options and will work with most insurers. We're committed to keeping our prices low so that you can get the care you need. We know you have a choice, and we appreciate your decision to trust us with your dental care.

A Clear, Written Estimate on the Cost of Treatment
Your dentist will provide you with a comprehensive treatment plan after assessing your overall oral health. We'll provide a clear, detailed estimate on the cost of your treatment plan in writing so you know what to expect, including your estimated insurance benefits. If you have any questions related to your insurance coverage, we encourage you to contact your insurance company.

Payment Policy
The following payment policies apply:

- Payment in full of the Patient Financial Responsibility amount, as specified in the Treatment Acceptance and Payment Arrangement Form, is due no later than when services are rendered. Acceptable forms of payment include cash, Visa®, Master Card®, American Express®, Discover®, assigned insurance benefits and select third-party financing programs.
- For comprehensive treatment plans requiring multiple office visits, you will be required to pay for the services received at each specific office visit.
- You may, at your discretion, elect to pay in full, in advance for comprehensive treatment plans.

Dental Insurance
If you have dental insurance, your insurance claim will be processed as follows:

- **In Network:** If your dentist is a participating provider with your insurance, you will be billed pursuant to the terms of your dentist's agreement with your insurer.
- **Out of Network:** If your dentist is not a participating or in-network provider with your insurance plan, we will honor your carriers in network fee structure. If your insurance carrier will not accept your assignment of benefits to your dentist, you are responsible for the estimated insurance benefit.

Third-Party Financing Disclosure
Cornerstone Family Dentistry accepts payment from non-affiliated, third-party finance companies (i.e., CareCredit issued by Synchrony Bank). The practices pay these companies fees on a sliding scale for making financing available to patients like you and for the finance companies cost of servicing these loans. As the aggregate amount of care financed through these finance companies increases, the fees they charge Cornerstone Family Dentistry decrease. This sliding scale pricing arrangement does not affect the amount you finance or the cost of your treatment.

Credit decisions are solely the responsibility of these third-party finance companies. You may elect to pay all or a portion of your treatment using one of these third-party financing products.

Printed Name of Patient (or Patient Representative):	
Signature of Patient (or Patient Representative):	**Date:**

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Appointment Cancellation Policy

We strive to render excellent dental care to you and the rest of our patients. In an attempt to be consistent with this, we have an Appointment Cancellation Policy that allows us to schedule appointments for all patients. When an appointment is scheduled, that time has been dedicated for you and when it is missed, that time cannot be used to treat another patient.

We require that you give our office 24 hours notice in the event that you need to reschedule your appointment. This allows for other patients to be scheduled into that appointment. If you miss an appointment without contacting our office within the required time, this is considered a missed appointment. A fee of $25.00 will be charged to you; this fee cannot be billed to your insurance company and will be your direct responsibility. No future appointments can be scheduled nor can records be transferred with out the payment of this fee.

Additionally, if a patient is more than 20 minutes late without prior notice for a scheduled appointment, we will consider a missed appointment and the $25.00 cancellation fee will be charged.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have.

We thank you for being a valued patient and for your understanding and cooperation with our policy.

I have read and understand the Appointment 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.

Printed Name of Patient (or Patient Representative):	
Signature of Patient (or Patient Representative):	**Date:**

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Acknowledgement of Receipt of Notice of Privacy Practices

You may refuse to sign this Acknowledgement. However, in refusing to sign we will not be allowed to process your Insurance Claims.

I, _____, have received a copy of this office's Notice of Privacy Practices.

Printed Name of Patient (or Patient Representative):

Signature of Patient (or Patient Representative):	**Date:**

Patient Communication

I authorize contact from this office to confirm my dental appointments via:

□ Cell Phone Confirmation □ Home Phone Confirmation □ Work Phone Confirmation □ Email Confirmation

I authorize information about my dental health be conveyed via:

□ Message on Cell Phone □ Message on Home Phone □ Message on Work Phone □ Email Message

I approve being contacted about special services, events, or new dental information via:

□ Cell Phone □ Home Phone □ Work Phone □ Email

Printed Name of Patient (or Patient Representative):

Signature of Patient (or Patient Representative):	**Date:**

* * * OFFICE USE ONLY * * *

As Privacy Officer, I attempted to obtain the patient's (or patient representative's) signature on this Acknowledgement but did not because:

□ It was emergency treatment □ I could not communicate with the patient □ The patient refused to sign

□ The patient was unable to sign □ Other _____

Signature of Privacy Officer:	**Date:**

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Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this information carefully.

1) Dental Practice Covered by this Notice

This Notice describes the privacy practices of Cornerstone Family Dentistry, PC ("Dental Practice"). "We" and "our" means the Dental Practice. "You" and "your" means our patient.

2) How to Contact Us/Our Privacy Official

If you have any questions or would like further information about this Notice, you can contact Cornerstone's Privacy Official at:

Barrett Wilson
404 Welshwood Drive
Nashville, TN 37211
(615) 333-3382 Phone
(615) 832-1293 Fax

3) Our Promise to You and Our Legal Obligations

The privacy of your health information is important to us. We understand that your health information is personal and we are committed to protecting it. This Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected health information is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required by law to:

- Maintain the privacy of your protected health information;
- Give you this Notice of our legal duties and privacy practices with respect to that information; and
- Abide by the terms of our Notice that is currently in effect.

4) Last Revision Date

This Notice was last revised on April 15, 2017.

5) How We May Use or Disclose Your Health Information

The following examples describe different ways we may use or disclose your health information. These examples are not meant to be exhaustive. We are permitted by law to use and disclose your health information for the following purposes:

a. Common Uses and Disclosures

i. **Treatment**. We may use your health information to provide you with dental treatment or services, such as cleaning or examining your teeth or performing dental procedures. We may disclose health information about you to dental specialists, physicians, or other health care professionals involved in your care.

ii. **Payment**. We may use and disclose your health information to obtain payment from health plans and insurers for the care that we provide to you.

iii. **Health Care Operations**. We may use and disclose health information about you in connection with health care operations necessary to run our practice, including review of our treatment and services, training, evaluating the performance of our staff and health care professionals, quality assurance, financial or billing audits, legal matters, and business planning and development.

iv. **Appointment Reminders**. We may use or disclose your health information when contacting you to remind you of a dental appointment. We may contact you by using a postcard, letter, phone call, voice message, text or email.

v. **Treatment Alternatives and Health-Related Benefits and Services**. We may use and disclose your health information to tell you about treatment options or alternatives or health-related benefits and services that may be of interest to you.

vi. **Disclosure to Family Members and Friends**. We may disclose your health information to a family member or friend who is involved with your care or payment for your care if you do not object or, if you are not present, we believe it is in your best interest to do so.

vii. **Disclosure to Business Associates**. We may disclose your protected health information to our third-party service providers (called, "business associates") that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use a business associate to assist us in maintaining our practice management software. All of our business associates are obligated, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

b. Less Common Uses and Disclosures

i. **Disclosures Required by Law**. We may use or disclose patient health information to the extent we are required by law to do so. For example, we are required to disclose patient health information to the U.S. Department of Health and Human Services so that it can investigate complaints or determine our compliance with HIPAA.

ii. **Public Health Activities**. We may disclose patient health information for public health activities and purposes, which include: preventing or controlling disease, injury or disability; reporting births or deaths; reporting child abuse or neglect; reporting adverse reactions to medications or foods; reporting product defects; enabling product recalls; and notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

iii. **Victims of Abuse, Neglect or Domestic Violence**. We may disclose health information to the appropriate government authority about a patient whom we believe is a victim of abuse, neglect or domestic violence.

iv. **Health Oversight Activities**. We may disclose patient health information to a health oversight agency for activities necessary for the government to provide appropriate oversight of the health care system, certain government benefit programs, and compliance with certain civil rights laws.

v. **Lawsuits and Legal Actions**. We may disclose patient health information in response to (i) a court or administrative order or (ii) a subpoena, discovery request, or other lawful process that is not ordered by a court if efforts have been made to notify the patient or to obtain an order protecting the information requested.

vi. **Law Enforcement Purposes**. We may disclose your health information to a law enforcement official for a law enforcement purposes, such as to identify or locate a suspect, material witness or missing person or to alert law enforcement of a crime.

vii. **Coroners, Medical Examiners and Funeral Directors**. We may disclose your health information to a coroner, medical examiner or funeral director to allow them to carry out their duties.

viii. **Organ, Eye and Tissue Donation**. We may use or disclose your health information to organ procurement organizations or others that obtain, bank or transplant cadaveric organs, eyes or tissue for donation and transplant.

ix. **Research Purposes**. We may use or disclose your information for research purposes pursuant to patient authorization waiver approval by an Institutional Review Board or Privacy Board.

x. **Serious Threat to Health or Safety**. We may use or disclose your health information if we believe it is necessary to do so to prevent or lessen a serious threat to anyone's health or safety.

xi. **Specialized Government Functions**. We may disclose your health information to the military (domestic or foreign) about its members or veterans, for national security and protective services for the President or other heads of state, to the government for security clearance reviews, and to a jail or prison about its inmates.

xii. **Workers' Compensation**. We may disclose your health information to comply with workers' compensation laws or similar programs that provide benefits for work-related injuries or illness.

6) Your Written Authorization for Any Other Use or Disclosure of Your Health Information

Uses and disclosures of your protected health information that involve the release of psychotherapy notes (if any), marketing, sale of your protected health information, or other uses or disclosures not described in this notice will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke this authorization at any time, in writing, except to the extent that this office has taken an action in reliance on the use of disclosure indicated in the authorization. If a use or disclosure of protected health information described above in this notice is prohibited or materially limited by other laws that apply to use, we intend to meet the requirements of the more stringent law.

7) Your Rights with Respect to Your Health Information

You have the following rights with respect to certain health information that we have about you (information in a Designated Record Set as defined by HIPAA). To exercise any of these rights, you must submit a written request to our Privacy Official listed on the first page of this Notice.

a. Right to Access and Review

You may request to access and review a copy of your health information. We may deny your request under certain circumstances. You will receive written notice of a denial and can appeal it. We will provide a copy of your health information in a format you request if it is readily producible. If not readily producible, we will provide it in a hard copy format or other format that is mutually agreeable. If your health information is included in an Electronic Health Record, you have the right to obtain a copy of it in an electronic format and to direct us to send it to the person or entity you designate in an electronic format. We may charge a reasonable fee to cover our cost to provide you with copies of your health information.

b. Right to Amend

If you believe that your health information is incorrect or incomplete, you may request that we amend it. We may deny your request under certain circumstances. You will receive written notice of a denial and can file a statement of disagreement that will be included with your health information that you believe is incorrect or incomplete.

c. Right to Restrict Use and Disclosure

You may request that we restrict uses of your health information to carry out treatment, payment, or health care operations or to your family member or friend involved in your care or the payment for your care. We may not (and are not required to) agree to your requested restrictions, with one exception: If you pay out of your pocket in full for a service you receive from us and you request that we not submit the claim for this service to your health insurer or health plan for reimbursement, we must honor that request.

d. Right to Confidential Communications, Alternative Means and Locations

You may request to receive communications of health information by alternative means or at an alternative location. We will accommodate a request if it is reasonable and you indicate that communication by regular means could endanger you. When you submit a written request to the Privacy Official listed on the first page of this Notice, you need to provide an alternative method of contact or alternative address and indicate how payment for services will be handled.

e. Right to an Accounting of Disclosures

You have a right to receive an accounting of disclosures of your health information for the six (6) years prior to the date that the accounting is requested except for disclosures to carry out treatment, payment, health care operations (and certain other exceptions as provided by HIPAA). The first accounting we provide in any 12-month period will be without charge to you. We may charge a reasonable fee to cover the cost for each subsequent request for an accounting within the same 12-month period. We will notify you in advance of this fee and you may choose to modify or withdraw your request at that time.

f. Right to a Paper Copy of this Notice

You have the right to a paper copy of this Notice. You may ask us to give you a paper copy of the Notice at any time (even if you have agreed to receive the Notice electronically). To obtain a paper copy, ask the Privacy Official.

g. Right to Receive Notification of a Security Breach

We are required by law to notify you if the privacy or security of your health information has been breached. The notification will occur by first class mail within sixty (60) days of the event. A breach occurs when there has been an unauthorized use or disclosure under HIPAA that compromises the privacy or security of your health information.

The breach notification will contain the following information: (1) a brief description of what happened, including the date of the breach and the date of the discovery of the breach; (2) the steps you should take to protect yourself from potential harm resulting from the breach; and (3) a brief description of what we are doing to investigate the breach, mitigate losses, and to protect against further breaches.

8) Special Protections for HIV, Alcohol and Substance Abuse, Mental Health and Genetic Information

Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including HIV-related information, alcohol and substance abuse information, mental health information, and genetic information. For example, a health plan is not permitted to use or disclose genetic information for underwriting purposes. Some parts of this HIPAA Notice of Privacy Practices may not apply to these types of information. If your treatment involves this information, you may contact our office for more information about these protections.

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9) Our Right to Change Our Privacy Practices and This Notice

We reserve the right to change the terms of this Notice at any time. Any change will apply to the health information we have about you or create or receive in the future. We will promptly revise the Notice when there is a material change to the uses or disclosures, individual's rights, our legal duties, or other privacy practices discussed in this Notice. We will post the revised Notice on our website (if applicable) and in our office and will provide a copy of it to you on request. The effective date of this Notice is April 15, 2017.

10) How to Make Privacy Complaints

If you have any complaints about your privacy rights or how your health information has been used or disclosed, you may file a complaint with us by contacting our Privacy Official listed on the first page of this Notice.

You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you in any way if you choose to file a complaint.