First:_____Middle:_____Last:_____

SSN:_____-_____-_____DOB_____/_____/_____ Circle one M / F

Street Address:_____

(city, state, zip)

Phone:_____Email:_____

Employer:_____Phone:_____

Emergency contact:_____

(name + phone number + relationship)

Responsible party (if not the patient)

Name_____SSN_____-_____-_____DOB_____/_____/_____

Address:_____

(city, state, zip)

Relationship to patient:_____Phone:_____

Employer:_____Phone:_____

PAYMENT POLICY

FULL payment is due when services are rendered. Any payment arrangements must be made prior to services and are approved only through the office manager. Insured patients must pay full copay at time of service, including all applicable downgrades and deductibles. Insured patients are already receiving a discount and no further discounts will apply. Quotes of insurance are ESTIMATES only, not a guarantee of insurance payment and may not reflect the final amount owed by the patient. Insurance is a contract between you and your insurance company and you are responsible for all balances left after insurance pays or denies a claim. We make every effort to get all claims approved, but in the event of a denial, you may be responsible for addressing the claim yourself. We are a third party and cannot guarantee approval or payment. Imperial Dental Care runs the mandatory drug screen on every patient to whom pain medicine is given.

Please initial:

____To the best of my knowledge the attached health history is accurate.

____I acknowledge receipt of Imperial Dental Care's Missed Appointment Policy and Payment Policy.

____I authorize payment of insurance benefits to Imperial Dental Care and release my personal health/benefit information from my insurance company or other medical offices to Imperial Dental Care.

_____ _____

Signature of Patient/Parent or Guardian Date

Hendersonville Imperial Dental Care

Eaglesoft Medical History(Copy)(Copy)

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

Have you ever received any form of botox or facial fillers? ◯ Yes ◯ No

Have you ever had or considered invisalign or traditional braces? ◯ Yes ◯ No

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:

HIPAA Disclosure Form

Patient Name: _____ Date: _____

Would you like our correspondence with you to be marked "Confidential"? ☐ Yes ☐ No

May we identify ourselves over the phone? ☐ Yes ☐ No May we leave messages? ☐ Yes ☐ No

I, the Patient, hereby authorize the doctor and/or hospital listed above to release my medical information (appointments, lab/x-ray results, diagnoses, treatments, medications, surgeries, etc.) via postal mail, telephone, fax, or email to the following family members:

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

Signature: _____ Date: _____

By signing this form you acknowledge us to release your information to insurance companies for payments

IMPERIAL DENTAL CARE

Our Commitment to You

We want to take this opportunity to thank you for allowing us to be your preferred dental office. We know that you have many choices and are grateful that you choose us. We feel that you deserve nothing less than excellence when it comes to your health. We only use the best materials and techniques available in order to provide you with the quality you deserve. We believe that our relationship with you, as with all relationships, needs open and clear communication. We will try to communicate all of your dental needs and estimate your financial information as soon as it becomes evident. We want you to be as informed as possible to help you in your decisions concerning your dental health. We understand how valuable your time is, so we make every effort to remain on time. We do not double book our appointments. We feel that you deserve our complete and focused attention so that we may provide the best care possible. Your reserved time is exclusively yours.

Your Commitment to Us

We want you to be comfortable with our team. If you ever have any questions about your dental treatment, financial or insurance questions, or any concerns at all, we ask that you notify us as soon as possible. We will be glad to clarify any uncertainties that may arise.

1. Your scheduled appointment is reserved exclusively for you. We have a 24 hour cancellation policy in order to provide you with this personalized attention. We understand that circumstances may arise that require an appointment to be rescheduled. If sufficient notice is not given, your account will automatically be charged a $25 missed appointment fee per hour scheduled. Appointments scheduled longer than 60 minutes will be charged an additional $15 per 30 minute increment. We ask that you make every effort to keep your reserved time. You agree by being a patient in our office to adhere to the missed appointment policy, including paying all fees associated with missed appointments.

2. Any patient who is more than 10 minutes late may be asked to reschedule their appointment. All 5pm or later appointments must be on time or the cancellation fee may apply and you will be rescheduled.

NOTICES OF PRIVACY PRACTICES

• The following describes how your information may be used or disclosed: Your dental information may need to be disclosed to another dentist, doctor, hospital, or other facility if it is necessary to refer you for diagnosis, treatment or assessment of your health condition. Your information may be used to verify your insurance via your employer or insurance company.

• You may revoke authorization for us to use this information at any time, but it must be done in writing. Revocation will not affect any treatment we will provide in this office. The following are circumstances where we may not be able to honor your request: if information was released prior to receipt of your written request; if we are required to by law or by insurance for purposes of obtaining insurance or for contestation of claims.

• You have the right to limit disclosures if there are certain healthcare providers, hospital employers, insurers, or other individuals or organizations that you do not want your information disclosed to, please let us know. We are not required to adhere to your restrictions and you are free to choose to seek care from another provider. UNDER FEDERAL LAW: We are permitted or required to use or disclose your information without prior consent in the following instances:

- The public health authority is authorized to collect or receive your information under state and/or federal law.
- If we believe you are a victim of abuse, neglect or domestic violence.
- For state and federal health oversight activities of the healthcare system and government benefit programs
- In response to a court order, subpoena, discovery request or other lawful purpose.
- If it necessary to prevent or lessen a threat to health or public safety to a person/public • If we provide emergency treatment or care to you that is related to a workplace injury and must comply with Tennessee's Workers Compensation Laws.

PAYMENT POLICY

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