CDG CLAYTON DENTAL GROUP
FAMILY & IMPLANT DENTISTRY

DENTAL / MEDICAL HISTORY

Patient's Name ______________________________

1. Date of last dental treatment ______________________ Purpose ______________________
   Was treatment completed? ☐ Yes ☐ No
2. Date of last cleaning ______________________ Date of last dental X-rays ______________________
3. List main dental complaint(s) ______________________
4. Are you happy with the cosmetic appearance of your teeth? ☐ Yes ☐ No
   If no, why? ______________________
5. Have you been under the care of a physician or in a hospital during the past 2 years? ☐ Yes ☐ No
   If so, for ______________________
6. Have you ever had any medical radiation treatment? ☐ Yes ☐ No
7. Have you ever taken a Bisphosphonate derivative medication? (Fosamax, Aredia, Boniva, etc.) ☐ Yes ☐ No
8. Have you ever taken any type of blood thinner medication? (Coumadin, Warfarin, Plavix, Aspirin, etc.) ☐ Yes ☐ No
   If so, what? ______________________
9. Have you taken any kind of medicine(s) or drugs during the past year? ☐ Yes ☐ No
   Please list medications ______________________
10. Are you allergic to penicillin or any drugs or medicine? ☐ Yes ☐ No If so, what? ______________________
11. Have you ever had any excessive bleeding requiring special treatment? ☐ Yes ☐ No
12. Have you ever had a test for HIV infection? ☐ Yes ☐ No If so, ☐ Positive ☐ Negative
13. Have you had or do you have any of the following?

☐ AIDS	☐ Cardiac Pacemaker	☐ Heart Trouble	☐ Mitral Valve Prolapse
☐ Allergies	☐ Congenital Heart Lesions	☐ Hepatitis	☐ Psychiatric Treatment
☐ Anemia	☐ Cough	☐ Herpes	☐ Rheumatic Fever
☐ Arthritis	☐ Diabetes	☐ High Blood Pressure	☐ Sinus Trouble
☐ Artificial Heart Valve	☐ Epilepsy	☐ Jaundice	☐ Stroke
☐ Asthma	☐ Emphysema-COPD	☐ Kidney Treatment	☐ Tuberculosis
☐ Cancer Treatment	☐ Heart Murmur	☐ Latex Allergy	

14. Have you ever had any other serious illness? ☐ Yes ☐ No If yes, explain ______________________
15. Have you had a joint replacement or organ transplant? ☐ Yes ☐ No If yes, explain ______________________
16. If female, are you pregnant now? ☐ Yes ☐ No Are you taking birth control medication? ☐ Yes ☐ No

Name of physician ______________________ Address ______________________
Last seen ______________________ Phone ______________________

I am seeking dental treatment in this office and verify the above information is accurate to the best of my knowledge.

Reviewed by ______________ **Date** ______________ **Signature** ______________
Reviewed by ______________ **Date** ______________ **Signature** ______________
Reviewed by ______________ **Date** ______________ **Signature** ______________

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PATIENT REGISTRATION

Date ____________ Patient Name (Last, First, MI) ____________________________

Street Address ____________________________ City ____________ State ________ Zip ________

Home Phone ____________________________ Cell Phone ____________________________

Email ____

Patient Employed By ____________________________________ Phone ____________

Employer's Address ____________________________ City ____________ State ________ Zip ________

Social Security Number ____________________________ Sex ____________ Date of Birth ____________

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced Name of Spouse ____________

Spouse's Place of Employment ____________________________________ Phone ____________

Employer's Address ____________________________ City ____________ State ________ Zip ________

Whom may we thank for referring you? ____

In case of emergency, whom should we contact outside your household? ____________________ Phone ____________

Relationship to patient ____________________________

Who will pay this account? ____________________________ Method of Payment ____________________________

Do you have insurance that may cover any part of our professional services? ☐ Yes ☐ No

Primary Insurance Company ____

Policy Number ____________________________ Group Number ____________________________

Secondary Insurance Company ____

Policy Number ____________________________ Group Number ____________________________

I understand that regardless of my insurance status, I am ultimately and primarily responsible for the balance of the account and for any professional services rendered.

Financial Agreement

Patient or other person(s) responsible for payment for services rendered to patient by C. Ashley Clayton, DDS, PLLC, agrees that all unpaid balances after 60 days accrue interest at the annual percentage rate of 12% or at the rate of 1% per month on such unpaid balances, computed by the adjusted balance method, with a minimum monthly charge of $1.00 An "adjusted balance" is computed by taking the balance owed at the end of the previous billing cycle and subtracting any payments or credits received during the present billing cycle. Our billing cycle is monthly, and you will receive monthly periodic statements for your account. It is also agreed that in the event this account balance is referred or turned over for collection, that patient or other person(s) responsible for payment will pay costs of collection including reasonable attorney's fees.

Undersigned has read and fully understands this contract and has received a copy of this disclosure statement.

Patient or individual responsible for this account ____

NOTICE OF PRIVACY PRACTICES

YOUR INFORMATION. YOUR RIGHTS. OUR RESPONSIBILITIES.

YOUR RIGHTS

Get a copy of your health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how.
- We will provide a copy or summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60-days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use

- You can ask us not to use or share certain health information for treatment, payment or our operations.
- We are not required to agree to your request, and we may say "no" if it would not affect your care.

Get a list of those with whom we've shared information

- You can ask us for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we've shared it with and why.
- We will include all disclosures except those about treatment, payment, and health care operations, and certain disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and choices about your health.
- We will make sure the person has the authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information at the bottom of this document.
- You can file a complaint with the US Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, SW, Washington DC 20201, calling 1-877-696-6775 or by visiting ocrportal.hhs.gov/ocr/smartscreen/main.jsf
- We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to

- Share information with your family, close friends or others involved in payment for your care.
- Share information in a disaster relief situation.
- Contact you for fundraising efforts.
- If you are not able to tell us your preference (for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest).

In these cases, we NEVER share your information unless you give us written permission

- Marketing purposes
- Sale of your information

OUR USES AND DISCLOSURES

How do we typically use or share your health information? We typically use or share your health information in the following ways:

Help manage the health care treatment you receive

- We can use your health information and share it with professionals who are treating you.
- EXAMPLE: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- EXAMPLE: We use health information about you to develop better services for you.
- We are not allowed to use generic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Pay for health services

- We can disclose your health information as we pay for your health services.
- EXAMPLE: We share information about your dental plan to coordinate payment for your dental work.

Administer your plan

- We may disclose your health information to your health plan sponsor for plan administration.
- EXAMPLE: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information? We are allowed or required to share your information in other ways—usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

Help with public health and safety issues

- We can share health information about you for certain situations such as:
  - Preventing disease
  - Helping with product recalls
  - Reporting adverse reactions to medications
  - Reporting suspected abuse, neglect or domestic violence
  - Preventing or reducing a serious threat to anyone's health or safety

Do research

- We can use or share your information for health research

Comply with the law

- We will share information about you if the state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

- We can use or share health information about you:
  - For workers' compensation claims
  - For law enforcement purposes or with law enforcement officials
  - With health oversight agencies for activities authorized by law
  - For special government functions such as military, national security, and presidential protective services.

Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order or in response to a subpoena.

OUR USES AND DISCLOSURES

We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/hipaa/for-individuals/notice-privacy-practices/index.html**

Changes to the terms of this notice

- We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be made available upon request, on our website, and we will mail a copy to you.

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ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES

****You may refuse to sign this acknowledgment****

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

______________________________ ______________________________
Please Print Patient's Name Signature

____
Date

FOR OFFICE USE ONLY:

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment 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)

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INSURANCE POLICY

As a COURTESY to our patients, we will electronically file insurance claims for all patients unless otherwise instructed. This will be done by the next business day and at NO CHARGE to our patients.

We assume NO RESPONSIBILITY for the lack of promptness of benefit payment. We also assume NO RESPONSIBILITY for the amount of the benefit payment as this is directly related to the particular insurance purchased by your employer. There may be occasions where we must personally talk to a representative of someone's insurance company. In such instances, we CANNOT BE RESPONSIBLE for any verbal quotes or mistakes made on their part.

There are thousands of insurance policies on the market and we cannot possibly be familiar with every policy. However, we will be more than happy to assist anyone with their insurance if so desired.

Therefore, patients must be responsible for their own insurance. This includes benefits, payments and also notifying us of policy changes. Patients are ultimately responsible for payment of all dental services rendered.

Once insurance is VERIFIED by our office and a financial agreement is SIGNED, we will submit your insurance for assignment of benefits. Patients will be responsible for their *estimated* portion of the fee at the time of treatment; however, any remaining balance will be the responsibility of the patient. Also, as a COURTESY to our patients, we allow (60) SIXTY days for insurance payment with no interest charged. Patients should be aware that interest will be charged after that time.

If anyone wishes to handle their own insurance claims, we will NOT be able to accept assigned benefits and their account will be on a cash basis only.

I have read and understand this office policy.

Signature ______________________________ Date ____________________

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ORAL CANCER SCREENING

In our continuing efforts to provide the most advanced technology and highest quality care available to our patients, this practice is proud to announce the inclusion of the **Velscope** exam as an integral part of our annual comprehensive oral cancer program.

One person dies every hour from oral cancer in the United States—and the mortality rate has remained unchanged for more than 40 years. More than 25% of oral cancer victims have no lifestyle risk factors. Clinical studies have determined that using **Velscope** after the standard oral cancer examination improved the clinician's ability to identify, evaluate and monitor suspicious areas at their earliest stages. Early detection of precancerous tissue can minimize or eliminate the potentially disfiguring effects of oral cancer and possibly save your life. Proven screening technologies such as mammogram, Pap smear, PSA and colonoscopy offer the same types of early detections of cancer. **Velscope** is an easy and painless examination that gives this practice the best chance to find any abnormalities you may have at the earliest possible stage. In fact, the **Velscope** system is the first adjunctive device cleared by the FDA and Health Canada to help clinicians detect cancerous and precancerous lesions and other lesions that might not be apparent to the naked eye.

ORAL CANCER RISK BY PATIENT PROFILE

Highest Risk: Patients age 40 and older and lifestyle risk factors (tobacco use), patients with history of oral cancer.

High Risk: Patients age 40 and older, tobacco users of any age.

Increased Risk: Patients age 18–39

Dental insurance may not cover this advanced oral cancer screening as an addition to the standard visual examination. This practice prescribes the **Velscope** exam for all patients at increased risk but especially for those at high risk and highest risk for oral cancer. We will be performing the **Velscope** exam following the standard oral cancer examination of the oral cavity for a fee of $25.

CLAYTON DENTAL GROUP | Dr. Ashley Clayton | 130 Donelson Pike, Nashville, TN 37214 | **O:** 615-889-7111 **F:** 615-889-6717 | **CDGNashville.com**