Hethcox PERIODONTICS

Dr. Joshua Hethcox
101 Sherlake Lane, Suite 103
Knoxville TN 37922
865.247.6250
Office@HethcoxPerio.com

Name____Birthdate________________________________

How do you prefer to be addressed________________________________SSN__________________________

Mailing Address____

City____State__________________Zip______________________

Email____

Home Phone________________Work Phone__________________Cell Phone_____________________________

Employer_______________________________________Occupation____________________________________

Employer's Address____

Employer's City________________________________Employer's State_______Employer's Zip______________

Whom may we thank for this referral?____

Your Dentist____________________________Date of Last Visit______________________________________

Emergency Contact Name____

Emergency Contact Phone______________________________Relationship to You_______________________

Primary Insurance Information

Policy Holder's (PH) Name________________________Relationship to Patient_________________________

Policy Holder's Birthdate______________________________PH's SSN_______________________________

PH's Employer____

PH's Employer's Address____

PH's Employer's City______________PH's Employer's State________PH's Employer's Zip______________

PH's Insurance Company____

PH's Insurance Co. Address____

Subscriber #____

Group #____

Secondary Insurance Information

Policy Holder's (PH) Name________________________Relationship to Patient_________________________

Policy Holder's Birthdate______________________________PH's SSN_______________________________

PH's Employer____

PH's Employer's Address____

PH's Employer's City______________PH's Employer's State________PH's Employer's Zip______________

PH's Insurance Company____

PH's Insurance Co. Address____

Subscriber #____

Group #____

Health History

Your overall health is important to us, and it may contribute to your oral health condition, including periodontal disease. Please complete this form in order that we may provide you with the most accurate assessment of your condition and establish the best treatment options for success.

Physician________________________________Location________________________________

Phone__________________Approx. Date of last Physical Exam______________________________

Yes	No	
☐	☐	**Are you in good health?** If no, please explain______________________________
☐	☐	**Are you under the care of a physician?** If yes, for what reason?______________________________
☐	☐	**Are you taking any medications?** Prescriptions______________________________ Over-the-counter, Herbal Supplements______________________________

Yes	No	
☐	☐	**Have you ever been hospitalized?** If yes, when and why?______________________________
☐	☐	**Do you have diabetes?**
☐	☐	**Has anyone in your family ever had diabetes?** If yes, who?______________________________
☐	☐	**Do you consider yourself to be under mental or emotional stress?**
☐	☐	**Do you smoke?** If yes, how much per day?______________________________
☐	☐	**Do you consume alcohol?** If yes, how many servings of alcoholic beverages do you have in a week?______________
☐	☐	**(Females) Are you pregnant?** If so, which trimester?______________________________
☐	☐	**(Females) Are you breast feeding?**

Please check all that apply.
Have you ever had any of the following?

- ☐ Heart Disease
- ☐ Pain, pressure, or tightness in chest
- ☐ Heart Attack/Stroke
- ☐ Rheumatic fever
- ☐ High cholesterol
- ☐ Sinus problems
- ☐ Asthma/shortness of breath
- ☐ Psychotherapy
- ☐ Fainting or dizzy spells
- ☐ Cancer or tumors
- ☐ Blood disorders (anemia, leukemia)
- ☐ Sexually transmitted disease
- ☐ Hepatitis, liver disease
- ☐ Swelling of the ankles or feet
- ☐ Chest pain on mild exertion
- ☐ Heart murmur
- ☐ High/Low blood pressure
- ☐ Artificial joints/valves
- ☐ Lung disease
- ☐ Headaches when lying down
- ☐ Epilepsy
- ☐ Frequent or sever headaches
- ☐ Chemotherapy
- ☐ Bleeding disorder (hemophilia)
- ☐ Radiation treatment
- ☐ Arthritis

Do you have an allergy to or been told not to take any of the following?

- ☐ Penicillin
- ☐ Sulfa drugs
- ☐ Codeine
- ☐ Tetracycline
- ☐ Aspirin
- ☐ Latex

☐ Other ___________________________________

Are you currently taking or have you taken in the past:

- ☐ Steroids or cortisone
- ☐ Medications for sleeping
- ☐ Anticoagulants
- ☐ Medications to control chronic pain

Dental History

Yes	No	
☐	☐	**Do your gums or teeth hurt now?**
☐	☐	**Have you ever had periodontal (gum) treatment?** If yes, when? ________________________
☐	☐	**Have you ever been treated by a periodontist?** If yes, when?__________________________
☐	☐	**Have you had abscesses within the past 3 months?**
☐	☐	**Have you had a toothache within the past 3 months?**
☐	☐	**Are any of your teeth sensitive to hot or cold?**
☐	☐	**Do you clench or grind your teeth?**
☐	☐	**Have you had any teeth extracted within the past 3 years?** If yes, how many? ___________
☐	☐	**Have you ever had orthodontic treatment (braces)?** If yes, when?_______________________

How often do you brush your teeth?____

How often do you floss between your teeth?____

When were your teeth last "cleaned" by a dentist or dental hygienist?_______________________

How frequently have your teeth been "cleaned" by a dentist in the past 3 years?________________

Is there anything you dislike about your smile? If yes, what? ___________________________

____

Patient Statement and Signature

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Signature____**Date**_____________________

Consent for Dental Treatment

I (print name),_________________________________, grant permission to Joshua M. Hethcox, DDS, MS and his dental office staff to perform the following procedures: A complete periodontal examination, diagnosis of oral conditions, order x-rays as needed for diagnosis and treatment, periodontal maintenance, clean teeth (scaling and root planning, prophylaxis), and administer local anesthetic.

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 staff to perform the following procedures: A complete periodontal examination, diagnosis of oral conditions, order x-rays as needed for diagnosis and treatment, periodontal maintenance, clean teeth (scaling and root planning, prophylaxis), and administer local anesthetic.

Signature of parent and/or legal guardian___________________________________

Date__________________

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 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 and 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.

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__________________________

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 and his staff understand that medical information about you and 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 in connection with our healthcare operations. Healthcare operations include quality assessment & improvement activities, reviewing the competence or qualifications of 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 Personal 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 persion 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 envent of your incapacity or emergency circumstances, we will disclose healthy information based on a determination using our professional judgement, disclsing only health information that is directly relevant to the person's nvolvement in your healthcare.
- For Law Enforcement or Specific Government Functions: We may disloce 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 Informationabout you to federal officials for intelligence, counter intelligence, and other national security activiteis aurhorized 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 inresponse to a court or administrative order. We may disclose Personal Health Information to any governmental agency or regulator with whom you have iled 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 authorsized to use or disclose Personal Health Information about you, you or your legally aurhorized representative may revoke that authorization, in writing, at any time, exdept to the extent that we have taken action relying on the aurhoriazation. you should understand that we would not be able to take back any dislosures 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

I, (print name) ____, have received and reviewed a copy of the Notice of Privacy Practices of Dr. Joshua M. Hethcox.

____
Please Print Name

____ Date ________________________
Signature

FOR OFFICE USE ONLY

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

☐ Individual refused to sign

☐ Communication barriers prohibitied obtaining the acknowledment

☐ An emergency situation prevented us from obtaining the acknowledgment

☐ Other ____