BRADLEY L. DYER DDS

PATIENT INFORMATION

Patient's Name: _____ Date of Birth: _____
Last First MI

Preferred Name: _____ Title: _____
Mr./Ms./Mrs./etc.

Gender: **Male** **Female** Family Status: **Single** **Married** **Child** **Other**

Address: _____,_____
Street City State Zip code

Social Security Number: ____-___-_____ Phone #: _____ _____ _____
Mobile Home Work

Email Address: _____

Employer: _____ Dental Insurance: **Yes** **No**

Other family members in this practice: _____

How did you hear about our practice? **Internet** **Insurance Company** **Friend or Family Member**

Website or name of the person who referred you: _____

- **Insurance - Primary**

Subscriber Name: _____ Relationship to Patient: _____
Subscriber SSN/ID: _____ Subscriber DOB: _____
Subscriber Employer: _____
Insurance Company Name: _____
Insurance Company Address: _____
Insurance Company Phone: _____ Group #: _____

- **Insurance - Secondary**

Subscriber Name: _____ Relationship to Patient: _____
Subscriber SSN/ID: _____ Subscriber DOB: _____
Subscriber Employer: _____
Insurance Company Name: _____
Insurance Company Address: _____
Insurance Company Phone: _____ Group #: _____

- **Assignment and Release**

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Bradley L. Dyer DDS PC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____

Print Name: _____ Relationship: _____

Date: _____

MEDICAL HISTORY

Patient's Name_____
Last First MI Date of Birth

Do you have a personal physician? **Yes No** Physician's Name: _____
Physician's Phone: _____ Date of last visit: _____
Are you currently under the care of a physician? **Yes No** Please explain: _____
_____

Have you ever taken Fosamax, Zometa, Aredia, or any other oral or intravenous treatment (bisphosphates) for bone tumors, excessive calcium in your blood, or osteoporosis? **(Please circle prescription drugs taken)**

Have you taken any prescription drugs fenfluramine, fenfluramine combined with phentermine (fen-phen), dexfenfluramine (redux), or other weight loss products? **(Please circle prescription drugs taken)**

Do you smoke, chew, use snuff or any other forms of tobacco? **Yes No**
Do you regularly consume more than one or two alcoholic beverages a day? **Yes No**
Do you habitually use controlled substances? **Yes No**
Have you had psychiatric treatment? **Yes No**
Have you ever been told you require pre-med antibiotics before dental treatment? **Yes No**

Allergies (Please circle): Aspirin * Codeine * Erythromycin * Penicillin * Latex * Sulfa * Dental Anesthetics * Novocain * Metals * Other: _____

Circle any conditions that apply to you, the patient:

Aids	Allergies	Allergy – Hay Fever	Anemia	Arthritis
Artificial Joints	Asthma	Blood Disease	Cancer	Chemo Diabetes
Dizziness	Epilepsy	Excessive Bleeding	Fainting	Glaucoma
Head Injuries	Heart Disease	Heart Murmur	Heart Valve Implant	Hepatitis
High Blood Pressure	HIV	Jaundice	Kidney Disease	Liver Disease
Low Blood Pressure	Mental Disorders	Metal Sensitivity	Mitral Valve Prolapse	Nervous Disorders
Other	Pacemaker	Radiation Treatment	Respiratory Problems	Rheumatic Fever
Rheumatism	Seizure Disorders	Sinus Problems	Stomach Problems	Stroke
Tuberculosis	Tumors	Ulcers	Venereal Disease	

Organ/Valve/Joint Replacement: **Y N** Type: _____Date: _____

Please list any medications or substances (prescription or non-prescription) that you are currently taking:
_____
_____

Please use the space below to provide any additional information or comments regarding the above information or provide any health related information not covered in this form: _____
_____

If female: Are you pregnant? **Y N** If so, # of weeks: ____ Are you nursing? **Y N** Are you taking birth control? **Y N**

Would you like to talk to the doctor privately about any problem? **Yes No**

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE:

Patient or Guardian's Signature: _____ Date: _____/_____/_____

Dentist's Signature: _____ Date: _____/_____/_____

BRADLEY L. DYER
DDS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
(Adult)

I have received a copy of the Notice of Privacy Practices of Bradley L. Dyer DDS, P.C. I hereby authorize, as indicated by my signature below, to use and to disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent form.

Print Name: _____ Date: _____

Signature: _____

Please check all means of communication that apply/ Include phone numbers:

- ☐ You may contact me at my home telephone number _____
- ☐ You may contact me on my mobile telephone number _____
- ☐ You may contact me on my work telephone number _____
- ☐ You may send me an email at: _____
- ☐ You may also text my mobile telephone for appointment reminders.

Please list authorized persons with whom we may discuss you Protected Health Information (PHI) in addition to custodial parents and legal guardians:

1. _____ Phone# _____ Date Added/Removed _____
2. _____ Phone# _____ Date Added/Removed _____
3. _____ Phone# _____ Date Added/Removed _____
4. _____ Phone# _____ Date Added/Removed _____
5. _____ Phone# _____ Date Added/Removed _____

For Office Use Only

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

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify) _____

Staff Person Initials _____

BRADLEY L. DYER DDS

PATIENT CONSENT

Clinical

1. I authorize Bradley L. Dyer DDS, P.C. to perform all recommended treatment.
2. I authorize the practice to take radiographs, study models, photos, and other diagnostic aids or materials (collectively, "Diagnostic Material") as needed to make a thorough diagnosis. I authorize that such Diagnostic Material may be released to third-party payers and/or other health professionals.
3. I authorize the use of anesthetics, sedatives, and other medication, as needed, and am fully aware that using anesthetic agents involves certain risks, including but not limited to redness and swelling of tissues, pain, itching, vomiting, dizziness, miscarriage, cardiac arrest, drowsiness, and/or lack of coordination.

After Hours Emergency

4. In the event of an emergency after regular business hours a $50.00 emergency fee will be charged for established patients in addition to the necessary treatment fees. Patients who are not established will be charged $100.00 for an after hour emergency.

Missed Appointments

5. I am aware Bradley L. Dyer DDS, P.C. requires a 24 hours notice of cancellation prior to my appointment. **The practice reserves the right to refuse to schedule appointments if a pattern of missed appointments without proper notice develops. I am aware after three missed appointments without proper notice may result in dismissal from Bradley L. Dyer DDS P.C.**

Insurance

6. I authorize the Practice to release to staff, hospitals, health care service plans, insurance companies, self-insurers or their representatives, any and all information, records, and other Diagnostic Material about my medical history, services rendered, or recommended treatment.
7. I authorize the Practice to submit claims for payment for services rendered or pre-authorizations necessary to my insurance company, on my behalf and in my name listed as "signature on file" and assign to the Practice the insurance benefits providing assignment is accepted. I am responsible for payment regardless of coverage provided.
8. I understand that Bradley L. Dyer DDS P.C. participates in several insurance plans including, but not limited to: Aetna, Assurant, Blue Cross Blue Shield of TN, Cigna, Delta Dental Premier/PPO, Humana PPO, and United Healthcare PPO. Most plans cover only a part of the dental fee, which means I am responsible for what my plan does not cover and any deductible. Many plans have exclusions and limitations, which will affect my out-of-pocket expense. **Please note that while we bill your insurance as a courtesy, it is ultimately your responsibility to understand the provisions and limitations of your policy.**

Financial

9. I am responsible for all services rendered on my behalf. I understand that **FULL PAYMENT IS DUE AT TIME OF SERVICE.** I am aware that a 1.5% MPR or 18% APR is automatically tabulated into my account if my balance is 30 days old or older. Should my account become delinquent, I will be responsible for all additional collection costs, including reasonable attorney fees.
10. We accept cash, checks, Visa, MasterCard, Discover, and American Express. Through **Care Credit**, a patient financing company, we offer 0% interest financing for 6 or 12 months with approval. Through Care Credit, charges of $200 or more are eligible for the 6 month financing plan and charges of $500 or more are eligible for the 12 month plan. **No other payment plans are available.**

I have read this Patient Consent and agree to all terms and conditions herein.

Print Patient's Name: _____ Date: _____

Patient's Signature: _____