COVINGTON PIKE DENTAL CLINIC
FRED C. HEROS, D.D.S.

3594 Covington Pike, Memphis, TN 38128
Phone: (901) 377.6800 Fax: (901) 377.5360

Welcome to our office

About You

Today's Date _____

Patient Name

Last First M

What You Prefer to be Called _____
Birthdate _____ Age _____
Social Security # _____
Mailing Address _____

City State Zip

Home Phone # _____
Work Phone # _____
Cell Phone # _____
e-mail Address _____

Referred By _____

Employer _____
How Long? _____
Employer's Address _____

City State Zip

Occupation _____

Status: Single ___ Married ___ Divorced ___ Widowed ___
Male ___ Female ___

Reason for this visit _____

Account Information

Person responsible for account

Name _____
Relationship _____
Billing Address _____

City State Zip

Date of Birth _____
Social Security # _____
Work Phone # _____
Home Phone # _____

Insurance Information

Primary Dental Insurance

Insurance Carrier _____
Group Plan # _____
Phone # _____
Insured's Name _____
Relation _____
Date of Birth _____
Insured SS# _____
Insured Employer _____
Insured ID _____

Secondary Dental Insurance

Insurance Carrier _____
Group Plan # _____
Phone # _____
Insured's Name _____
Relation _____
Date of Birth _____
Insured SS# _____
Insured Employer _____
Insured ID _____

In Event of Emergency

Who should we contact? _____
Relationship: _____
Home Phone # _____
Work Phone # _____
Cell Phone # _____

Are you currently under the care of a physician?

If so, why? _____
Doctor Name: _____
Phone Number: _____

Please continue on back →

Office Policies for Covington Pike Dental Clinic

We are so glad you have chosen us as your family dental practice. We strive to provide you and your family the best dental care possible, but feel that proper communication between our patients and staff is of utmost importance. The following guide is a summary of our guidelines and office policies. We ask that you review these guidelines and refer to them any time you have a question or problem.

Appointment Policies:

- A parent or legal guardian MUST accompany a child under age 18.
- If you are unable to keep an appointment, please notify our office at least 24 hours in advance. Failure to do so could result in suspension from our dental practice. We understand emergencies warrant short term cancellations, but broken appointments can be costly and unfair to other patients, so we ask that you notify us as soon as possible if you are unable to keep an appointment.
- Failure to arrive to your appointment on time can cause delays for those who arrive promptly. Please call our office as soon as possible if you know you will be late. We will make every attempt to work you in, but it may be necessary for you to reschedule your appointment if you are more than 10 minutes late or do not show up for your appointment. This will be counted as a broken appointment. **Once you have broken 2 appointments, we will no longer be able to see you as a patient in our office.**

Treatment Room Policies:

- It is our policy that parents remain in the waiting room while we are treating your child. We understand this may be a nervous time for you and your child, but we would appreciate your cooperation in this matter.

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on friendly, mutual understanding between provider and patient.

- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collection of your unpaid balance.

- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims; for additional specialist consultation; or in the event I request my records to be transferred to another dental office.

- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature_____ Date_____

☐ Adult Patient ☐ Parent or Guardian ☐ Spouse

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Medical history for:

Patient Name _____ **Nickname** _____ **Date of Birth** _____

Are you allergic to any of the following?

Latex___ Penicillin___ Amoxicillin___ Aspirin___ Ibuprofen___ Codeine___ or any reaction to a substance or medication not listed? _____

Have you ever had a reaction after receiving dental anesthetic or dental treatment? ___Yes ___No

Explain reaction: _____

Are you currently pregnant? Yes___ No___ **DUE DATE:** _____

HAVE YOU BEEN HOSPITALIZED? ___YES ___ NO WHEN? _____

For What Condition? _____

Please check yes or no to the following medical conditions & date when the condition occurred:

	Yes	No	Date
Heart Attack	___	___	_____
Stroke	___	___	_____
Heart Surgery	___	___	_____
Angina / Chest Pain	___	___	_____
Heart Murmur	___	___	_____
Pacemaker / Defibrillator	___	___	_____
Congenital Heart Defect	___	___	_____
Artificial Valves	___	___	_____
Mitral Valve Prolapse	___	___	_____
High / Low Blood Pressure	___	___	_____
Allergies	___	___	_____
Asthma	___	___	_____
Breathing Problems	___	___	_____
Respiratory Disease	___	___	_____
Sinus Problems	___	___	_____
Tuberculosis TB	___	___	_____
Eating Disorders	___	___	_____
Drug / Alcohol Abuse	___	___	_____
Tobacco Use	___	___	_____
HIV	___	___	_____
AIDS	___	___	_____
Dizziness	___	___	_____
Seizure Disorder	___	___	_____
Fainting	___	___	_____
Head Injuries	___	___	_____

	Yes	No	Date
Cancer / Tumors	___	___	_____
Chemotherapy	___	___	_____
Radiation Treatment	___	___	_____
Leukemia	___	___	_____
Artificial Joints	___	___	_____
Arthritis	___	___	_____
Rheumatism	___	___	_____
Jaw Problems / TMJ	___	___	_____
Bleeding Problems	___	___	_____
Diabetes / Hypoglycemia	___	___	_____
Hepatitis	___	___	_____
Kidney Disease	___	___	_____
Liver Disease	___	___	_____
Rheumatic Fever	___	___	_____
Scarlet Fever	___	___	_____
Shingles / Chicken Pox	___	___	_____
Thyroid Problems	___	___	_____
Herpes	___	___	_____
Venereal Disease	___	___	_____
Mental Disorders	___	___	_____
Nervous Disorders	___	___	_____
Stomach Problems	___	___	_____
Are you taking a blood thinner?	___	___	_____

Please list any medical conditions you have ever had that are not listed above:

_____

_____

Please list any medications you are currently taking (including herbal medications / vitamins):

_____

_____

_____

Have you ever taken the drug Phen-fen or Redux? Yes___No___

Signature _____ (if parent or guardian, please circle) Date _____

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FINANCIAL POLICY

We are committed to providing you with the highest quality dental care utilizing only the best materials and technology available. In our process of doing so, we have formulated a financial policy to continue to provide you with several options to choose from, in order to meet your financial needs.

DENTAL INSURANCE:

Our office is happy to cooperate with our patients who are covered by dental insurance. However, it is your responsibility to inform us when your policy changes, so we can bill the correct insurance company. We also ask that you **"READ YOUR POLICY THOROUGHLY"** so you are fully aware of benefits provided and the limitations imposed. Please call your insurance company if you have any questions concerning your plan. In order to provide you with optimal treatment, each patient is treated according to their individual dental needs; we do not diagnose according to your insurance plans benefits. (Please check with our office to see what insurance plans we are Preferred Providers for).

All incurred charges are ultimately your responsibility, regardless of insurance coverage. Your employer and the insurance company negotiated a contract that "our office" was not involved in. We **DO NOT** control how your benefits are paid or your contractual limitations. What that means is, if you have a concern over what your insurance pays on a dental procedure due to a contractual limitation or a non-covered procedure, you will need to take the issue up with your insurance company and not our office. We will attempt to do all we can to get your insurance to pay; however, all balances not paid by your insurance company are due by you 30 days after you receive our final statement.

PAYMENT OPTIONS:

For your convenience, we accept Debit, Visa, Master Card, American Express, Discover, Care Credit and Cash.

Interest free payment plans are available (6 & 12 month options) via Care Credit. Please see one of our front desk team members to discuss this option.

Patient Signature_____ Date_____

This individual is authorized to bring my child to dental appointments and sign consent for treatment:

_____

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Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Covington Pike Dental Clinic. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Covington Pike Dental Clinic reserves the right to change the privacy practices that are described in the Statment of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

ADDITIONAL DISCLOSURE AUTHORITY In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.				
ANY MEMBER OF MY IMMEDIATE FAMILY		YES		NO
SPOUSE ONLY		YES		NO
OTHER (*PLEASE SPECIFY*):		YES		NO

Name of Patient or Personal Representative

Signature of Patient or Personal Representative

Date

Description of Personal Representative's Authority