

Patient Name _____ Preferred Name: _____

Parent(s) Name (if minor) _____ Patient Date of Birth _____ Sex M F

Address _____ City _____ State _____ Zip _____

Phone: C () _____ W () _____ H () _____ Text Yes No

Email Address _____ Marital Status (Circle) Single / Married / Divorced / Widowed

PREMED ANTIBIOTIC Required (Circle) YES or NO NITROUS OXIDE Preferred (Circle) YES or NO

Social Security # _____ Driver's License # _____

Patient Employer _____ Employer City/State _____

How did you hear about us? Please Circle: Google Search / Drove By / Facebook / Insurance Company

Family/Friend/Coworker (Please list so we may thank them for the referral.) _____

Emergency Contact: Name/Relationship _____ Phone # _____

RESPONSIBLE PARTY

Responsible Party _____ Relationship Self Spouse Parent Other

Address _____ City _____ State _____ Zip _____

Phone: H () _____ W () _____ C () _____ Text Yes No

Social Security # _____ Date of Birth _____ Sex M F

DENTAL INSURANCE

Primary Insurance _____ Policy # _____ Group # _____

Subscriber's Name _____ Subscriber's Employer _____

Relationship to Patient _____ Subscriber's DOB _____ Social Security # _____

Secondary Insurance _____ Policy # _____ Group # _____

Subscriber's Name _____ Subscriber's Employer _____

Relationship to Patient _____ Subscriber's DOB _____ Social Security # _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES, OFFICE POLICIES, AND PATIENT CONSENT

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Dr. Andrea Hannahan, DDS, PLLC Notice of Privacy Practices and Office Policies. I hereby certify that the foregoing information is complete and accurate, and I will notify this office of any changes in a timely manner. I hereby also give consent for recommended and agreed upon treatment. I understand that I am responsible for ALL fees regardless of insurance. My signature below confirms I have read, understand, and agree to comply with this office's policies.

Patient Name (Print): _____ Date: _____

Signature of Patient or Legal Guardian: _____



Patient's Name _____ Date: _____

Physician's Name _____ City/State _____ Phone _____

Are you under a physician's care now? Yes No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____

Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____

Are you taking ANY medications, pills or drugs? Yes No **If YES, PLEASE LIST ALL:** _____

Are you on a special diet? Yes No _____

Do you use tobacco? Yes No _____

Do you use controlled substances? Yes No _____

Do you take, or have you taken, Boniva or Fosamax? Yes No If yes, for how long? _____

Women: Are you Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you ALLERGIC to any of the following? (Circle) Aspirin / Penicillin / Codeine / Acrylic / Metal / Latex / Local Anesthetics

Other: If yes, please explain: _____

Current and Previous Conditions: Select any of the following if you currently have or have had the condition in the past.

Have you ever had any serious illness not listed above? Yes No If YES, please explain: _____

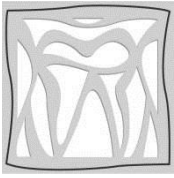
AIDS/HIV Positive	<input type="radio"/> Yes <input type="radio"/> No	Cortisone Medicine	<input type="radio"/> Yes <input type="radio"/> No	Hemophilia	<input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss	<input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease	<input type="radio"/> Yes <input type="radio"/> No	Diabetes	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis A	<input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis	<input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis	<input type="radio"/> Yes <input type="radio"/> No	Drug Addiction	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis B	<input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever	<input type="radio"/> Yes <input type="radio"/> No
Anemia	<input type="radio"/> Yes <input type="radio"/> No	Easily Winded	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis C	<input type="radio"/> Yes <input type="radio"/> No	Rheumatism	<input type="radio"/> Yes <input type="radio"/> No
Angina	<input type="radio"/> Yes <input type="radio"/> No	Emphysema	<input type="radio"/> Yes <input type="radio"/> No	Herpes	<input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever	<input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout	<input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures	<input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Shingles	<input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve	<input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding	<input type="radio"/> Yes <input type="radio"/> No	Hives or Rash	<input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease	<input type="radio"/> Yes <input type="radio"/> No
Artificial Joint	<input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst	<input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia	<input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble	<input type="radio"/> Yes <input type="radio"/> No
Asthma	<input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizzy	<input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat	<input type="radio"/> Yes <input type="radio"/> No	Spina Bifida	<input type="radio"/> Yes <input type="radio"/> No
Blood Disease	<input type="radio"/> Yes <input type="radio"/> No	Frequent Cough	<input type="radio"/> Yes <input type="radio"/> No	Kidney Problems	<input type="radio"/> Yes <input type="radio"/> No	Stomach Disease	<input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion	<input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea	<input type="radio"/> Yes <input type="radio"/> No	Leukemia	<input type="radio"/> Yes <input type="radio"/> No	Stroke	<input type="radio"/> Yes <input type="radio"/> No
Breathing Problem	<input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches	<input type="radio"/> Yes <input type="radio"/> No	Liver Disease	<input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs	<input type="radio"/> Yes <input type="radio"/> No
Bruise Easily	<input type="radio"/> Yes <input type="radio"/> No	Genital Herpes	<input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No
Cancer	<input type="radio"/> Yes <input type="radio"/> No	Glaucoma	<input type="radio"/> Yes <input type="radio"/> No	Lung Disease	<input type="radio"/> Yes <input type="radio"/> No	Tonsillitis	<input type="radio"/> Yes <input type="radio"/> No
Chemotherapy	<input type="radio"/> Yes <input type="radio"/> No	Hay Fever	<input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse	<input type="radio"/> Yes <input type="radio"/> No	Tuberculosis	<input type="radio"/> Yes <input type="radio"/> No
Chest Pains	<input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure	<input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints	<input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths	<input type="radio"/> Yes <input type="radio"/> No
Cold Sores/Fever Blisters	<input type="radio"/> Yes <input type="radio"/> No	Heart Murmur	<input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease	<input type="radio"/> Yes <input type="radio"/> No	Ulcers	<input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder	<input type="radio"/> Yes <input type="radio"/> No	Heart Pace Maker	<input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care	<input type="radio"/> Yes <input type="radio"/> No	Venereal Disease	<input type="radio"/> Yes <input type="radio"/> No
Convulsions	<input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease	<input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments	<input type="radio"/> Yes <input type="radio"/> No	Yellow Jaundice	<input type="radio"/> Yes <input type="radio"/> No

Previous Dentist _____ Month/Year of Last Visit _____

To help us understand any specific needs, please explain any issues that may have occurred, which led to you to change dental provider.

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 (patients) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT/PARENT/OR GUARDIAN: _____ DATE: _____



Andrea Hannahan, DDS, PLLC

Family and Cosmetic Dentistry

1012C Crossings Blvd

Spring Hill, TN 37174

www.drhannahan.com

Phone (931) 487-9997

Fax (931) 487-9998

info@drhannahan.com

Notice of Privacy Policies-Effective September 19, 2013 Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully. Please see the front desk to sign that you have read and received this notice.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

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

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is 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 say “yes” to all reasonable requests.

Ask us to limit what we use or share

- 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 affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

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

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other 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 make choices about your health information.
- We will make sure the person has this 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 on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- 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 your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

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. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

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.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

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 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

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

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 a law enforcement official
- 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 Responsibilities

- 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/ocr/privacy/hipaa/understanding/consumers/noticepp.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 available upon request, in our office, and on our web site.



INITIAL PLEASE

_____ **Patient Authorization Signature:** The undersigned hereby authorizes the release of any information relating to all claims for the benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my dentist to submit claims for the benefits for services rendered or for services to be rendered without obtaining my signature on each and every claim. I will be bound by this signature as though the undersigned had personally signed the particular claim.

_____ **Patient Consent:** I authorize Dr. Andrea Hannahan and staff to take all necessary X-rays, Study Models, and other diagnostic aids as needed to make a thorough diagnosis. **The standard of care for X-rays is a minimum of one time per year regardless of insurance coverage. Dr. Hannahan and her staff follow the standard of care.** Similarly, I authorize Dr. Andrea Hannahan to perform all recommended and agreed upon treatment. I also authorize the use of anesthetics (as needed), and I am fully aware that using anesthetic agents involves certain risks.

_____ **Minor Children:** Children under the age of 18 years old must be accompanied by a parent or legal guardian to **ALL** dental visits, **and that parent and/or guardian must remain in the office for the duration of the child's dental visit.**

_____ **Financial Policy: Payment is due when services are rendered.** Dr. Andrea Hannahan and staff realize that dental insurance is a confusing and sometimes overwhelming experience for our patients. As a result, we agree to file your insurance as a courtesy to you. I (the Patient) understand that I (the patient) am responsible for **ALL fees regardless of insurance coverage.** I (the patient) also understand Andrea Hannahan, DDS, PLLC attempts to estimate charges covered by insurance; however, adjustments may be necessary and responsibility remains with the patient. After 60 days, you (the patient) are responsible for any balance on your account not paid by the insurance company for any reason. Should my account become delinquent, I (the patient) will assume all additional collection costs and legal fees.

_____ **Broken Appointment Policy:** Dr. Andrea Hannahan and staff respect our patients and strive to stay on schedule. It is important for our patients to understand that an appointment is a time set aside for you. Due to this, it is important that you give our office ample time if you need to reschedule your appointment. If you must change your appointment, we require at least 48 hours notice to avoid a \$25.00 per hour cancellation fee. If 48 hours notice is not given, it will be deemed a broken appointment. After three broken appointments we will no longer be able to make a scheduled appointment for you. However, if you need to be seen for an appointment we will put you on our call list and call you should we have a cancellation.

_____ **Returned Check Policy:** Various payment types are welcomed at Dr. Andrea Hannahan, DDS, PLLC, including personal checks. Patients are asked to ensure that checks made out to the office are written with the knowledge that sufficient funds are present in their accounts, and we reserve the right to additionally charge you a fee of \$35.00 for returned checks.

_____ **Cell Phone and Mobile Device Policy:** Due to HIPAA regulations and for patient privacy and safety, cell phones and other mobile devices are not allowed in treatment areas. Please turn off or silence all devices and store them while being treated.

_____ **Patient Safety:** For the safety of our patients and staff we must inform you that our dental treatment chairs have a manufacturer recommended weight limit of 350 lbs. To prevent possible chair malfunction and patient and/or staff injury, patients exceeding the weight limit will not be treated in a dental chair. Other treatment options may be available and Dr. Hannahan or a member of our staff will be happy to discuss these options with you in a private and confidential manner.

_____ **Treatment Area:** Due to HIPAA regulations and for patient and staff safety, only those being treated will be allowed in the treatment area. Parents, a member of the staff will bring you back to the treatment area if needed while we are with your children.

ACKNOWLEDGEMENT OF OFFICE POLICIES

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Dr. Andrea Hannahan, DDS, PLLC Office Policies. I understand that I am responsible for ALL fees regardless of insurance. My signature below confirms I have read, understand, and agree to comply with this office's policies.

Patient Name (Print): _____ Date: _____

Signature of Patient or Legal Guardian: _____



Dr. Andrea Hannahan, DDS, PLLC
Family and Cosmetic Dentistry
Information Release

I, _____, give **Dr. Andrea Hannahan** and/or employees of **Dr.**
(Patient or legal guardian)

Andrea Hannahan, DDS, PLLC permission to discuss and/or release information concerning my dental treatment, financial/account information, and/or insurance information with the following:

Name: _____ Relationship: _____

Address: _____

Phone: _____ Email: _____

Name: _____ Relationship: _____

Address: _____

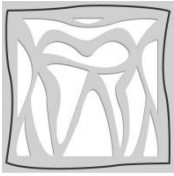
Phone: _____ Email: _____

Patient name (print): _____

Signature: _____ **Date:** _____

(Patient or legal guardian)

Witness: _____ Date: _____



Andrea Hannahan, DDS, PLLC

Family and Cosmetic Dentistry

1012C Crossings Blvd

Spring Hill, TN 37174

www.drhannahan.com

Phone (931) 487-9997

Fax (931) 487-9998

info@drhannahan.com

Insurance/Financial Understanding

I, _____, understand that any treatment plans and prices

(Patient or legal guardian)

discussed with the office of Dr. Andrea Hannahan, DDS are estimated charges and once my insurance company processes my claim there is the possibility I will still have a balance due. I also understand if my insurance does not cover its portion, I am then responsible for the entire balance.

I agree that all charges remaining on my account that have not already been paid and were not covered by my insurance, I will pay to Dr. Andrea Hannahan upon receipt of an invoice.

If any payment is not made by its due date, I understand that I may be charged additional fees and if my account is not paid in full after 90 days, I understand that my account will be sent to a collection agency.

If I am unable to pay the outstanding balance on my account, I understand that I need to contact the office of Dr. Andrea Hannahan to discuss options.

Patient name (Print): _____

Patient (Signature): _____ **Date:** _____

(Patient or legal guardian)