WEBB DENTISTRY

In consideration of professional services performed by Dr. Mark H. Webb/Dr. Brenden M. Webb, the undersigned hereby accepts total and absolute responsibility for all costs incurred as a result of such treatment and services not covered by an acceptable insurance. In the event of default in payment of any amount due, after thirty (30) days, the undersigned agrees to pay a service charge in an amount not exceeding 1.5% per month on this account. Further in the event this account is referred to an attorney or collection agency, the undersigned agrees to pay reasonable attorney's fees, but in no case less than $100.00, or collection fees and court costs as permitted by laws governing these transactions.

Signature _____ Date _____

ABOUT YOU

Today's Date: ___/___/___ Patient Name: _____
LAST FIRST MI

What You Prefer To Be Called: _____ ☐ Male ☐ Female Birthdate: ___/___/___ Age: ___ SS#: _____

Street Address: _____
CITY STATE ZIP

Home Phone #: (___) _____ Work Phone #: (___) _____

Cell Phone #: (___) _____ Referred By: _____

Employer: _____ How Long? _____

Employer's Address: _____
CITY STATE ZIP

Occupation: _____ Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Spouse's Name: _____ Do you have children? ☐ Yes ☐ No How many? _____

INSURANCE INFORMATION

Primary Dental Insurance

Co. Name: _____ Address: _____
CITY STATE ZIP

Phone #: (___) _____ Insured's SS #: _____ Group # (Plan, Local, or Policy #): _____

Insured's Name: _____ Relation: _____ Date of birth: ___/___/___

Insured's Employer: _____

Secondary Dental Insurance

Co. Name: _____ Address: _____
CITY STATE ZIP

Phone#: (___) _____ Insured's SS#: _____ Group # (Plan, Local, or Policy #): _____

Insured's Name: _____ Relation: _____ Date of birth: ___/___/___

Insured's Employer: _____

IN THE EVENT OF AN EMERGENCY

Whom should we contact? _____ Relation: _____

Home Phone#: (___) _____ Work Phone #: (___) _____ Cell Phone #: (___) _____

Who is your medical doctor? _____ Medical Doctor's Phone#: (___) _____

COMPLETE IN INK

DENTAL PATIENT MEDICAL HISTORY

NAME (Last, First, Middle Initial)	SSN	AGE	Date of Birth

The answers to the following questions will assist the dentist in evaluating your general health prior to providing your dental treatment.
PLEASE READ CAREFULLY AND ANSWER EACH QUESTION AS ACCURATELY AS POSSIBLE.

1.WHAT IS YOUR IMPRESSION OF YOUR PRESENT HEALTH?

2. YEAR LAST MEDICAL PHYSICAL?

3. PLEASE DRAW A CIRCLE AROUND ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR HAVE AT PRESENT.

Heart Disease or Condition	Rheumatic Fever	Asthma	Hepatitis	Venereal Disease (Syphilis, Gonorrhea)
Anglina Pectoris	Stroke	Hay Fever	Thyroid Disease	
Frequent Chest Pains	Hemophilia	Emphysema	Glaucoma	Drug Addiction
High Blood Pressure	Bruise Easily	Tuberculosis (TB)	Epilepsy or Seizures	Psychiatric Treatment
Shortness of Breath	Prolonged or Unusual Bleeding	Diabetes	Fainting or Dizzy Spells	Cancer
Swollen Ankles	Anemia	Ulcers	AIDS or AIDS Related Complex	Radiation Therapy
Artificial Heart Valve	Blood Transfusion	Kidney Trouble	HIV Positive	Chemotherapy
Congenital Heart Disease	Sickle Cell Disease	Liver Disease	Cold Sores	Implant Prosthesis
Heart Murmur	Arthritis	Jaundice (Other than at birth)	Genital Herpes	Unexplained Weight Loss

CIRCLE YES OR NO FOR THE FOLLOWING QUESTIONS. (IF IN DOUBT, CIRCLE YES.)
(IF YES, PLEASE GIVE DETAILS.) **CONTINUE COMMENTS ON BACK IF NECESSARY**

4. ARE YOU PRESENTLY, OR HAVE YOU BEEN UNDER THE CARE OF A PHYSICIAN DURING THE PAST YEAR?	YES	NO
5. LIST ANY MEDICINE OR DRUGS INCLUDING HERBAL SUPPLEMENTS YOU ARE CURRENTLY TAKING. USE BACK OF PAGE IF NECESSARY.	YES	NO
6. ARE YOU ALLERGIC TO ANY MEDICINE OR MATERIALS INCLUDING LATEX?	YES	NO
7. HAVE YOU EVER HAD A REACTION TO A LOCAL ANESTHETIC?	YES	NO
8. HAVE YOU EVER EXPERIENCED ANY COMPLICATION OR ILLNESS FOLLOWING DENTAL TREATMENT?	YES	NO
9. DO YOU HAVE ANY DISEASES OR CONDITIONS NOT LISTED ABOVE?	YES	NO
10. HAVE YOU EVER BEEN TOLD YOU WERE NOT ELIGIBLE TO BE A BLOOD DONOR?	YES	NO
11. DO YOU USE TOBACCO (IF YES, please circle and give frequency) **SMOKE:** Cigarettes Cigars Pipe **Smokeless:** Chewing Tobacco Snuff or "Dip" **FREQUENCY:** _____	YES	NO

12. WOMEN: ARE YOU PREGNANT? (IF YES, Circle Trimester Block)	YES	NO	1	2	3

PATIENT COMMENTS Check this box if you have added comments on the back of this form	**SIGNATURE OF PATIENT** (or legal guardian if patient is a minor.) X	**DATE** X

DENTIST'S COMMENTS:

(If necessary continue on reverse side and check this box.) ❑

BLOOD PRESSURE	DATE	BLOOD PRESSURE	DATE	BLOOD PRESSURE	DATE	BLOOD PRESSURE

DENTISTS SIGNATURE	DATE	REVIEWER	DATE	REVIEWER	DATE	REVIEWER

Medical Information Release Form

(HIPPA Release Form)

Name: _____ Date of Birth: ___ /___ /___

Release of Information

( ) I authorize the release of information to include: diagnosis records, examination rendered to me, and claims information. This information may be released to:

( ) Spouse _____

( ) Child(ren) _____

( ) Other _____

( ) Information is not to be released to anyone.

This *Release of Information* will remain in effect until terminated by me in writing.

Messages

Please call ( ) my home ( ) my work ( ) my cell number

If unable to reach me:

( ) you may leave a detailed message

( ) please leave a message asking me to return your call

( ) _____

The best time to reach me is (day) _____ between (time) _____.

Signed: _____ Date: ___ /___ / ___

Webb Dentistry

Help Us Help You

Insurance Coverage: No matter how hard we try, we simply cannot keep up with all the insurance plans and subtypes with which our patients present. In fact, your insurance cannot discuss your plan with us unless you are present due to HIPPA regulations.

You are given an insurance membership handbook and/or online site and ID card at the time you become a participating member of your insurance company. This should allow you to determine what your insurance plan will cover.

Acknowledgement of Receipt of Notice of Privacy Practices

You may refuse to sign this acknowledgement

I,_____, have/had been made available a copy of this office's Notice of Privacy Policy.

_____

Signature

_____

Date

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

( ) Communication barriers prohibited obtaining the acknowledgement

( ) An emergency situation prevented us from obtaining acknowledgement

( ) Other (Please specify)

_____

_____

Webb Dentistry

523 HOLSTON DRIVE SUITE 3| BRISTOL TN, 37620 | (423) 968-5112

Written Financial Policy

Thank you for choosing Webb Dentistry. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

- Cash, Check, Visa, MasterCard, American Express or Discover Card (a 3% convenience fee is applied to all credit card transactions)
- Please note: Webb Dentistry requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.
- We accept payment in thirds for treatments over $200.00 without interest. Interest charges are applied after 90 days.
- For plans requiring more than 2 appointments, alternative payment arrangements may be provided. For patients with dental insurance, we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment. [1]
- A fee of $50 is charged for patients who miss or cancel more than 2 times in a calendar year without 24-hour notice.
- Webb Dentistry charges $20 for returned checks.
- If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

However, if we do not receive payment from your insurance carrier within 60 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.