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

Patient Name: _____ Preferred Name: _____

Parent(s) Name (if minor): _____

Address _____ City _____ State _____ Zip _____

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

Date of Birth: _____ Sex: ☐ M ☐ F

Social Security # _____ Driver's License # _____

Email Address _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Emergency Contact: Name/Relationship _____ Phone # _____

How did you hear about us? ☐ Google Search ☐ Drive By ☐ Facebook ☐ Insurance ☐ Family ☐ Friend/Coworker

Who may we thank for your referral? _____

Premedication antibiotics required? ☐ Yes ☐ No Amoxicillin / Clindamycin / Other_____

NITROUS OXIDE preferred for cleanings? ☐ Yes ☐ No Treatment? ☐ Yes ☐ No

DENTAL INSURANCE

Primary Insurance _____ Policy # _____ Group # _____

Subscriber's Name _____Subscriber's Employer_____

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

Address if different than patient _____

Secondary Insurance _____ Policy # _____ Group # _____

Subscriber's Name _____ Subscriber's Employer_____

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

Address if different than patient _____

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: _____

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

Medical History

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, had a major operation, or serious head or neck injury? ☐ Yes ☐ No If **YES**, please list: _____

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

_____

_____

Do you take any **blood thinners**? ☐ **Yes** ☐ **No** Do you take, or have you taken, **Boniva or Fosemax**? ☐ **Yes** ☐ **No**

Are you on a special diet? ☐ **Yes** ☐ **No** Do you use tobacco? ☐ **Yes** ☐ **No** Do you use controlled substances? ☐ **Yes** ☐ **No**

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

Are you ALLERGIC to any of the following? ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other: _____

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 below? ☐ Yes ☐ No If YES, please explain: _____

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

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

Office Policies

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**: In accordance with Tennessee Law, 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-hour notice to avoid a $75.00 per hour cancellation fee. If 48-hour notice is not given, it will be deemed a broken appointment. I understand that after 3 broken appointments I may be discharged from the practice.

_____ **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 $50.00 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 and use is prohibited during treatment. 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
Insurance/Financial Understanding and Responsible Party

I, _____(Responsible Party)**, understand that any treatment plans and prices discussed with the office of Dr. Andrea Hannahan, DDS are estimated charges. Once my insurance company processes the claim, there is the possibility I will still have a balance due. I also understand if 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 insurance, I will pay to Dr. Andrea Hannahan upon receipt of an invoice.

I also understand Dr. Hannahan prepares a Treatment Plan Estimate so that patients can understand the estimated costs of their recommended treatment prior to its start. The Treatment Plan Estimate is a good-faith attempt to predict the cost of your treatment based on the facts known to Dr. Hannahan when the estimate is made. As your treatment progresses, Dr. Hannahan may determine that different or additional treatment is necessary and your financial responsibility may change.

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.

I agree to be the responsible party for the following patient(s)

_____ _____
Name Date of Birth

_____ _____
Name Date of Birth

_____ _____
Name Date of Birth

Responsible Party (Print): _____

Address if different than patient _____

Responsible Party (Signature): _____Date: _____

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

I, _____, give **Dr. Andrea Hannahan** and/or employees of
(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:

[ ] Spouse: _____

[ ] Children: _____

[ ] Parents: _____

[ ] Other: _____ Relationship: _____

[ ] Information is not to be released to anyone

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

Patient name (print): _____

Signature: _____ **Date:** _____
(Patient or legal guardian)

Witness: _____ Date: _____

Andrea Hannahan, DDS, PLLC
Family and Cosmetic Dentistry
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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.