SAVELL DENTISTRY
Lauren Everett Savell DDS

SAVELL DENTISTRY
LAUREN EVERETT SAVELL, D.D.S.

PATIENT REGISTRATION
(Please Print)

Date: _____

First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name: _____

SECTION 1 – PATIENT INFORMATION

Address: _____ Address 2: _____

City: _____ State/Zip: _____

Telephone: Home _____ Cellular _____ Other _____

Birth Date: _____ Social Security #: _____ Sex: Male ____ Female ____

E-mail: _____ Marital Status: Married___ Single___ Divorced___ Separated___ Widowed____

Do we have permission to contact you via telephone, text, and e-mail? Yes _____ No _____

Occupation: _____

Employer: _____ Business Phone: _____

Employer Address: _____ City/State/Zip _____

Pharmacy Name, Telephone & Address: _____

Spouse's Name: _____

Birth Date: _____ Social Security #: _____ Occupation: _____

Employer: _____ Business Phone: _____

Employer Address: _____ City/State/Zip _____

SECTION 2 – RESPONSIBLE PARTY (if other than patient)

Name: _____

Address: _____ Address 2: _____

City: _____ State/Zip: _____

Telephone: Home _____ Work _____, ext. ____ Cellular _____

Birth Date: _____ Social Security #: _____ E-mail: _____

Responsible Party is: O Policy Holder for Patient O Primary Insurance Policy Holder O Secondary Insurance Policy Holder

SECTION 3 – PERSON TO CONTACT IN CASE OF EMERGENCY

Name: _____ Phone: _____

Relationship: _____

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PATIENT REGISTRATION

(continued)

DO YOU HAVE INSURANCE? ○ **YES (proceed to SECTION 4 and/or SECTION 5)** ○ **NO (proceed to SECTION 6)**

SECTION 4 – PRIMARY INSURANCE INFORMATION

Name of Insured: _____ Relationship to Insured: Self __ Spouse __ Child __ Other __

Insured's Social Security #: _____ Insured's Birth Date: _____

Insured's Employer: _____

Address: _____

City, State, Zip: _____

Insurance Company: _____

Insurance ID #: _____ Insurance Company Telephone #: _____

SECTION 5 – SECONDARY INSURANCE INFORMATION

Name of Insured: _____ Relationship to Insured: Self __ Spouse __ Child __ Other __

Insured's Social Security #: _____ Insured's Birth Date: _____

Insured's Employer: _____

Address: _____

City, State, Zip: _____

Insurance Company: _____

Insurance ID #: _____ Insurance Company Telephone #: _____

SECTION 6 – APPOINTMENT CANCELLATION POLICY

We kindly request 48 hours' notice in the event an appointment is to be cancelled. Failure to do so may result in a fee in accordance with the time set aside for you or dismissal from the Practice. You are valued as a patient, and we ask that you make arrangements to be here as scheduled.

SECTION 7 – PAYMENT FOR DENTAL SERVICES

Payment is due at the time of service. If you have insurance, it will be filed for you and your estimated portion and/or estimated co-payments will be due at the time of service. In the event we have submitted your insurance claim and we then become aware that your insurer will not pay for certain services, you will be billed for those charges and payment will be promptly expected. You may pay with cash, check, VISA, MasterCard, Discover, or Care Credit.

Date Signed: _____ _____

Signature of Patient (or Guardian)

SAVELL DENTISTRY

Lauren Everett Savell DDS

Name _____

Last First

Date _____

Please tell us how you learned about our practice. (Select **ALL** that apply)

_____	Referral - Patient	*Name:* _____
_____	Referral - Staff	*Name:* _____
_____	Referral - Dentist/Dr	*Name:* _____
_____	Our website	
_____	Internet search	(e.g. a basic search for "dentist")
_____	Insurance Company	*Which insurance?* _____
_____		
_____		
_____		

SAVELL DENTISTRY
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Lauren Savell D.D.S.

Eaglesoft Medical History

Date 4/30/2019

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	Yes No	If yes	
Have you ever been hospitalized or had a major operation?	Yes No	If yes	
Have you ever had a serious head or neck injury?	Yes No	If yes	
Are you taking any medications, pills, or drugs?	Yes No	If yes	
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes	
Are you on a special diet?	Yes No		
Do you use tobacco?	Yes No		
Do you use controlled substances?	Yes No	If yes	

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 Sulfa Drugs Local Anesthetics

Other? If yes

Do you have, or have you had, any of the following?

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

Have you ever had any serious illness not listed above? Yes No If yes

Comments:

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 (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____

APPOINTMENT POLICIES

Your dental health is our utmost priority! Keeping your appointments is very important to your overall health!

Appointments in our office are in high demand. Your appointment time is reserved *exclusively for you*, and we will make every effort to honor that time and keep you from waiting. Please review and adhere to the following appointment policies. Failure to do so will result in consequences as outlined in the last policy shown here.

How to Properly Cancel or Reschedule Your Appointment

In the event that is necessary to cancel or reschedule your appointment, we require that you contact our office by 10:00 a.m. one (1) business day BEFORE your appointment. Please call **731-852-4621** to speak with an office representative. If you do not reach an office representative, you may leave a detailed message on the office voicemail. You may not cancel a scheduled appointment via email or text.

What is a Late Cancellation?

This includes same-day cancellations as well as cancellations made after 10:00 a.m. one business day prior to the appointment. Late cancellations will be recorded in your patient chart.

What is a No-Show?

A "no-show" occurs when a patient fails to show for their scheduled appointment. Failure to be present at the time of your reserved appointment will be recorded in your patient chart as a no-show.

Late Arrivals

We ask that you please arrive to your appointments by your scheduled time. We will not compromise the care we give to you or to others. Therefore, with that purpose in mind, if you arrive after your scheduled appointment time, it will be at our discretion whether or not we will still be able to see you. If you are fifteen (15) minutes or more late, we will require the appointment to be rescheduled.

*** Late Cancellation/No-Show Policy ***

We understand that illness or other emergent problems can occur, sometimes without warning. We will gladly reschedule your appointment the first time a late cancellation or no-show occurs. However, in the event of a second occurrence, a $40.00 charge will be billed. In the event of three or more occurrences within an annual period, another $40.00 charge will be billed each time. You will also be placed on a same-day only list; and you may ultimately be dismissed from the practice.

By signing below, I certify that I have read and fully understand the terms and conditions of Savell Dentistry's appointment policies.

_____ _____

Patient/Guardian Signature **Date**

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LAUREN EVERETT SAVELL, D.D.S.

PAYMENT POLICY

Thank you for choosing us as your primary care provider! We are committed to providing you with quality, comprehensive dental care. In an effort to make you aware of your payment and insurance responsibility for services rendered, we have developed this policy. Please read it carefully; ask us any questions you may have; date and initial each section; and sign in the space provided at the bottom. A copy will be provided to you upon request.

INSURANCE - We accept most insurance plans. If you are not insured, or not insured by a plan we accept, payment in full is expected at each visit. If you are insured by a plan we accept but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

If you have insurance, your portion of costs will be estimated based on what your insurance company tells us it will pay. You are expected to pay your portion the day services are rendered. If your insurance does not pay as much as is expected, or in the event it pays nothing at all, you will be billed for those charges and payment will be promptly expected. Initial/Date _____

CO-PAYMENTS AND DEDUCTIBLES - All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit. Initial/Date _____

NON-COVERED SERVICES - Please be aware that some—and perhaps all—of the services you receive may be noncovered or not considered reasonable or necessary by some insurers. You must pay for these services in full at the time of visit. In the event we have submitted your insurance claim and we then become aware that your insurer will not pay for certain services, you will be billed for those charges and payment will be promptly expected. Initial/Date _____

PAYMENT METHODS - Preferred payment method is cash or check, but payment will be accepted by VISA, MasterCard, Discover, or Care Credit. Initial/Date _____

PROOF OF INSURANCE - All patients must complete our patient registration form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim. Initial/Date _____

CLAIMS SUBMISSION - We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract. Initial/Date _____

PAYMENT AUTHORIZATION - Your signature on this form authorizes the use of this form on all your insurance submissions and authorizes the release of your information to all your insurance carriers. Your signature further authorizes your dentist to act as your agent in assisting in obtaining payment from your insurance carriers. Your signature further authorizes payment by your insurance carrier to be made directly to your dentist. You are also permitting a copy of this authorization to be used in place of the original. Initial/Date _____

COVERAGE CHANGES - If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

NONPAYMENT - If your account is over 90 days past due, you may be subject to a 5% interest charge. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency. Also be aware that in addition to any balance owed on your account, you may be subject to any and all fees associated with the collection of your account. You and your immediate family members may be discharged from this practice in the event of nonpayment, and our doctor will recommend an alternative dental provider to you. Initial/Date _____

MISSED APPOINTMENTS - If the need arises to cancel your appointment, we require 48 hours' notice of cancellation. Whenever possible, we will attempt to contact you 48 hours in advance to confirm your appointment and ask that you respond within 24 hours prior to your appointment time. We work hard to respect your commitments by scheduling your appointment at a time most convenient for you, and that time is reserved especially for you. Failure to notify on multiple occasions may result in a charge in accordance with the time set aside for you or dismissal from the practice. Initial/Date _____

Our practice is committed to providing the best treatment to our patients. Thank you for understanding our payment policy.

I have read and understand the payment policy and agree to abide by its guidelines.

_____ _____

Signature of Patient, Guardian and/or Other Responsible Party **Date**

SAVELL DENTISTRY
LAUREN EVERETT SAVELL, D.D.S.

NOTICE OF PRIVACY PRACTICES

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.

YOUR RIGHTS AND CHOICES

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. 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, by calling 1-800-368-1019 or by visiting www.hhs.gov/hipaa/filing-a-complaint/index.html. We will not retaliate against you for filing a complaint.

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

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 for health plans or other entities. *Example: We give information about you to your health insurance plan so it will pay for your services.*

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, ad 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.

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. 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 if applicable. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html or contact Lauren Savell at savelldentistry@yahoo.com or 731-852-4621.

SAVELL DENTISTRY

LAUREN EVERETT SAVELL, D.D.S.

I have read the "Notice of Privacy Practices" Form given to me and understand that any medical records may be disclosed as explained in that form.

_____ _____

Patient (or Guardian) Signature Date

I do authorize immediate family members to call and inquire about my medical record with regard to results of tests, questions about my condition, etc. This would include my mother, father, sisters, brothers, husband, wife, and/or caregiver.

_____ _____

Patient (or Guardian) Signature Date

This consent is a disclosure of protected health information for the purpose of treatment, operations, or payment.

I understand that Lauren Everett Savell, D.D.S., may need to use and disclose information about my health or medical problems for the purposes of arranging, conducting, or referring for my treatment, for obtaining payment for the services rendered me, and for the operations of the practice. I consent to the use of my information for the purposes of treatment, payment, and health care operations.

I understand that my consent is not needed if the law requires Lauren Everett Savell, D.D.S., to report some aspect of my protected health information to a government agency. Examples would include suspected abuse, communicable disease, and potential for serious bodily harm to myself or others.

I understand that I have the right to review Lauren Everett Savell, D.D.S.'s, privacy notice, to request restrictions on the use of my information, and to revoke my consent at any later date.

I understand that if I withhold consent for the use of my information for the purposes of treatment, payment, or operations, Lauren Everett Savell, D.D.S., may decline to undertake my care.

_____ _____

Patient (or Guardian) Signature Date