Welcome to the Office of Dr. Dennis K. Roman, D.M.D.

Patient Information

Name ____ ______________________
Last First MI Nick Name

Home # ____________________ Work # ____________________ Cell # ____________________

Email Address __________________________________ ________________________________
Whom may we thank for referring you?

How you prefer to be contacted by our office? ( ) cell phone ( ) e-mail ( ) home phone

Address __________________________________ Zip ________ City ______________ ST__ ___

Birthdate ___________________ Age _________ Soc. Sec. # ____________________________

Sex ( ) M ( ) F ( ) Single ( ) Married ( ) Widowed

Patient Employed By ________________________ Occupation __________________________

Emergency Contact _________________________ Phone ______________________________

Primary Insurance

Person Responsible for Account ____

Relation to Patient _______________ Birthdate _____________ Soc. Sec. # ________________

Address ____

Employed by _______________________ Insurance Company ___________________________

Group # __________________________ Subscriber ID #_______________________________

Please let us know if you have Secondary Insurance

Dental History

Reason for Today's Visit________________________ Last Dental Care ____________________

Previous Dentist ________________________ ____ Last Dental X-Rays_____________________

Check if you have or ever had any of the following:

( ) Bad Breath
( ) Sensitivity when biting
( ) Crowded teeth or spacing
( ) Food collects between teeth
( ) Grinding or clenching teeth
( ) Clicking or Popping
( ) Snoring or Apnea
( ) Broken fillings
( ) Sensitivity to hot or cold
( ) Missing or loose teeth
( ) Bleeding Gums
( ) Yellow or gray teeth

How often do you floss? ______________________ How often do you brush? ___________________

Medical History

Physician's Name ________________________________ Date of last visit ________________________

Are you being treated for any medical problems? ( ) Yes ( ) No

If yes, please explain: ____

Have you ever been hospitalized? ( ) Yes ( ) No

If yes, please explain: ____

Do you bleed excessively when cut? ( ) Yes ( ) No Do you smoke? ( ) Yes ( ) No If yes, how much?_________

Check if you have or ever had any of the following:

( ) Heart Murmur
( ) Prolapsed Heart Valve
( ) Angina
( ) Pacemaker
( ) Other Heart Disease
( ) High Blood Pressure
( ) Bleeding Disorder
( ) Other Blood Disease
( ) Blood Transfusion
( ) Asthma or Apnea
( ) Sinus Problems
( ) Respiratory Problems
( ) Stroke
( ) Arthritis
( ) Prosthetic Joint
( ) Tumor History
( ) Cancer Therapy
( ) Rheumatic Fever
( ) Hepatitis
( ) Kidney Disease
( ) Tuberculosis
( ) Aids or HIV
( ) Venereal Disease
( ) Pregnant
( ) Diabetes
( ) Thyroid Disease
( ) Seizures
( ) Glaucoma
( ) Cold Sores
( ) Persistent Swollen Neck Glands
( ) Allergy to Penicillin
( ) Allergy to other antibiotics
( ) Allergy to anesthetics
( ) Allergy to latex
( ) Other Allergies
( ) Drug/Alcohol Addiction

List any medication you are taking: ______________________________ ______________________________

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Authorization

The undersigned hereby authorizes Dr. Dennis K. Roman and staff to perform whatever dental procedures and anesthesia are necessary for the treatment of the above named patient. I understand there is a slight element of risk inherent in the administration of any drug or anesthesia, or in the performance of any type of dental procedure. I am aware the practice of dentistry is not an exact science and I acknowledge that no guarantees can be made concerning the results of any operation or procedure.

I acknowledge that all my questions about the inquiries set forth above have been answered to my satisfaction. I will not hold Dr. Roman or any member of his staff responsible for errors or omissions that I may have made in the completion of this form. I attest to the accuracy of the information on this page. I agree to inform Dr. Roman of any change in my health status prior to each appointment.

I agree to assume full financial responsibility for all treatment rendered, including any necessary collection and legal fees. I understand a monthly late fee of 1.5% (8% annual), with a $6.00 minimum, may be added to any account with a balance over 30 days old. I understand a cancellation fee may be assessed for appointments missed without 24-hour notice. I certify that I have read and understand all of the above.

Signature ____ Date __________________________

Payment is due in full at time of treatment unless prior arrangements have been approved.

Dr. Dennis K. Roman, D.M.D.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: ____

Address: ____

Telephone:_________________________________E-mail: ______________________________

Social Security Number: ____________________

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Dr. Dennis K. Roman, D.M.D
785 Old Hickory Boulevard Suite 200
P.O. Box 1744,
Brentwood, TN 37024
615-377-9707 - Phone 615-377-9709 - Fax
drdroman11@gmail.com

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I,___________________________________, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature:____Date: ___________________________

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: ____

Relationship to Patient: ____