Parent or Guardian Information

Today's Date:_____ Patient #_____

Child's Name:_____ Birthdate_____

MOTHER'S INFORMATION

MOTHER'S NAME_____
LAST FIRST ML

DATE OF BIRTH____/____/____ AGE:____ SS#_____

MAILING ADDRESS_____

_____
CITY STATE ZIP

HOME PHONE(____)_____ CELL (____)_____

EMAIL_____

EMPLOYER_____HOW LONG_____

ADDRESS_____

_____
CITY STATE ZIP

OCCUPATION_____

STATUS: SINGLE MARRIED DIVORCED SEPERATED WIDOWED

FATHER'S INFORMATION

FATHER'S NAME_____
LAST FIRST ML

DATE OF BIRTH____/____/____ AGE:____ SS#_____

MAILING ADDRESS_____

_____
CITY STATE ZIP

HOME PHONE(____)_____ CELL (____)_____

EMAIL_____

EMPLOYER_____HOW LONG_____

ADDRESS_____

_____
CITY STATE ZIP

OCCUPATION_____

STATUS: SINGLE MARRIED DIVORCED SEPERATED WIDOWED

INSURANCE INFORMATION

Ins Co. Name:_____

Insured's ID#:_____

Group or Account #:_____

Insured's Name:_____

Primary Insured's S.S.# _____

Relation:_____ Date of Birth:_____

Insured's Employer:_____

_____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.

EMERGENCY CONTACT

EMERGENCY CONTACT_____

RELATION_____HOME#_____

WORK#_____ CELL#_____

- **We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.**
- **Our policy requires payment in full for all services rendered at the time of our visit, unless other arrangements have been made with our business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.**
- **I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.**
- **I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.**

Signature _____ **Date**_____

Dental History

Is this your child's first visit to the dentist? _____

If not, how long since the last visit to the dentist? _____

Previous Dentist's Name_____

Were any x-rays taken at previous dental visits? _____

Have there been any injuries to the teeth, face or mouth? _____

If yes, please explain _____

_____

_____

Why did you bring the child to the dentist today? _____

_____

_____

Does the child have any of the following habits?

Y N Lip Sucking / Biting Y N Nail Biting

Y N Nursing / Bottle Habits Y N Thumb / Finger Sucking

Has the child ever had a serious or difficult problem associated with previous dental work? Yes No

If yes, please explain _____

_____

Is the child's water fluoridated? Yes No

Is the child taking fluoride supplements? Yes No

Has the child ever had any pain or tenderness in his/her jaw/ joint? (TMJ/TMD)? Yes No

Does the child brush his/her teeth daily? Yes No

Floss his / her teeth daily? Yes No

Health History

Has the child ever had any of the following conditions?

Y N Abnormal Bleeding
Y N Allergies to any Drugs
Y N Any Hospital Stays
Y N Any Operations
Y N Asthma
Y N Cancer
Y N Congenital Birth Defects
Y N Convulsions/Epilepsy
Y N Pregnancy
Y N Tuberculosis
Y N Handicaps/Disabilities
Y N Hearing Impairment
Y N Heart Disease/Murmur
Y N Hemophilia/Blood Disorders
Y N Hepatitis
Y N HIV + / AIDS
Y N Kidney/Liver Conditions
Y N Rheumatic/Scarlet Fever
Y N Allergies to Latex Product
Y N Diabetes

Please discuss any serious medical conditions the child has had

_____

_____

Please list all drugs the child is currently taking _____

_____

Please list all drugs the child is allergic to _____

_____

Child's Physician _____

Phone (_____) _____

Is the child currently under the care of a physician? Yes No

Please describe the child's current physical health...

Good Fair Poor

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA the CDC, and the ADA.

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

_____ _____ _____

Signature of Parent or Guardian Date Relationship to Patient

For Office Use Only

I verbally reviewed the medical / dental information above with the parent / guardian and patient named herein.

Initials _____ Date _____

Doctor's Comments _____

_____

_____

_____

Centre for Holistic and Biological Dentistry
THOMAS J. LOKENSGARD, DDS, NMD, ABAAHP
1600 Westgate Circle, Suite 175, Brentwood, TN 37027
615.481.4555 info@HolisticDentistryTN.com

Financial and Insurance Agreement

I hereby agree to accept full financial responsibility for any dental work provided to_____(Print Patient's name)

I understand that as a courtesy to me, there will be a treatment plan printed out, that is an "***estimate only",*** based on standard insurance fee schedules and coverage. It is not the clinic's responsibility to know in detail each individual's specific insurance policy. "***Our staff will do its absolute best to provide you with the most accurate estimate",*** but I understand that I will be responsible for interpreting my own insurance policy, benefits, and coverage. Any remaining balance after insurance coverage is expected to be paid in full on the day of service. Any balance remaining on the account after ninety days will be turned over for collections. Also, as a courtesy to you, personal checks will be accepted. However, we will forward the amount that the bank will charge us to the patient's account on any check that does not clear the bank. A money order, certified check, cash, or credit/debit card payment will be expected if a personal check does not clear.

I understand that I am responsible for the entire cost of treatment. I further understand that if it ever becomes necessary for this account to be turned over for collection, I am responsible for any collection fees.

Authorization I authorize the release of any information needed to process my insurance claims. I further understand that I am responsible for the entire cost of treatment regardless of insurance coverage or payments. I authorize payment of insurance benefits directly to the dentist otherwise payable to me. I hereby authorize and acknowledge that any scanned signature is to be considered an original signature.

Acknowledgement of Receipt of Privacy Practices Notice

I hereby acknowledge that I have received a Notice of Privacy Practices from the practice as listed above.

Upon signing this statement, I have thoroughly read the above policy and will be in compliance.

Name (Please Print)_____

Signature:_____

Date:_____

OUT-OF-NETWORK CONSENT FORM

Centre for Holistic and Biological Dentistry
info@HolisticDentistryTN.com
615.481.4555 615.472.8925 fax

I, _____,
(Print Full Name)

a member of _____,
(Print Insurance Company)

have been informed by _____,
(Print Name of Dentist, and/or Financial Manager)

That, Thomas J. Lokensgard, and the *Centre for Holistic and Biological Dentistry*, located at 1600 Westgate Circle, Brentwood, TN is an out-of- network, non -participating facility. Therefore, I understand that if I receive services at this facility, my out-of-network benefits will apply. In such case, I may have additional out-of-pocket expenses not covered by my insurance company for which I will be personally responsible. I also understand that in some instances, my insurance may not cover any benefits at all.

For example: If a service is performed at a participating business and incurs a charge of $2,000, your insurance company may have a payment allowance of $922 for the service. Your benefits will pay the $922 allowance less any applicable deductible, and balance bill you for the difference.

A participating in-network provider cannot ***balance bill*** you the difference between what they have allowed and their actual charges. However, when using an out-of-network provider, you are personally responsible for the difference between the charges and the allowance paid by your insurance provider, which in *this example* would be $1,078.

I acknowledge by signing this Consent Form that I have been informed by the Billing and Insurance manager, of alternative participating facilities within my participating network. However, I have chosen to receive services at the above out-of-network facility and accept responsibility for the additional costs that may be incurred.

I understand this facility is not a participating network of my insurance provider and that I will be financially responsible for any additional out-of- pocket costs that may result. I further acknowledge that it is my responsibility to verify my out-of-network benefits with my insurance company and will not hold Dr Thomas J. Lokensgard liable for any obscure or omitted contractual language in my insurance contract.

Patient or Responsible Party Signature Date

Staff member witness Date

CENTRE FOR HOLISTIC AND BIOLOGICAL DENTISTRY

Thomas J. Lokensgard, DDS, NMD, ABAAHP

Patient Policies

Due to the growing nature of our practice, we are making some policy changes to better serve all of our patients. We sincerely appreciate your continued support of our office.

*__Please allow up to one (1) business day__ for an assistant to return messages regarding dental questions.

*__To respect other patients' time__, we ask that you only be seen for the dental issues for which you were scheduled. Any other dental problems outside of the scope of your appointment will need to be addressed in a separate appointment.

*__If you arrive more than 15 minutes late__ for your appointment, you may be asked to reschedule.

***We require a 24 hour confirmation on all appointments.** Any appointments that are not confirmed will be removed from our schedule.

*__We require 48-hour notice for cancellation__ of a scheduled appointment. Please call the office to reschedule or remove your appointment. If you are considered a *"no show"* for three (3) missed appointments or have excessive cancellations, we retain the right to dismiss you from our practice.

*__It is your responsibility__ to contact your insurance company prior to the appointment to verify coverage of your visit.

***Copays and past due balances** are due at the time of service.

I hereby acknowledge I have read the policies listed above, and I understand my responsibilities as a patient of Dr. Thomas Lokensgard.

_____

Patient's Printed Name Patient's Signature

_____

Date

THOMAS J. LOKENSGARD, DDS, NMD, ABAAHP
Centre for Holistic and Biological Dentistry
1600 Westgate Circle, Suite 175, Brentwood, TN 37027
info@HolisticDentistryTN.com
615.481.4555 615.472.8925 fax

HIPAA PRIVACY DISCLOSURE

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I understand I may receive a paper copy with this authorization at my request. This notice is effective as of _____. This authorization will expire seven years after the date in which you last received services from us.

CONSENT TO TREAT: I voluntarily authorize whomever Dr. Thomas Lokensgard designates as assistants or associates to administer examinations and care as deemed necessary for my condition.

Emergency Contact Name_____

Contact Phone_____

AUTHORIZATION TO RELEASE RECORDS: I voluntarily authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in my case.

Print Patient Name_____

Patient Signature_____

Date_____

Witness Signature_____

Position_____

Date_____

Acknowledgement of Receipt of Notice of Privacy Practices

Please read *Notice of Privacy Practices* below. ***Submitting this completed form with patients' samples constitutes acknowledgement and agreement of our Privacy Practices, the use of practitioner and patient contact information for customer service purposes, and the use of test data for research purposes.***

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on May 7, 2003, and will remain in effect until it is amended or replaced by us. It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please read and sign the acknowledgement of privacy practices.

Typical Uses and Disclosures of Health Information

We are committed to maintaining the privacy of your health information. This notice lists some of the reasons and examples why we might use or disclose your health information. Not every use or disclosure is covered, but all of the ways we are allowed to use and disclose information will fall into one of the categories.

Treatment: We may use and disclose medical information about you to provide health care treatment to you. In other words, we may use and disclose medical information about you to provide, coordinate or manage your health care and *related* services with other health care professionals. We have established a "minimum necessary or need to know" standard that limits various staff members' access to your health information according to their primary job functions.

Payment: We may use and disclose health information about your treatment and services to bill and collect payment from your insurance company or a third party payer.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities. Medical information about you may be used to determine whether certain treatments are effective, additional services
should be offered, services should be discontinued, or to notify you of additional services offered that might benefit your health or be of interest to you, such as research studies conducted by Quicksilver Scientific.

Persons involved in your care: We may disclose medical information about you to a relative, close personal friend or any other person you identify if that person is involved in your care and the information is relevant to your care. However, we may require you to give written permission. If the patient is a minor, we may disclose medical information about the minor to a parent, guardian or other person responsible for the minor except in limited circumstances (prohibited by state law). You may ask us not to disclose medical information about you to persons involved in your care. We will agree to your request and not disclose the information except in certain limited circumstances (such as emergencies). If the patient is a minor we may or may not be able to agree to your request.

Emergencies: We may use or disclose your health information to notify or assist in the notification of a family member or anyone responsible for your care in case of any emergency involving your care, your location, and your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or *administrative* orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

Your Privacy Rights As Our Patient Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian). There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Our lab personnel can provide you a copy of the form, the cost for the appointment and fees for each copied page. If you want the copies mailed to you, postage will also be charged. Once approved, an appointment can be made to review your records. Applicable fees will be collected prior to releasing the records.