Jeffrey R. Yost, D.D.S.
100 Cool Springs Blvd., Suite 100
Franklin, TN 37067
Ph. (615) 771-4007 Fax (615) 771-1990

PATIENT INFORMATION

DATE _____

Patient Name_____ Legal Name _____
Parent Name (if minor) _____

Address _____ City _____ State_____ Zip_____

Home Phone ( ) _____ Work Phone ( ) _____ Cell Phone ( ) _____

Email Address _____ Date of Birth _____ Sex ☐ M ☐ F

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed Social Security # _____

Responsible Party _____
Relationship ☐ Self ☐ Spouse ☐ Parent ☐ Other _____

Whom may we thank for referring you? ☐ Real Yellow Pages ☐ Letter ☐ Newspaper Ad ☐ Friend/Family

Referring Friend/Family Name _____ Other source of referral _____

Patient Employer _____ Employer Address _____

City _____ State _____ Zip _____

Spouse's Name _____ Spouse's Employer _____

Spouse's Date of Birth _____ Spouse's Social Security # _____

EMERGENCY CONTACT: Name/Relationship _____ Ph. Number _____

DENTAL INSURANCE

Primary Insurance Company _____ Subscriber Name _____

Relationship to Patient ☐ Self ☐ Spouse ☐ Parent ☐ Other _____

ID# _____ Group # _____ Subscriber's DOB _____

Subscriber's Employer _____

Secondary Insurance Company _____ Subscriber Name _____

Relationship to Patient ☐ Self ☐ Spouse ☐ Child ☐ Other _____

ID# _____ Group # _____ Subscriber's DOB _____

ASSIGNMENT AND RELEASE

I authorize Yost Dental Group to release any information to expedite insurance claims. I understand that I am responsible for all charges regardless of insurance coverage. Payment is expected in full the day of service unless financial arrangements are in place prior to treatment. Patients are responsible for any attorney or collection fees. I agree to comply with the office policy and payment arrangements.

Signature _____ **Date** _____

PATIENT'S DENTAL HISTORY **DATE** _____

Reason for today's visit

_____

Former Dentist _____ City/State _____

Month/Year of Last Visit _____ What was done at your last visit? _____

How often do you visit the dentist? ☐ Annual Check-Up ☐ Twice a Year Check-Up
☐ Only when I have a problem

Please choose the appropriate answer:

Are you nervous about receiving dental treatment?	☐ Yes	☐ No
Are you missing teeth that have not been replaced?	☐ Yes	☐ No
Do you gag easily?	☐ Yes	☐ No
Have you had excessive bleeding after an extraction?	☐ Yes	☐ No
Have you had previous problems with dental care?	☐ Yes	☐ No

If so, please explain:

_____

_____

Have you had mouth sores that take long to heal?	☐ Yes	☐ No
Do you have any dental implants?	☐ Yes	☐ No
Do you wear dentures (partials or full)?	☐ Yes	☐ No
Do you have any crowns (caps) or bridges?	☐ Yes	☐ No
Do you smoke?	☐ Yes	☐ No
Are your teeth sensitive to hot, cold, pressure or sweets?	☐ Yes	☐ No
Do you chew tobacco?	☐ Yes	☐ No
Do you have problems with teeth/fillings breaking?	☐ Yes	☐ No
Do you have a dry mouth?	☐ Yes	☐ No
Are you aware of an uncomfortable bite?	☐ Yes	☐ No
Are you unhappy with the appearance of your teeth?	☐ Yes	☐ No
Do your gums feel tender and/or bleed?	☐ Yes	☐ No
Would you like your smile to look better?	☐ Yes	☐ No
Does food catch between your teeth?	☐ Yes	☐ No
Would you like whiter teeth?	☐ Yes	☐ No
Have you had periodontal (gum) treatments?	☐ Yes	☐ No
Do you regularly use dental floss?	☐ Yes	☐ No
Do you hear a "clicking" sound when you open/close your mouth?	☐ Yes	☐ No
Does your jaw ever get "stuck?"	☐ Yes	☐ No
Do you have a Temporomandibular (TMJ) jaw disorder?	☐ Yes	☐ No
Do you get sores in or around your mouth?	☐ Yes	☐ No
Do you brush at least once daily?	☐ Yes	☐ No
Do you have regular headaches, earaches or neck pains?	☐ Yes	☐ No
Do you grind or clench your teeth?	☐ Yes	☐ No
Is there anything else that you would like us to know?	☐ Yes	☐ No

_____

_____

PATIENT'S MEDICAL HISTORY **DATE** _____

Physician's Full Name _____ City, State, Zip _____

Are you currently under a physician's care? ☐ Yes ☐ No

If Yes, please explain. _____

Have you been hospitalized in the last two years? ☐ Yes ☐ No

If Yes, please explain. _____

Are you taking any medications? ☐ Yes ☐ No

If Yes, please list the names and dosages of each. _____

Do you smoke? ☐ Yes ☐ No

Women Only

Are you pregnant? ☐ Yes ☐ No Are you taking birth control pills? ☐ Yes ☐ No

Are you nursing? ☐ Yes ☐ No Are you on Hormone Therapy? ☐ Yes ☐ No

Patient's Current or Previous Conditions

Select any of the following if you presently have or have had the condition in the past:

Medical Alerts

☐ Allergic to Penicillin
☐ Allergic to Tetracycline
☐ Allergic to Aspirin
☐ Prior Hepatitis
☐ Other Allergy _____

☐ Allergic to Codeine
☐ Allergic to Novocain
☐ Allergic to Latex Rubber
☐ Pacemaker/Defibrilator

☐ Pre-Medication required
☐ Mitral Valve Prolapse
☐ Heart Problems
☐ HIV Positive
☐ Other Alert _____

☐ Artificial Joint Replacement
☐ Rheumatic Fever

Medical Conditions

☐ Heart Attack
☐ Heart Murmur
☐ Chest Pain
☐ Congenital Heart Problem
☐ Artificial Heart Valve
☐ Heart Surgery
☐ High Blood Pressure
☐ Low Blood Pressure
☐ Anemia
☐ Blood Disease
☐ Blood Transfusion
☐ Stroke
☐ Deep Vein Clot
☐ Hemophilia
☐ Fainting or Dizziness
☐ Cold Sores/Fever Blisters

☐ Chemical Dependency
☐ Excessive Bleeding when Cut
☐ Diabetes
☐ Excessive Thirst
☐ Thyroid Disease
☐ Kidney Disease
☐ Liver Disease
☐ Hepatitis A or B
☐ Cancer
☐ X-Ray Cobalt Treatment
☐ Chemotherapy
☐ Ulcers
☐ Gastrointestinal Upset
☐ Acid Reflux
☐ Lung Disease
☐ Hypoglycemia
☐ Venereal Disease

☐ Osteoporosis
☐ Tuberculosis
☐ Shortness of Breath
☐ Emphysema
☐ Asthma
☐ Sinus Trouble
☐ Hay Fever
☐ Frequent Cough
☐ Rheumatism
☐ Arthritis/Gout
☐ Swelling of Feet/Ankles
☐ Psychiatric Care
☐ Epilepsy or Seizures
☐ Extreme Nervousness
☐ Hives
☐ Cortisone Treatment

I hereby certify that the foregoing information is accurate and complete and that I will notify this office of any changes in a timely manner. I will not hold Dr. Jeffrey R. Yost, or any member of his staff responsible for any errors or omissions that I may have made in completion of this form.

Signature _____ **Date** _____

Yost Dental Group
Financial Policy

Thank you for choosing our office as your dental provider. Because we realize that every person's financial situation is different, we provide a variety of payment options to help you receive the dental care you need and deserve. To maintain the practice operations and prevent potential misunderstanding, we ask patients to accept and adhere to the following financial arrangements regarding their dental treatment.

- Payment for services is due at the time services are rendered unless prior arrangements have been made with Dr. Yost and the business manager. A 50% deposit is required at the time of the first impression for crowns, bridges, dentures, or partial dentures. The remaining balance is due at the time the prosthesis is cemented or inserted.
- Parents are responsible for any payment due for their minor child/children at the time of their appointment. Payment arrangements for non-emergency treatment on unaccompanied minors must be pre-authorized before the appointment date.
- We accept the following forms of payment: Cash, Check, Visa, Mastercard, Discover, and American Express
- We also provide the ability for our patients, upon approval, to obtain an interest-free term loan through CareCredit. This is a term loan for up to 6 months with no down payment, no annual fee, and no prepayment penalty. Longer term loans, which charge interest, extending up to 60 months are also available through CareCredit.
- Checks returned to our office from your financial institution are subject to a $25.00 returned check fee.
- Interest at a rate of 1.25% (14.99% APR) will accrue on past due accounts with balances over 60 days.
- Unpaid accounts that are submitted for collection incur a collection fee of 28% on the account balance.
- All legal fees for unpaid accounts that are submitted to collection are the patient's responsibility.
- A specific amount of time is reserved especially for you. If you must change your appointment, we require at least 24 hours notice to avoid a $35.00/hour cancellation fee (emergencies are an exception).

Regarding Insurance

- Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid your account in full within 60 days, any remaining balance is your responsibility. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and customary under the terms of your insurance policy. Our practice is committed to providing the best treatment for our patients and we charge what is the usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- All insurance co-pays and deductibles must be paid at the time of service

My signature below confirms that I have read and understand this Financial Policy. I understand that parents are responsible for all fees and services rendered for treatment of a child. I understand that I am responsible for ALL fees regardless of insurance coverage. I also understand that Yost Dental Group attempts to estimate charges covered by insurance; however, adjustments may be necessary and responsibility remains with the patient.

_____ _____

Patient Signature **Date**

Yost Dental Group, PLLC
100 Cool Springs Blvd., Ste.100
Franklin, TN 37067

(615) 771-4007
www.yostdentalgroup.com

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVATE PRACTICES

*You May Refuse To Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
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)

_____

_____

_____