Don Henson, D.D.S.
6230 Highland Place Way, Suite 202
Knoxville, TN 37919
865-588-0578

PATIENT INFORMATION

Patient Name ______________________________ Preferred Name: _________________________________
Address _______________________________________City _______________State ______Zip ____________
Cell ____________________ Other Phone ____________________ Email ____________________________
Employer _____________________________________ Birth Date ________________ SS# ______________
Spouse ___________________________ Employer ___________________________________

Previous dentist: _____________________________________
Last cleaning (approx): _________________
Please send any current x-rays to: hensondds@comcast.net
Who may we thank for referring you: ____

Insurance Policy Holder / Responsible Party Information (If different from above)

Dental Insurance Card Required At Time Of Visit
Name____ Phone _______________________________
Address ______________________________City_________________Zip__________________
Employer ____________________________ SS# ______________________ Birth Date _______________
Patient Relation to Responsible Party: Spouse _____ Child _____ Other ____________________________

Office Policies

Insurance: In order for us to file your insurance, we require you to have your dental insurance card present. It is important for you to understand your dental insurance coverage and requirements, including your deductible and required co-payments. Please remember your insurance is a contract between you and the insurance carrier. You alone are responsible for your account. If we do not receive a response from your insurance company within 30 days of filing your claim, you are responsible for payment of your account in full.

Payment: Payment is expected at the time of your treatment. We accept cash, checks, MasterCard and Visa. A finance charge of 1.5% per month (18% per year) will be applied to accounts 60 days past due. Written treatment options with associated costs will be explained to you upon request. We offer payment plans through Care Credit. The parent or legal that requests treatment for a minor will be responsible for payment in full. I acknowledge responsibility for all charges incurred. I understand and acknowledge that if my dental account becomes delinquent, I will be responsible for payment of all collection fees, court costs, and attorney fees.

Appointments: In order to provide timely dental care, this office reserves this time especially for you. If you are unable to keep your appointment, please notify us at least 48 hours in advance. No-shows or cancellation may result in a $50 cancellation fee. All appointments over one hour may require prepay.

Assignment of Benefits: I authorize the release of any information necessary for processing of insurance claims and referring dentists.

I have read and/ or received a copy of Dr. Donald D. Henson's Notice of Privacy Practices.

Patient Signature:_____________________________________ Date:___________________________