

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. To fill out these forms completely. It will enable us to help you more effectively. If you have any questions at any time, please ask. The better we communicate, the better we can serve you.

ABOUT YOU

Today's date: _____

Name: _____
LAST FIRST MI MR MRS MS DR

I prefer to be called: _____

Birthdate: _____ Age: _____ SS #: _____

Home Address: _____
APT/CONDO#
CITY STATE ZIP

___ Single ___ Married ___ Divorced ___ Widowed ___ Separated

Home #: _____ Cell #: _____

WK #: _____ Ext. _____ DL #: _____

Email: _____

Fax: _____

EMPLOYER: _____

Employer's Address: _____

How Long there? _____ Occupation: _____

Where & when are best times to reach you? _____

Who may we THANK for referring you? _____

Other family members seen by us: _____

Previous / Present Dentist: _____
(Please Circle)

SPOUSE/PARENT INFORMATION

Spouse/Parent Name _____

Employer: _____

Employer's Address: _____

WK #: _____ Ext. _____ SS #: _____

Birthdate: _____ DL #: _____

Person Responsible for Account: _____

WK #: _____ Ext. _____ HM #: _____

Email _____ Fax: _____

Billing

Address: _____ ZIP

Relationship: _____ SS #: _____

DENTAL INSURANCE

PRIMARY DENTAL INSURANCE

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local or Policy #): _____

Identification #: _____

Insured's

Name: _____ Relation: _____

Insured's Birthday: _____ Insured's SS # _____

Insured's Employer: _____

SECONDARY DENTAL INSURANCE

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthday: _____ Insured's SS #: _____

Insured's Employer: _____

In the event of an emergency,
is there someone who lives near you
that we should contact?

Their Name: _____ Relation: _____

Phone #: _____

MEDICAL HISTORY

Do you have a personal physician? __No __Yes

Physician's Name: _____

Phone #: _____ Date of last visit: _____

Your current physical health is __Good __Fair __Poor

Are you currently under the care of a physician? __Yes __No

Please explain _____

continued on next form

MEDICAL HISTORY *continued*

What Pharmacy do you use? _____ Phone# _____

Are you taking any prescription / over the counter drugs? No Yes

Please list each one _____

For Women Are you taking birth control pills? No Yes

Are you pregnant? No Yes Week # _____

Are you nursing? No Yes

Have you taken Fosamax or any other Osteoporosis medications? No Yes

Have you ever taken Phenylen or Redux?

Do you smoke or use other tobacco products?

Have you ever had any of the following diseases or medical problems?

- | | |
|---|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Attack / Stroke | <input type="checkbox"/> Y <input type="checkbox"/> N Psychiatric Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cancer / Chemotherapy | <input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy/Seizures/Fainting Spells |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Murmur | <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes / Tuberculosis (TB) |
| <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic Fever | <input type="checkbox"/> Y <input type="checkbox"/> N Drug / Alcohol Abuse |
| <input type="checkbox"/> Y <input type="checkbox"/> N HIV+ / AIDS | <input type="checkbox"/> Y <input type="checkbox"/> N Venereal Disease |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Surgery/Pacemaker | <input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia / Abnormal Bleeding |
| <input type="checkbox"/> Y <input type="checkbox"/> N Shingles | <input type="checkbox"/> Y <input type="checkbox"/> N Ulcers / Colitis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Mitral Valve Prolapse | <input type="checkbox"/> Y <input type="checkbox"/> N Congenital Heart Defect |
| <input type="checkbox"/> Y <input type="checkbox"/> N Kidney Problems | <input type="checkbox"/> Y <input type="checkbox"/> N Anemia / Radiation Treatment |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial Bones / Joints | <input type="checkbox"/> Y <input type="checkbox"/> N Asthma / Arthritis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial Valves | <input type="checkbox"/> Y <input type="checkbox"/> N Difficulty Breathing |
| <input type="checkbox"/> Y <input type="checkbox"/> N Sinus Problems | <input type="checkbox"/> Y <input type="checkbox"/> N Hospitalized for Any Reason |
| <input type="checkbox"/> Y <input type="checkbox"/> N High / Low Blood Pressure | <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Fever Blisters | <input type="checkbox"/> Y <input type="checkbox"/> N Blood Transfusion |
| <input type="checkbox"/> Y <input type="checkbox"/> N Severe/Frequent Headaches | <input type="checkbox"/> Y <input type="checkbox"/> N Emphysema / Glaucoma |

Please list any serious medical condition(s) that you have ever had:

Are you allergic to any of the following drugs?

- Y N Penicillin Y N Tetracycline Y N Latex
 Y N Aspirin Y N Dental Anesthetics
 Y N Other Y N Erythromycin Y N Codeine

Please list any other drugs that you are allergic to:

DENTAL HISTORY

Why have you come to the dentist today? _____

Are you currently in pain? No Yes

Have you ever had a serious / difficult problem associated with any previous dental work? No Yes

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? No Yes

Your current dental health is Good Fair Poor

Do you like your smile? No Yes

Do your gums ever bleed? No Yes

How many times a week do you floss? _____ a day do you brush? _____

How long has it been since your last dental cleaning? _____

Have you ever been diagnosed with perio disease? _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I give consent to allow use of photos or movies of my mouth in dental publications or presentations. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

Signature _____

Date _____

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

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have any questions at any time, please ask us. We are happy to help.

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

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient named herein. Initials _____ Date _____

Doctor's Comments: _____

MEDICAL HISTORY UPDATE

- Date _____ Comments _____ Signature _____
- Date _____ Comments _____ Signature _____
- Date _____ Comments _____ Signature _____

Medication and Supplement Record

	What I am taking	Form (pill, injection, liquid, patch, etc.)	Dosage	How Much and When	Use (regularly or occasionally)	Start/Stop Dates	Notes, Directions, Reasons for Use
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							

**Be sure to include ALL prescription drugs, over-the-counter drugs, vitamins, and herbal supplements.*

**IMPLANT
& GENERAL
DENTISTRY**
OF MIDDLE TENNESSEE

WELCOME:

My staff & I appreciate the selection of our office to serve your dental needs. Our goal in this practice is to provide you with the optimal dental care; my diagnosis of your needs will be the same, as I would make for a member of my own family. The following is an explanation of our financial policies. If you have any questions, please ask.

APPOINTMENTS:

Our goal is to provide quality dental care in a timely manner. In order to do so we have implemented an appointment/cancellation policy. The policy enables us to better utilize available appointments for our patients in need of dental care. Appointments are in high demand. Therefore, if it is necessary to cancel your scheduled appointment we require that you provide us with 24 hours notice. Your early cancellation will give another person the possibility to have access to timely dental care. If an appointment is missed without 24 hours notice being given, you will be subject to a \$30 fee.

FINANCIAL POLICIES:

Professional services are to be paid for on the day that they are rendered. If a service requires more than one visit (example: a crown), you may pay 1/2 of the fee at the start of treatment, with the balance to be paid in full once treatment is completed. For your convenience, we also accept Visa, MasterCard, American Express, & Discover. If extended payments are desired, this option is available through Wells Fargo Financial (6 months same as cash).

** All OVERDUE ACCOUNTS WILL RECEIVE A \$15.00 MONTHLY LATE FEE THAT BECOMES THE RESPONSIBILITY OF THE ACCOUNT HOLDER TO PAY.*

If your account is placed for collections, the undersigned agrees to pay all, but not limited to, attorney fees & collection costs.

INSURANCE:

Our office policy is to bill your dental insurance carrier as a courtesy to you, although you are responsible for the balance as services are rendered. Once the carrier is billed, payment must be made in full within 60 days. If your insurance carrier does not remit payment in full within 60 days, the balance is due in full by you. Since we are not a party to the agreement with your insurance carrier, it is not our policy to contact carriers to establish why they haven't paid differently than originally indicated.

* Please be advised that if you have treatment rendered that you would like to file with your medical insurance carrier, we do not file medical claims. We do not have access to medical diagnosis codes or treatment codes.

PHILOSOPHY : Our goal is to provide the best dental service possible. Proper dental care enhances your well-being; we want you to feel good about yourself and your oral health. Please feel free to ask any questions. We are honored to serve you, other members of your family, & your friends.

I have read and agreed to the above policy.

Signature (Patient, Parent, or Responsible Party): _____ Date: _____