IMPLANT & GENERAL DENTISTRY OF MIDDLE TENNESSEE

Welcome to Our Office

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. P fill out these forms completely. It will enable us to help you more effectively. If you have any questions at any time, please as 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 Circe)

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 Phen Phen or Redux?

Do you smoke or use other tobacco products?

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

___Y	___N	Heart Attack / Stroke	
___Y	___N	Cancer / Chemotherapy	
___Y	___N	Heart Murmur	
___Y	___N	Rhumatic Fever	
___Y	___N	HIV+ / AIDS	
___Y	___N	Heart Surgery/Pacemaker	
___Y	___N	Shingles	
___Y	___N	Mitral Valve Prolapse	
___Y	___N	Kidney Problems	
___Y	___N	Artificial Bones / Joints	
___Y	___N	Artificial Valves	
___Y	___N	Sinus Problems	
___Y	___N	High / Low Blood Pressure	
___Y	___N	Fever Blisters	
___Y	___N	Severe/Frequent Headaches	
___Y	___N	Psychiatric Problems	
___Y	___N	Epilepsy/Seizures/Fainting Spells	
___Y	___N	Diabetes / Tuberculosis (TB)	
___Y	___N	Drug / Alcohol Abuse	
___Y	___N	Venereal Disease	
___Y	___N	Hemophilia / Abnormal Bleeding	
___Y	___N	Ulcers / Colitis	
___Y	___N	Congenital Heart Defect	
___Y	___N	Anemia / Radiation Treatment	
___Y	___N	Asthma / Arthritis	
___Y	___N	Difficulty Breathing	
___Y	___N	Hospitalized for Any Reason	
___Y	___N	Hepatitis	
___Y	___N	Blood Transfusion	
___Y	___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

1. Date_____ Comments_____ Signature_____
2. Date_____ Comments_____ Signature_____
3. 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

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/cancelation 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 cancelation 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 cancelation 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 ½ 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 REPSONSIBILITY OF THE ACCOUNT HOLDER TO PAY.*
If your account is placed for collections, the undersigned agrees to pay all attorney & collection fees.

INSURANCE:
Our office policy is to bill your dental insurance carrier as a courtesy to you. **Although, you are responsible to pay your estimated portion on the day of service**. Once the carrier is billed, payment must be made in full within 60 days. If your insurance carrier does not remit payment in full with in 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:_____