PATIENT INFORMATION

Name: ____

Date of Birth:______________________________

Social Sec #:______________________(this is incase we need it for insurance purposes)

Phone number: _____________________________

Address: ____

____

Emergency Contact Name:_________________________________

Emergency Contact Phone #:_______________________________

***Any other person/persons we can communicate with regarding your appointments or account:____

Employer Name:____

Dental Ins Company:_______________________________________

Subscriber ID #:____

Health History Update

Prescription Medications and over the counter medications you take on a regular basis:

____

____

Are you allergic to any of the following (circle) Penicillin Sulfa Acetaminophen Aspirin Ibuprofen Codeine Latex Acrylic N/A Other(list):

____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?
YES NO ____

Do you use tobacco? YES NO If yes frequency: ____________________

Do you have, or have you been diagnosed with any of the following conditions? (Please use "X" to mark your answers)

	Y	N	?
Heart (Cardiac) Health			
Pacemaker/implanted defibrillator			
When?			
Artificial heart valve			
When?			
Previous infective endocarditis			
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD			
Repaired (completely) in last 6 months			
Repaired CHD with residual defects			
Arteriosclerosis			
Coronary Artery disease			
Congestive heart failure			
Damaged heart valves			
Heart attack			
When?			
Heart murmur/rhythm disorder			
Rheumatic heart disease			
Stroke			
When?			
Stent			
When?			
Breathing (Respiratory) Health			
Asthma			
Bronchitis			
COPD			

	Y	N	?
Emphysema			
Sinus trouble			
Tuberculosis			
Blood (Circulatory) Health			
Anemia			
Blood transfusion			
If yes, date: ________			
High cholesterol			
High blood pressure			
Low blood pressure			
Brain (Neurological)/Mental Health			
Anxiety			
Depression			
Epilepsy			
Mental health disorders			
Post traumatic stress disorder			
TBI or concussion			
Autoimmune Disease			
AIDS or HIV infection			
Lupus			
Rheumatoid Arthritis			
Other			
Digestive Health			
GI disease			
GE reflux/persistent heartburn			
Stomach ulcers			

	Y	N	?
Cancer			
Type: ____________ Date of Diagnosis: ____________ Chemotherapy: ____________ Radiation treatment: ____________			
Other			
Arthritis			
Chronic pain			
Diabetes			
Type I or II?			
Drug addiction			
Eating disorder			
Glaucoma			
Hepatitis, jaundice or liver disease			
Immune deficiency			
Kidney problems			
Osteoporosis			
STI			
Thyroid problems			
Pregnancy			
Due date?			
Nursing?			
Joint Replacement			
When?			
Pre-med?			

Anything significant in your Med History not addressed in the above list?______________________________

____

Physician name and city:______________________________

Previous Dentist name and city:______________________________

Patient or Guardian print:______________________________ **Sign**______________________________

Date:____________________

Broken Appointment Policy

Our practice is dedicated to giving you excellent quality dental care and is pleased to reserve an appointment time for you. **Should a change in your appointment time be necessary, we require a 24-hour notice.** This permits another patient to receive dental care in your absence. **If a 24-hour notice is not given, a $25 charge could be added to your account.** This policy allows us to make the best of our appointment time for those patients in need of dental care.

Signature:____ **Date:**__________________________

Financial Policy

We accept Cash, Checks, Care Credit and all major credit cards. Although we do accept the assignment of most insurance companies, your insurance is an agreement between you and your insurance company. We do our best to see that you receive your full benefits. However, we are not responsible for determining what your benefits are, we do this as a courtesy. It is required that you inform us of any changes in your dental insurance. **Payment is expected at the time you receive dental services.**

***There is a $35 fee for any check payment returned for non-payment.**

Signature:____ **Date:**__________________________

Complaints

If you think we have not properly respected the privacy of your health information, you are free to complain to us or the US department of Health and Human Services, Office for Civil Rights. If you want to complain to us, send a written complaint to: 100 Main St, Suite 105, Portland TN 37148.

Signature:____ **Date:**__________________________

Authorization for Release of Health Information

I authorize the professional office of my dentist to release health information identifying me (including if applicable information about HIV or AIDS, information about substance abuse treatment and information about mental health services) under the following terms and conditions:

1. Detailed description of the information to be released
2. To whom may the information be released
3. The purpose of the release

It is completely your decision whether to sign this authorization form. We can not refuse to treat you if you choose not to sign this authorization. If you sign this authorization you can revoke it later.

Signature:____ **Date:**__________________________