PERIODONTICS & IMPLANT DENTISTRY OF MIDDLE TENNESSEE

PATIENT INFORMATION

First Name _____ M.I. _____ Last Name_____ Nickname_____
Sex: Male/Female Birth Date _____ Age_____ S.S.# _____ Email _____
Street _____ Apt. _____ City_____ State_____ Zip_____
Home Tel. (____) _____ Cell (____) _____ Have you ever been a patient of our practice? Yes No
Referring Dentist _____ Medical Doctor_____

In case of emergency, please contact _____ Tel. (____) _____ Relation _____
Pharmacy Name: _____ Phone: _____ Address: _____

How did you find our office? (circle one) Referred, Internet Search, Website, Testimonials, Friend, Other _____

MEDICATIONS & ALLERGIES

Are you taking or have you ever taken:

- ❑ Nerve pills
- ❑ Diet pills
- ❑ Blood thinners (Coumadin/Aspirin/Advil)
- ❑ Any bone density medication or Bisphosphones (Aredia, Zometa, Fosamax, Actonel)
- ❑ Pain killers (including aspirin)
- ❑ Tranquilizers
- ❑ Muscle relaxers
- ❑ Insulin
- ❑ Stimulants
- ❑ Antidepressants

Are you allergic to or had a reaction to:

- ❑ Penicillin or Amoxicillin
- ❑ Sodium pentothal/valium/other tranq.
- ❑ Local anesthesia (numbing medicine)
- ❑ Codeine or other narcotics
- ❑ Aspirin
- ❑ I have no known allergies
- ❑ Sulfites
- ❑ Latex
- ❑ Soy
- ❑ Sulfa drugs
- ❑ Eggs/yolks

Please list any other medications you are taking (including natural, herbal or homeopathic products:
Medication [Dosage] Frequency

Please list any other medications or antibiotics you are allergic to:

Please list any allergies other than drug allergies:

1-4 below are for women only:
Please note that antibiotics (such as penicillin) may alter the effectiveness of birth control. Consult your physician or gynecologist for assistance regarding additional methods of birth control.

1. Is there a possibility of pregnancy? ❑ Yes ❑ No
2. Are you nursing? ❑ Yes ❑ No
3. Expected delivery date: _____
4. Are you taking birth control pills? ❑ Yes ❑ No

MEDICAL INFORMATION

Are you in good health? ❑ Yes ❑ No Height _____ Weight _____ Are you under the care of a physician? _____
Has a physician or previous dentist recommended that you take antibiotics prior to dental treatment? ❑ Yes ❑ No
Have you or a family member had any unusual or serious reactions to general anesthesia? ❑ Yes ❑ No

Do you have, or have you had, any of the following diseases, medical conditions or procedures?

- ❑ Rheumatic Fever
- ❑ Mitral Valve Prolapse
- ❑ Heart Murmur
- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Chest pain/Angina
- ❑ Heart attack(s)
- ❑ Irregular heart beat
- ❑ Cardiac pace maker
- ❑ Heart surgery
- ❑ Pneumonia/Bronchitis/Chronic Cough
- ❑ Chronic fatigue/Night sweat
- ❑ Trouble climbing 1-2 flights of stairs
- ❑ Mental health problems
- ❑ Damaged heart valves
- ❑ Asthma
- ❑ Are you immunosuppressed *(possibly from transplant surg.)*
- ❑ Hay fever/sinus problems
- ❑ Snoring/sleep apnea
- ❑ Respiratory problems
- ❑ Tuberculosis
- ❑ Emphysema
- ❑ Do you smoke? *If so, # packs per day?* ____
- ❑ Do you use chewing tobacco?
- ❑ Blood transfusion
- ❑ Blood disorder
- ❑ Bleed easily
- ❑ History of drug abuse
- ❑ Eye diseases/Glaucoma
- ❑ Abnormal bleeding
- ❑ Bleeding tendency
- ❑ Problems w/ immune system (Possibly from med. or surg.)
- ❑ Jaundice/Liver disease
- ❑ Hepatitis
- ❑ Infectious mononucleosis
- ❑ Gallbladder trouble
- ❑ Fainting spells
- ❑ Convulsions/Epilepsy
- ❑ Stroke
- ❑ Thyroid trouble
- ❑ Diabetes
- ❑ History of alcohol abuse
- ❑ Sexually transmitted diseases
- ❑ Swollen ankles
- ❑ Kidney trouble
- ❑ Are you in dialysis?
- ❑ Arthritis/Joint disease
- ❑ Prosthetic joint/Implant
- ❑ Osteoporosis/Osteopenia
- ❑ Osteonecrosis
- ❑ Stomach ulcers
- ❑ Contagious diseases
- ❑ Delay in healing
- ❑ Anemia
- ❑ Tumor or growth
- ❑ Cancer/radiation/chemotherapy
- ❑ Are you on a diet?
- ❑ Contact lenses
- ❑ Low blood sugar

DENTAL INFORMATION

Reason for today's visit _____

Please indicate any of the following problems by checking off the corresponding box:

- ❑ Discomfort, clicking, or popping in jaw
- ❑ Red, swollen or bleeding gums
- ❑ A removable dental appliance
- ❑ Blisters/sores in or around mouth
- ❑ Prolonged bleeding from an injury/extraction
- ❑ Recent infections or sore throat
- ❑ My teeth are sensitive to: Hot/Cold/Sweets/Biting
- ❑ Loose/shifting teeth
- ❑ Lost/broken fillings
- ❑ Teeth grinding/clenching
- ❑ Ringing in ears
- ❑ Broken/chipped tooth
- ❑ Gum disease
- ❑ Stained teeth
- ❑ Bad breath
- ❑ Difficulty closing jaw
- ❑ Difficulty opening jaw
- ❑ Locking jaw
- ❑ Food caught between teeth
- ❑ Swelling in mouth
- ❑ Burning tongue/lips
- ❑ Toothache

Are you in pain? ❑ No ❑ Yes, or how long? _____ How would you rate your smile? (worst) 1 2 3 4 5 6 7 8 9 10 (best)
Last dental exam _____ Last dental x-rays_____ Times a day you brush? _____ Times per week you floss? _____

I certify that I have read and understand the above questions. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any member of his/her staff, responsible for any errors or omissions that I have made in completing this form.

_____

Signature of Patient (Parent of Guardian if Minor) **Reviewed by** **Date**

FINANCIAL INFORMATION & PAYMENT AGREEMENT

PATIENT INFORMATION

First Name _____ Last Name_____ Date _____

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT *(If Self, skip this section)*

Name_____ S.S.#_____ Birth Date_____ Age_____ Tel: Tel.(____) _____
Street _____ Apt. _____ City_____ State_____ Zip_____
Driver's Lic. #_____ Employer_____ Bus. Tel.(____) _____

SPOUSE OR OTHER GUARANTOR INFORMATION (if different from above)

Name_____ S.S.#_____ Birth Date_____ Age_____ Tel: Tel.(____) _____
Street _____ Apt. _____ City_____ State_____ Zip_____
Driver's Lic. #_____ Employer_____ Bus. Tel.(____) _____

PRIMARY DENTAL INSURANCE COMPANY

Employer _____
Bus. Address _____ Bus. Tel. (_____) _____
Ins. Co. Name _____ I.D.#_____
Address _____ City _____ State _____ Zip _____
Group #_____ Group Name _____
Insured Party_____ Relation _____ Sex: M/F Birth Date _____ S.S.#_____

FEES & PAYMENTS

We make every effort to keep down the cost of your care. You can help by paying upon completion of your care. Other arrangements can be made with our financial coordinator depending on special circumstances. Any estimate of the charge for any procedure or surgery your request will be given to you upon request. If you have any dental or medical insurance, we will be glad to fill out the proper forms, but please fill out the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or other balance not paid by your insurance. You will be responsible for all collection costs, attorney fees, and court costs.

CANCELLATION AGREEMENT

Our practice is dedicated to quality care and exceptional service. Our team spends extensive amounts of time preparing for your visit. Broken and missed appointments create scheduling problems for our team as well as other patients. With this in mind, this office reserves the right to charge 1/3 of a scheduled appointment fee if less than (2) business days' notice is given before cancellation.

_____

Signature of Patient (Parent or Guardian if Minor) **Date**

This signature is authorization for the release of information necessary to process my claim. I hereby authorize to this doctor named of the benefits otherwise payable to me.

_____

Signature of Patient (Parent or Guardian if Minor) **Date**