Patient Information

Patient Name: ____ Preferred Name: _______________
Last First M
☐ Male ☐ Female ☐ Married ☐ Single ☐Child ☐Other: ___________________
Social Security #: _______________ Email: _________________________________ D.O.B: __________
Cell Phone #:_____________________ Home Phone #:___________________
Address: ____
Street Apartment #
____
City State Zip Code

Health Information

Date of last Dental visit: _______________ Reason for today's visit: _______________________________

Describe the nature of any health conditions you are currently being treated for:

Conditions | Date of Onset | Physician/ Physician's Phone # | Medicines being taken

____
____
____
____

List all other medications you are currently taking: (Please provide a detailed list of ALL medications)

____
____
____

Describe any other conditions you have been treated for in the past five years.

Condition | Date Treated | Physician | Physician's Phone #

____
____

- Do you have any health problems that need further clarification? ☐ Yes ☐ No
- If yes, please explain: ____
- Are you currently pregnant or think you may be pregnant? If so, when is your due date? _______________
  - Are you currently nursing? Yes___ No___
- Do you smoke? Yes ___ No___

Have you ever had any of the following? Please check those that apply, if not already noted above:

☐ AIDS/HIV	☐ Excessive Bleeding	☐ High Blood Pressure	☐ COPD or Emphysema
☐ Allergies	☐ Fainting	☐ Joint Replacement Date:_______	☐ Sinus Problem
☐ Anemia	☐ Chest Pain	☐ Kidney Disease	☐ Stomach Problems or Ulcers
☐ Chemotherapy	☐ Osteoporosis Medication	☐ Blood Thinner	
☐ Asthma	☐ Thyroid Problem	☐ Liver Disease	☐ Stroke Date:________
☐ Benign Tumors	☐ Heart Attack Date: ________	☐ Mental or Nervous Disorder	☐ Tuberculosis
☐ Cancer	☐ Heart Disease	☐ Pacemaker	☐ Prosthetic Heart Valve
☐ Diabetes	☐ Head Injuries	__________	☐ Penicillin Allergy
☐ Dizziness	☐ Hepatitis	☐ Radiation Treatment Date:__________ Location:__________	☐ Other Medication cannot take ____________________
☐ Epilepsy			

- Have you ever had any complications following dental treatment or dental injections? ☐Yes ☐No
  If yes, please explain. ____
- Are you interested in Sedation? ☐ Yes ☐ No
- Is there anything you want to change about your smile? _______________________________________
  ____

To the best of my knowledge, all the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform my doctor at the next appointment without fail.

____ Date: ___________________________
Signature of Patient, Parent, or Guardian

Referral Information

Whom may we thank for referring you to our practice?

☐ Internet ☐ Yellow Pages ☐ Newspaper ☐ Flyer ☐ Work ☐ Other: ____________________

☐Another patient, friend ☐Another patient, relative

Name of person or office referring you to our practice: ____

Spouse or Responsible Party Information

The following is for: ☐ The patient's spouse ☐ The person responsible for patient

Name: ____

☐Male ☐Female ☐Married ☐Single ☐Child ☐Other:___________________

Social Security #:____ Birth Date: ____________________________________

Phone: (Home): __________________________ (Work): __________________________ (Cell): __________________________

Address: ____

Street Apartment #

____

City State Zip Code

In case of Emergency, call: ______________________________ Phone (Work): ________________ (Cell) _______________

(Close Relative not living at your home address)

Employment Information

The following is for: ☐ The Patient ☐ The person responsible for payment

Employer Name: ____ Occupation: ____

Address: ____

Street City State Zip Code

Insurance Information

Primary

Name of Insured: ____ Is insured a patient? ☐Yes ☐No

Last First Middle

Insured's Birth Date: ______________ ID#: _______________________________ Group #: _______________________________

Insured's Employer Name: ____

Patient's relationship to insured: ☐Self ☐Spouse ☐Child ☐Other: _______________________

Insurance Plan Name and Address: ____

Secondary

Name of Insured: ____ Is insured a patient? ☐Yes ☐No

Last First Middle

Insured's Birth Date: _______________ ID#: ________________________________ Group #: _______________________________

Insured's Employer Name: ____

Patient's relationship to insured: ☐Self ☐Spouse ☐Child ☐Other: ____

Insurance Plan Name and Address: ____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time of services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment if all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I grant permission to Chattanooga Dental Arts for use of my photographs for educational and commercial purposes.

A service charge of 1.5% per month (18% per annum) or $5.00, which ever is greater, will be charged on the unpaid balance of all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within (5) days billing if credit shall be extended. I further agree that a waiver if any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all collections and reasonable attorney fees if suit be instituted hereunder.

I grant permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

____ Date: ________________________ Relationship to Patient: ______________________

Signature of Patient, Parent, or Guardian

____Date: ________________________ Relationship to Patient: ______________________

Signature of Guarantor of payment/ responsible party