

**SECTION 1: The Patient.**

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone: \_\_\_\_\_ [E-mail:](#) \_\_\_\_\_

Patient Number: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

**SECTION 2: Acknowledgement of Receipt of Privacy Practices Notice.**

I, \_\_\_\_\_, acknowledge that I have received a Notice of Privacy Practices from the above-named practice.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If a personal representative signs this authorization on behalf of the individual, complete the following:

Personal Representative's Name: \_\_\_\_\_

Relationship to Individual: \_\_\_\_\_

**SECTION 3: Good Faith Effort to Obtain Acknowledgement of Receipt.** Describe your good faith effort to obtain the individual's signature on this form: \_\_\_\_\_  
\_\_\_\_\_

Describe the reason why the individual would not sign this form: \_\_\_\_\_  
\_\_\_\_\_

**SIGNATURE.**

I attest that the above information is correct.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print name: \_\_\_\_\_ Title: \_\_\_\_\_

Include this acknowledgement of receipt in the individual's records.

**ACKNOWLEDGEMENT OF RECEIPT OF  
PRIVACY PRACTICES NOTICE**

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Last First Initial

Male  Female

If Child: Parent's Name \_\_\_\_\_

How do you wish to be addressed \_\_\_\_\_  
Single  Married  Separated  Divorced  Widowed  Minor

Residence – Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Business Address \_\_\_\_\_

Telephone: Res. \_\_\_\_\_ Bus. \_\_\_\_\_

Fax \_\_\_\_\_ Cell Phone # \_\_\_\_\_

eMail \_\_\_\_\_

Patient/Parent Employed By \_\_\_\_\_

Present Position \_\_\_\_\_

How Long Held \_\_\_\_\_

Spouse/Parent Name \_\_\_\_\_

Spouse Employed By \_\_\_\_\_

Present Position \_\_\_\_\_

How Long Held \_\_\_\_\_

Who is Responsible for this account \_\_\_\_\_

Drivers License No. \_\_\_\_\_

Method of Payment: Insurance  Cash  Credit Card

Purpose of Call \_\_\_\_\_

Other Family Members in this Practice \_\_\_\_\_

Whom may we thank for this referral \_\_\_\_\_

Patient/parent Social Security No. \_\_\_\_\_

Spouse/Parent Social Security No. \_\_\_\_\_

Someone to notify in case of emergency not living with you: \_\_\_\_\_

**CONSENT:**

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.

I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care. My consent to disclosure of records shall be effective until I revoke it in writing.

I authorize Payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payor. I attest to the accuracy of the information on this page.

PATIENTS OR GUARDIAN'S

SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

**DENTAL INSURANCE**

**1 ST COVERAGE**

Employee Name \_\_\_\_\_ DOB \_\_\_\_\_

Relationship to patient \_\_\_\_\_

Employer Name \_\_\_\_\_ Yrs. \_\_\_\_\_

Name of Insurance \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_

ID or SSI # \_\_\_\_\_

Group # \_\_\_\_\_

**DENTAL INSURANCE**

**2 ST COVERAGE**

Employee Name \_\_\_\_\_ DOB \_\_\_\_\_

Relationship to patient \_\_\_\_\_

Employer Name \_\_\_\_\_ Yrs. \_\_\_\_\_

Name of Insurance Co. \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_

ID or SSI # \_\_\_\_\_

Group # \_\_\_\_\_

**REGISTRATION**

1. Purpose of initial visit \_\_\_\_\_
2. Are you aware of a problem? \_\_\_\_\_
3. How long since your last dental visit? \_\_\_\_\_
4. What was done at that time? \_\_\_\_\_
5. What was done at that time? \_\_\_\_\_
6. When was the last time your teeth were cleaned? \_\_\_\_\_

Circle the appropriate answer. If you do not know the correct answer, please write "do not know" on the line following the question.

- |  |     |    |
|--|-----|----|
| 7. Have you made regular visits?   | YES | NO |
| 8. Were dental x-rays taken?   | YES | NO |
| 9. Have you lost any teeth or have any teeth been removed?   | YES | NO |
| 10. Have they been replaced?   | YES | NO |
| 11. How have they been replaced?   |     |    |
| a. fixed bridge .....yr _____  |     |    |
| b. removable bridge.....yr _____   |     |    |
| c. denture.....yr _____  |     |    |
| d. implant .....yr _____   |     |    |
| 12. Are you unhappy with the replacement?  | YES | NO |
| If yes, explain _____  |     |    |
| 13. Would you like to know about permanent replacements?   | YES | NO |
| 14. Have you ever had any problems or complications with previous dental treatment?                                      | YES | NO |
| If yes, explain:   |     |    |
| 15. Do you clench or grind your teeth?   | YES | NO |
| 16. Does your jaw click or pop?  | YES | NO |
| 17. Have you experienced any pain or soreness in the muscles or your face or around your ear?                            | YES | NO |
| 18. Do you have frequent headaches, neckaches or shoulder aches?   | YES | NO |
| 19. Does food get caught in your teeth?  | YES | NO |
| 20. Are any of your teeth sensitive to:      Hot      Cold      Sweet      Pressure                                      |     |    |
| 21. Do your gums bleed or hurt?  | YES | NO |
| When? _____  |     |    |
| 22. Do you experience dry mouth?   | YES | NO |
| 23. How often do you brush your teeth? _____ When? _____   |     |    |
| 24. Do you use dental floss?   | YES | NO |
| How often? _____   |     |    |
| 25. Are any of your teeth loose, tipped, shifted or chipped?   | YES | NO |
| 26. Are you unhappy with the appearance of your teeth?   | YES | NO |
| 27. How do you feel about your teeth in general? _____   |     |    |
| 28. Do you feel your breath is offensive at times?   | YES | NO |
| 29. Have you ever had gum treatment or surgery?  | YES | NO |
| What? _____  |     |    |
| Where? _____   |     |    |
| When? _____  |     |    |
| 30. Have you had any orthodontic work?   | YES | NO |
| 31. Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike? _____ |     |    |
| 32. Do you have any questions or concerns? _____   |     |    |

I certify that the above information is complete and accurate

Patient's/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

Dentist's Signature \_\_\_\_\_ Date \_\_\_\_\_

## DENTAL HISTORY

1. Physician's Name \_\_\_\_\_  
Address \_\_\_\_\_
2. Are you under a physician's care? YES NO
3. When was your last complete physical exam?
4. Are you taking any medication or substances? YES NO  
(If yes, please list medications in comments section or on the back of this form.)
5. Do you routinely take health related substances? (Vitamins, herbal supplements, natural products)
6. Are you allergic to any medications or substances? (please list on back of this form) YES NO
7. Do you have any other allergies or hives? YES NO
8. Do you have any problems with penicillin, antibiotics, anesthetics or other medications?
9. Are you sensitive to any metals or latex? YES NO
10. Are you pregnant or suspect you may be? YES NO
11. Do you use any birth control medications? YES NO
12. Have you ever been treated for or been told you might have heart disease? YES NO
13. Do you have a pacemaker, an artificial heart valve implant, or been diagnosed with mitral valve prolapse?
14. Have you ever had rheumatic fever? YES NO
15. Are you aware of any heart murmurs? YES NO
16. Do you have high or low blood pressure?(please circle)
17. Have you ever had a serious illness or major surgery? YES NO  
If so, explain \_\_\_\_\_
18. Have you ever had radiation treatment, chemo treatment for tumor, growth or other condition? YES NO
19. Have you ever taken, Fosamax, Zometa, Aredia or any other oral or intravenous treatment (bisphosphonates) for bone tumors, excessive calcium in your blood or osteoporosis?
20. Do you have inflammatory diseases, such as arthritis or rheumatism? YES NO
21. Do you have any artificial joints/ prosthesis? YES NO
22. Do you have any blood disorders, such as anemia, leukemia, etc? YES NO
23. Have you ever bled excessively aft being cut or injured:
24. Do you have any stomach problems? YES NO
25. Do you have any kidney problems? YES NO
26. Do you have any liver problems? YES NO
27. Are you diabetic? YES NO
28. Do you have fainting or dizzy spells? YES NO
29. Do you have asthma? YES NO
30. Do you have epilepsy or seizure disorder? YES NO
31. Do you or have you had venereal or any sexually transmitted disease? YES NO
32. Have you tested HIV positive? YES NO
33. Do you have AIDS? YES NO
34. Have you had or do you test positive for hepatitis? YES NO
35. Do you or have you had T.B.? YES NO
36. Do you smoke, chew, use snuff or any other forms of tobacco? YES NO
37. Do you regularly consume more than one or two alcoholic beverages a day? YES NO
38. Do you habitually use controlled substances? YES NO
39. Have you had psychiatric treatment? YES NO
40. Have you taken any prescription drugs fenfluramine, fenfluramine combined with phentermine (fen-phen), dexfenfluramine (redux), or other weigh loss products YES NO
41. Do you have any disease condition, or problem not listed? If so , explain \_\_\_\_\_
42. Is there anything else we should know about your health that we have not covered in this form?
43. Would you like to speak to the Doctor privately about any problem?

I certify that the above information is complete and accurate

Patient's/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

Dentist's Signature \_\_\_\_\_ Date \_\_\_\_\_

## MEDICAL HISTORY

In order to keep our fees down and provide quality dental care with the latest in sterilization techniques and dental procedures, we have established the following financial policy:

Payment in full is expected on the day of service by cash, check or bank card (Visa and Mastercard only). We also offer a couple lines of credit specifically, for dental treatment.

Dental insurance: Estimated Co-payments (the part of dental fees not covered by your dental policy and deductibles) are due on the day of service. You must provide a completed dental insurance form with assignment of benefits to the doctor.

Children: The parent or guardian who brings the child into the office for dental treatment is financially responsible regardless of dental insurance or legal responsibility another parent or guardian may have to this child.

**Cancellation Policy:** Nearly all dental procedures are invasive procedures and require the uninterrupted attention of the doctor. This being the nature of dental treatment, appointments are scheduled for a specific amount of time with doctor.

As a courtesy to the doctor and so emergency patients can receive immediate care, we require a forty-eight (48) hour notice of change or cancellation of your appointment.

Charge of \$50 per half hour will be charged- if less than 48 hour notice is given. We will gladly make exceptions for extreme family medical emergencies.

If you are unable to meet the above requirements please see someone in our business office at this time.

**Patient Agreement:**

I have read the above policy and understand my financial responsibility. I have completed this form and to the best of my knowledge all answers are true and correct. If I ever have any change in my health or change in my medication, I will inform the doctor at the next, appointment. I give my permission for a credit history report to be obtained cover. I accept full responsibility for all fees regardless of dental insurance coverage.

In any event this account is referred to an outside agency, credit reporting bureau, or attorney for collection, I agree to pay all attorney fees, collection costs, and/or any other expenses incurred in its collection, according to 1989 statutes of the State of Tennessee,

I hereby authorize Dr. Brock to furnish information to insurance carriers concerning my illness and treatments. I understand that I am responsible for any amount not covered by insurance.

Signature

Date

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## FINANCIAL POLICY