# TENNESSEE FAMILY DENTAL CARE

**Patient Information:** **Today's Date:** _____

____Male ____Female ____Minor ____Single ____Married

Patient Name: _____ Date of Birth: _____ Phone: _____

SS#:_____ Address: _____City:_____ State:_____

Zip:_____ Email:_____ Preferred Pharmacy: _____

Person responsible for this account: _____SS#: _____ DOB: _____

**Primary Insurance Information:**

Name of Subscriber: _____ Relationship to Patient: _____ DOB: _____ SS#: _____

Dental Insurance Co._____ Employer: _____ Member ID#: _____ Group#: _____

**Secondary Insurance Information:**

Name of Subscriber: _____ Relationship to Patient: _____ DOB: _____ SS#: _____

Dental Insurance Co._____ Employer: _____ Member ID#: _____ Group#: _____

***Patient Medical History: Medical Alert:** ☐**YES** ☐**NO** ***Prophylaxis Antibiotic (PRE-MED) Prior to Dental Treatment:** ☐**YES** ☐**NO**

Name of Physician: _____Phone: _____ Currently Being Treated? _____

**List of All Medications Currently Taking:** _____

_____

**Are you allergic to, or have you had a reaction to any of the following?**

- Local Anesthetics _____ • Sulfa Drugs _____ • Aspirin _____ • Penicillin _____ • Other Antibiotics _____
- Metals _____ • Barbiturates _____ • Sedatives _____ • Iodine _____ • Latex _____ • Other: _____

**Do you have or have you had any of the following:**

| | | | | | |
|---|---|---|---|---|---|
| • Rheumatic Fever | ☐YES ☐NO | • Mitral Valve Prolapse | ☐YES ☐NO | • Bleeding Disorder | ☐YES ☐NO |
| • Diabetes Type 1 | ☐YES ☐NO | • Heart Attack | ☐YES ☐NO | • Psychiatric Disorder | ☐YES ☐NO |
| • Diabetes Type 2 | ☐YES ☐NO | • Heart Murmur | ☐YES ☐NO | • Cancer | ☐YES ☐NO |
| • Asthma | ☐YES ☐NO | • Liver Disease | ☐YES ☐NO | • Pulmonary Disease | ☐YES ☐NO |
| • Kidney Disease | ☐YES ☐NO | • Hepatitis | ☐YES ☐NO | • Cardiovascular Disease | ☐YES ☐NO |
| • Joint replacement | ☐YES ☐NO | • Seizures | ☐YES ☐NO | • Osteoporosis | ☐YES ☐NO |
| • High Blood Pressure | ☐YES ☐NO | • Tuberculosis | ☐YES ☐NO | • AIDS/HIV | ☐YES ☐NO |
| • Epilepsy/Convulsions | ☐YES ☐NO | • Sleep Apnea | ☐YES ☐NO | • Any Surgeries | ☐YES ☐NO |

***If <u>YES</u> to any of the above medical conditions or any conditions not listed, please provide more information (ex: when diagnosed, when treated, what type, what medications you are/were on for it and/or if you are still being treated) Please also list any other medical conditions we should be aware of:**

_____

_____

_____

**Emergency Contact:** _____ **Relationship:** _____ **Phone:** _____

Consent: I authorize the Doctor to take radiographs, study models, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with my, or my dependents treatment, and further authorize and consent that Doctor choose and employ such assistance as s/he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I further authorize and request my insurance company to pay directly to the dentist of dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less that the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

**X**_____ _____

**Patient Signature (parent/guardian signature if patient is a minor)** **Date**

Provider Signature: _____

# TENNESSEE FAMILY DENTAL CARE

**FOR WOMEN ONLY:**

Are you currently taking birth control pills? ☐YES ☐NO

Are you pregnant? ☐YES ☐NO

Is there a possibility of pregnancy? ☐YES ☐NO

Are you nursing/breastfeeding? ☐YES ☐NO

Expected delivery date:_____

**NOTE: Antibiotics (such as penicillin) may alter the effect of birth control pills. Consult with your physician/gynecologist for assistance regarding additional methods of birth control.**

**It is TDA's policy, along with our policy, that for the safety of our patients, all minors must be accompanied to all of their appointments by a parent or legal guardian until the age of 18.**

**Name of Parent or Guardian Responsible for Minor: _____ Relationship to patient: _____**

## Dental History Information

Date of last dental visit? _____

Previous dental office name? _____

Reason for today's visit? _____

Have you ever had an oral cancer screening done? ☐YES ☐NO

How often do you floss your teeth? _____

Have you or a family member ever been treated for periodontal disease? ☐YES ☐NO

Have you ever had complications from an extraction? ☐YES ☐NO

Have you ever had orthodontic treatment? ☐YES ☐NO

Have you ever had an allergic reaction to a crown, metal filling or dental appliance? ☐YES ☐NO

Have you ever used an electric Toothbrush? ☐YES ☐NO

Do you snore? ☐YES ☐NO

Do your gums bleed when you brush? ☐YES ☐NO

Are your teeth sensitive to hot, cold or pressure? ☐YES ☐NO

Have you ever experienced popping or clicking near your ear when you chew? ☐YES ☐NO

Are you prone to frequent headaches? ☐YES ☐NO

Do you grind or clench your teeth? ☐YES ☐NO

Do you have problems with bad breath? ☐YES ☐NO

Do you have sores, blisters, or swelling on your gums, lips or cheeks? ☐YES ☐NO

Do you have anxiety with dental treatment? ☐YES ☐NO

Do you drink alcohol, smoke or chew tobacco, use controlled substances or other drug use? ☐YES ☐NO

If yes, please explain what type and how often:

_____

On a scale from 1 to 10, with 10 being the highest, how important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

If you could change something about your smile what would it be:

☐ Whiter ☐ Straighter ☐ Close space

☐ Repair chipped tooth/teeth ☐ Replace missing tooth/teeth

☐ Less gums showing ☐ Replace old crowns that don't match

**How did you hear about us? Google/Internet _____ Facebook _____ TV _____ Flyer _____ Insurance _____**

**Family Member/Friend/Referral _____ Name: _____ Other _____**

I certify that I have read and understand the questions above. I acknowledge that my questions have been answered to my satisfaction. I will not hold my dentist or any other of his/her staff responsible for any errors that I have made in the completion of this form.

**Patient Name: _____ Date: _____**

**X_____**

**Patient Signature (Parent/Guardian Signature if patient is a minor)**

TENNESSEE
FAMILY DENTAL CARE

## Patient Acknowledgement and Consent Form

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future. To comply with one of the HIPAA's requires us to disclose regarding our privacy practices.

Existing Tennessee Law requires (in addition to our attempt to obtain your written acknowledgement, discussed above) us to first obtain your written consent prior to disclosing any of your information except for our disclosures in connection with: a defense to a claim challenging our professional competence; a review entity's functions; a claim for payment of fees; a third party payer's examination of our records; a court order as part of a criminal investigation; an identification of a dead body; a licensure investigation; or a child abuse/neglect investigation.

From time to time it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to, or consult with another dentist, or other health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

## Patient Acknowledgement

*Please sign this form below under the heading "acknowledgement" to acknowledge that you have today received a copy of our notice of privacy practices.*

I acknowledge that I have today received a copy of the Notice of Privacy Practices.

**Patient Name: _____ Date: _____**

**X_____**
**Patient Signature (Parent/Guardian Signature if patient is a minor)**

In addition to the authorization for release of my Protected Health Information (PHI), I furthermore acknowledge that I have the right to authorize access and disclosure of my PHI to anyone of my choosing for billing, condition, treatment, and prognosis to the following individual(s):

**Name: _____ Relationship:_____**

**Name: _____ Relationship: _____**

I request the following **restriction(s)** to releasing: _____

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contact a claim.

**X_____ _____**
**Patient Signature (Parent/Guardian Signature if patient is a minor) Date**

**For Office Use Only**

**Patient refused to sign:**
The following circumstances prohibited the patient from signing the Acknowledgement:
_____

An emergency situation prevented the patient from signing the Acknowledgment:
_____
_____ _____
Office Personnel (Signature) Office Personnel (Print Name)

**Patient Consent**

*Please sign this form below under the heading "consent" to consent to our disclosures of your information that we deem necessary in order to provide you with proper treatment.*

I consent to your disclosures of my information, which you deem are necessary in connection with my treatment.
I understand that send disclosures may not be of the type listed above.

**X_____ _____**

**Patient Signature (Parent/Guardian Signature if patient is a minor) Date**

TENNESSEE
FAMILY DENTAL CARE

# Informed Consent for Dental Treatment

It is our goal to provide a safe and comfortable dental care for our patients. In order to achieve this goal, the following methods of treatment may be necessary for you or your child/minor/dependent. Please sign below stating your understanding of the treatment provided (may be performed today with verbal permission).

**Dental Fillings**- Diagnosis: Decay or fracture Prognosis: Good/Fair. This may include cracked teeth, future abscess requiring extraction or endodontic treatment. Tooth may need a crown in the future if the filling is large. Alternatives to treatment: Inlay, onlay or extraction (we do not advocate extraction when a tooth can be filled). Composite/resin material or amalgam may be used. Tooth numbers: per attached treatment plan.

**Sealants**- A resin material is placed on the pits and fissures of permanent molars in order to prevent decay. Diagnosis: Deep pits and fissures in permanent molars. Prognosis: Good Risks: Future decay if proper oral hygiene and diet are not followed. Alternatives to treatment: No Sealant. Tooth numbers: per attached treatment plan.

**Stainless Steel Crown**- used to restore a tooth that has had a pulpotomy or large carious lesion. Helps to maintain space and good occlusion. Diagnosis: decay or fracture. Prognosis: Good/fair. Risks: Minimal. Alternatives to treatment: Large filling which usually fractures or extraction of primary tooth. Tooth numbers: per attached treatment plan.

**Nerve or Pulp Treatment or Pulpotomy**- Baby teeth respond well to removal of the diseased portion of the nerve (pulp) while leaving the healthy portion intact. The cavity and diseased pulp tissue are removed, the pulp disinfected, IRM placed (filling with a medicament in it) and a stainless-steel crown placed over the tooth. Diagnosis: Decay to nerve (pulp) tooth. Prognosis: Good. Risks: pulp treatment may be unsuccessful resulting in extraction. Alternatives to treatment: Extraction. Tooth numbers: per attached treatment plan.

**Extraction/Removal of Teeth** – Diagnosis: Decay, Necrotic pulp, abscess, non-restorable/fractured. Prognosis: Poor infection or death. Tooth numbers: per attached treatment plan.

**Space Maintainer** – Diagnosis: Space due to extraction of primary tooth. Risks: Few. Alternatives to treatment: No space maintainer and loss of space, malocclusion possible. Tooth numbers: per attached treatment plan.

**Lab Fabricated Crown** – Diagnosis_____ Prognosis: Good. Alternatives to treatment: Large filling that may fracture in the future, extraction. Tooth numbers: per attached treatment plan.

**Partial Denture/Interim Partial Denture (flipper)** – Diagnosis: _____Prognosis: _____ Risks:____ Alternative to treatment:_____

**Occlusal Guard/Bite Splint Therapy–** Diagnosis: Bruxism/Attrition/TMD. Prognosis:_____
Risks: Future TMI dysfunction, pain or muscle pain which may lead to surgery or physical therapy. Alternatives to treatment: Orthodontics, occlusal adjustment, full mouth reconstruction.

**Athletic Guard** – used to prevent any dental injuries while participating in sports. Risks: Teeth/alveolar bone may still fracture. Alternative to treatment: no athletic guard.

**Fluoride Treatment** – used to prevent decay and promote healthy dentition. Risks: If excessive amounts are taken internally, bones and teeth may develop fluorosis and become stained brown or become mottled. Alternatives to treatment: no fluoride.

**Prophylaxis (cleaning)/Full Mouth Debridement** – used to promote dental and gingival health by removing plaque, calculus and food debris. Risks: Slight discomfort/incidental gingival trauma. Alternatives to treatment: No cleaning. Lack of regular dental cleanings may result in loss of periodontal attachment and eventual tooth loss. Studies have shown a link between periodontal disease and other diseases such as diabetes, heart disease and low birth weight in babies with affected mothers.

**Periodontal Scaling and Root Planning** – removal of calculus and debris from below the gum line and on the surfaces of the roots of teeth. Risks: Discomfort/incidental gingival trauma. Alternatives to treatment: No periodontal treatment or regular dental cleanings. Lack of regular dental cleanings may result in loss of periodontal attachment and eventual tooth loss. Studies have shown a link between periodontal disease and other diseases such as diabetes, heart disease and low birth weight in babies with affected mothers.

**X-rays** – used as a diagnostic tool for caries and dental/head and neck anomalies and disease. Risks: Radiation Alternatives to treatment: No x-rays. (Doctors are unable to treat a tooth without an x-ray to confirm diagnosis).

**Local Anesthetic** – used to numb the area of treatment. Risks: Patient may bite cheek or abrade area while numb, causing pain and swelling. Hematoma or bruising at injection site/area may result. Alternatives to treatment: No administration of local anesthetic for dental procedures.

I understand the above procedures may be performed as needed, I consent to treatment discussed with the dental professionals in this office and recorded in my treatment plan. I agree to the treatment with verbal permission given on the day of the procedure. This consent applies to this and every dental visit to this office as long as I am a patient. A written statement must be submitted to nullify this agreement.

**Patient Name: _____ Date: _____**

**X_____**

**Patient Signature (Parent/Guardian Signature if patient is a minor)**

TENNESSEE
FAMILY DENTAL CARE

## Insurance Policy

It is your responsibility to know your insurance information. As a courtesy to you, we may check insurance details such as:

- Percentage of Coverage
- Deductible
- Yearly Maximums

**Please understand that any and all information given to us by your insurance company is an ESTIMATE and may change once the claims are reviewed. If something is not covered by your insurance company, it will be your responsibility to pay for it.**

- As a dental provider, we have no leverage or control over what your insurance company decided to cover or not to cover.
- Your estimated portion for treatment (which may include a deductible) is due at the time of service.
- By signing this document, you understand the topics discussed above.

**X**_____ _____

**Patient Signature (Parent/Guardian Signature if patient is a minor)** **Date**

## Cancellation & Missed Appointment Policy

At Tennessee Family Dental Care, we strive to provide you with the best and most time efficient care. We ask that you give us at least a 48-hour notice to cancel and/or reschedule your appointment.

**A missed appointment is defined as:**

- **an appointment that you do not show up for**
- **an appointment that you provide less than 48-hour notice to cancel or reschedule**

**If you have two missed appointments, we will no longer reserve a spot on the schedule for you. We will notify you of any same day appointments that may become available and you may accept or decline the appointment depending on your schedule.**

**Please Confirm Your Appointment**

**We will contact you multiple times prior to your appointment by either text, email, and/or telephone. You must reply to one of these contacts to confirm your appointment. It is as easy as stating or clicking "confirm" and "yes." Please note: you can also cancel, reschedule, or confirm your appointment via voicemail if it is after business hours.**

**If you have not confirmed your appointment within 48-hours prior to your appointment, we reserve the right to reschedule you.**

**Late Arrivals**

**Please keep in mind that we maintain a very full schedule. Even one patient running late can impact the schedule of the entire office. Please call us and let us know if you are running behind so we can manage accordingly. However, if you are running more than 10 minutes behind, depending on what you are being seen for, we may not be able to complete all that is scheduled or we may need to reschedule your appointment entirely.**

Thank you for your understanding and cooperation.

I, the undersigned, understand and agree to the above written cancellation policy and agree to honor all terms and conditions.

**X** _____ _____

**Patient Signature (parent/guardian signature if patient is a minor)** **Date**