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	• Pregnant? ☐YES ☐NO
• Diabetes Type 1 ☐YES ☐NO	• Heart Attack ☐YES ☐NO	• Psychiatric Disorder ☐YES ☐NO	If Yes, Delivery Date: _____
• Diabetes Type 2 ☐YES ☐NO	• Heart Murmur ☐YES ☐NO	• Cancer ☐YES ☐NO	• Seizures ☐YES ☐NO
• Asthma ☐YES ☐NO	• Liver Disease ☐YES ☐NO	• Pulmonary Disease ☐YES ☐NO	• Sleep Apnea ☐YES ☐NO
• Kidney Disease ☐YES ☐NO	• Hepatitis ☐YES ☐NO	• Cardiovascular Disease ☐YES ☐NO	• Tuberculosis ☐YES ☐NO
• Joint Replacement ☐YES ☐NO	• AIDS/HIV ☐YES ☐NO	• Osteoporosis ☐YES ☐NO	• Surgeries? ☐YES ☐NO
• High Blood Pressure ☐YES ☐NO	• Sleep Apnea ☐YES ☐NO	• Epilepsy/Convulsions ☐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: _____