LYNNWOODDENTAL

PATIENT FORMS

Sara B. Boren, DDS | 122 Lynnwood Drive, Knoxville, TN 37918
(865) 687-9350 | www.lynnwooddental.com

LYNNWOODDENTAL

WELCOME

Age _____ Today's Date _____

PATIENT INFORMATION

Last Name _____ First Name _____ Initial _____

Preferred Name _____

Date of Birth _____ ☐ Male ■ Female If Child: Parent's Name _____

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Minor

Home Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email _____

Patient / Parent Employed By _____

Occupation _____

Responsible Party Name _____

Whom may we thank for this referral? _____

Patient SS# _____ Spouse / Parent SS# _____

Someone to notify in case of an emergency _____ Phone # _____

Dental Insurance Primary Coverage

Employee Name _____ DOB _____

Relationship to Patient _____

Employer Name _____

Insurance Company _____

Insurance Phone # _____

Subscriber / Client # _____

Subscriber _____

Subscriber SS # _____

Group # _____

Dental Insurance Secondary Coverage

Employee Name _____ DOB _____

Relationship to Patient _____

Employer Name _____

Insurance Company _____

Insurance Phone # _____

Subscriber / Client # _____

Subscriber _____

Subscriber SS # _____

Group # _____

Patient's Signature _____

LYNNWOODDENTAL

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____
Name of Physician/and their specialty _____
Most recent physical examination _____ Purpose _____
What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1. hospitalization for illness or injury _____	☐	☐
2. an allergic or bad reaction to any of the following:	☐	☐
○ aspirin, ibuprofen, acetaminophen, codeine _____		
○ penicillin _____		
○ erythromycin _____		
○ tetracycline _____		
○ sulfa _____		
○ local anesthetic _____		
○ fluoride _____		
○ chlorhexidine (CHX) _____		
○ Iodine _____		
○ metals (nickel, gold, silver, _____)		
○ latex _____		
○ nuts _____		
○ fruit _____		
○ milk _____		
○ red dye _____		
○ other _____		
3. heart problems, or cardiac stent within the last six months _____	☐	☐
4. history of infective endocarditis _____	☐	☐
5. artificial heart valve, repaired heart defect (PFO) _____	☐	☐
6. pacemaker or implantable defibrillator _____	☐	☐
7. orthopedic or soft tissue implant (e.g joint replacement, breast implant) ___	☐	☐
8. heart murmur, rheumatic or scarlet fever _____	☐	☐
9. high or low blood pressure _____	☐	☐
10. a stroke (taking blood thinners) _____	☐	☐
11. anemia or other blood disorder _____	☐	☐
12. prolonged bleeding due to a slight cut (or INR > 3.5) _____	☐	☐
13. pneumonia, emphysema, shortness of breath, sarcoidosis _____	☐	☐
14. chronic ear infections, tuberculosis, measles, chicken pox _____	☐	☐
15. breathing problems (e.g. asthma, stuffy nose, sinus congestion) _____	☐	☐
16. sleep problems (e.g. sleep apnea, snoring, insomnia, restless sleep, bedwetting) __	☐	☐
17. kidney disease _____	☐	☐
18. liver disease or jaundice _____	☐	☐
19. vertigo (e.g. "the room is spinning") _____	☐	☐
20. thyroid, parathyroid disease, or calcium deficiency _____	☐	☐
21. hormone deficiency or imbalance (e.g. poly cystic ovarian syndrome) ____	☐	☐
22. high cholesterol or taking statin drugs _____	☐	☐
23. diabetes (HbA1c = _____) _____	☐	☐
24. stomach or duodenal ulcer _____	☐	☐
25. digestive or eating disorders (e.g. celiac disease, gastric reflux, bulimia, anorexia) _____	☐	☐

	YES	NO
26. osteoporosis/osteopenia or ever taken anti-resorptive medications (e.g. bisphosphonates) _____	☐	☐
27. arthritis or gout _____	☐	☐
28. autoimmune disease (e.g. rheumatoid arthritis, lupus, scleroderma) _____	☐	☐
29. glaucoma _____	☐	☐
30. contact lenses _____	☐	☐
31. head or neck injuries _____	☐	☐
32. epilepsy, convulsions (seizures) _____	☐	☐
33. neurologic disorders (e.g. Alzheimer's disease, dementia, prion disease) _	☐	☐
34. viral infections and cold sores _____	☐	☐
35. any lumps or swelling in the mouth _____	☐	☐
36. hives, skin rash, hay fever _____	☐	☐
37. STI/STD/HPV _____	☐	☐
38. hepatitis (type ____) _____	☐	☐
39. HIV/AIDS _____	☐	☐
40. tumor, abnormal growth _____	☐	☐
41. radiation therapy _____	☐	☐
42. chemotherapy, immunosuppressive medication _____	☐	☐
43. emotional difficulties _____	☐	☐
44. psychiatric treatment or antidepressant medication _____	☐	☐
45. concentration problems or ADD/ADHD _____	☐	☐
46. alcohol/recreational drug use _____	☐	☐
ARE YOU:		
47. presently being treated for any other illness _____	☐	☐
48. aware of a change in your health in the last 24 hours (e.g., fever, chills, new cough, or diarrhea) _____	☐	☐
49. taking medication for weight management _____	☐	☐
50. taking dietary supplements, vitamins, and/or probiotics _____	☐	☐
51. often exhausted or fatigued _____	☐	☐
52. experiencing frequent headaches or chronic pain _____	☐	☐
53. a smoker, smoked previously or other (e.g. smokeless tobacco, vaping, e-cigarettes, and cannabis) _____	☐	☐
54. considered a touchy/sensitive person _____	☐	☐
55. often unhappy or depressed _____	☐	☐
56. taking birth control pills _____	☐	☐
57. currently pregnant _____	☐	☐
58. diagnosed with a prostate disorder _____	☐	☐

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections) _____

_____

List all medications, supplements, vitamins, and/or probiotics taken within the last two years.

Drug	Purpose	Drug	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____
Doctor's Signature _____ Date _____

ASA _____ **(1-6)**

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LYNNWOODDENTAL

DENTAL HISTORY

Patient Name _____ Nickname _____ Age _____
Referred by _____ How would you rate the condition of your mouth ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Previous Dentist _____ How long have you been a patient? _____ Months/Years
Date of most recent dental exam ___ / ___ / ___ Date of most recent x-rays ___ / ___ / ___
Date of most recent treatment (other than cleaning) ____ / ____ / ____
I routinely see my dentist every ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not Routinely
WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

PERSONAL HISTORY	YES	NO
1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____]	☐	☐
2. Have you had an unfavorable dental experience?	☐	☐
3. Have you ever had complications from past dental treatment?	☐	☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic?	☐	☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age?	☐	☐
6. Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma?	☐	☐

GUM AND BONE	YES	NO
7. Do your gums bleed sometimes or are they ever painful when brushing or flossing?	☐	☐
8. Have you ever been treated for gum disease, had scaling and root planing, or been told you have lost bone around your teeth?	☐	☐
9. Have you ever noticed an unpleasant taste or odor in your mouth?	☐	☐
10. Is there anyone with a history of periodontal disease in your family?	☐	☐
11. Have you ever experienced gum recession, or can you see more of the roots of your teeth?	☐	☐
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?	☐	☐
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth?	☐	☐

TOOTH STRUCTURE	YES	NO
14. Have you had any cavities within the past 3 years?	☐	☐
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?	☐	☐
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?	☐	☐
17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?	☐	☐
18. Do you have grooves or notches on your teeth near the gum line?	☐	☐
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?	☐	☐
20. Do you frequently get food caught between any teeth?	☐	☐

BITE AND JAW JOINT	YES	NO
21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	☐	☐
22. Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together?	☐	☐
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?	☐	☐
24. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed?	☐	☐
25. Are your teeth becoming more crooked, crowded, or overlapped?	☐	☐
26. Are your teeth developing spaces or becoming more loose?	☐	☐
27. Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together?	☐	☐
28. Do you place your tongue between your teeth or close your teeth against your tongue?	☐	☐
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?	☐	☐
30. Do you clench or grind your teeth together in the daytime or make them sore?	☐	☐
31. Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth?	☐	☐
32. Do you wear or have you ever worn a bite appliance?	☐	☐

SMILE CHARACTERISTICS	YES	NO
33. Is there anything about the appearance of your mouth (smile, lips, teeth, gums) that you would like to change (shape, color, size, display)?	☐	☐
34. Have you ever bleached (whitened) your teeth?	☐	☐
35. Have you felt uncomfortable or self conscious about the appearance of your teeth?	☐	☐
36. Have you been disappointed with the appearance of previous dental work?	☐	☐

Patient's Signature _____ Date _____
Doctor's Signature _____ Date _____

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LYNNWOODDENTAL

CONSENT

GENERAL CONSENT FOR TREATMENT

Thank you for choosing our office for your dental care. We will work with you to help you achieve excellent oral health. While recognizing the benefits of a pleasing smile and teeth that function well, you should be aware that dental treatment, like treatment of any other part of the body, has some inherent risks. These are seldom great enough to offset the benefits of treatment, but should be considered when making treatment decisions.

Benefits of dental treatment can include: relief of pain, the ability to chew properly, and the confidence and social interaction that a pleasing smile can bring. Nonetheless, there are some common risks associated with virtually any dental procedure, including:

1. **Drug or chemical reaction.** Dental materials and medications may trigger allergic or sensitivity reactions causing symptoms such as redness, swelling, itching, and/or anaphylactic shock and death.
2. **Long-term numbness (paresthesia)**. Local anesthetic, or its administration, while almost always adequate to allow comfortable care, can result in transient, or in rare instances permanent, numbness.
3. **Muscle or joint tenderness.** Holding one's mouth open can result in muscle or jaw joint tenderness, or in a predisposed patient, precipitate a TMJ disorder.
4. **Sensitivity in teeth or gums, infection, or bleeding.**
5. **Swallowing or inhaling small objects.**

I have advised the office of any and all allergies I have and will inform them in the future of any changes.

Consent for Composite Restorations on Posterior Teeth
Tooth colored composite fillings are a modern day improvement over amalgam (mercury) fillings of the past. It is for this reason that Lynnwood Dental performs only composite fillings. Some insurance policies do not cover composite fillings on posterior teeth. These companies reimburse for what they would pay for an amalgam restoration, with the balance the responsibility of the patient. I agree to be financially responsible for all copays related to posterior composites for myself and those for whom I am financially responsible.

Cancellation Policy
Our office is a busy one – we have many patients, and our schedule can be quite full. As such, we request at least 24 hours notice before canceling and/or rescheduling any dental appointment. Each appointment is a valuable block of time in our schedule, and when proper notice is given, we are still able to offer your canceled appointment time to another patient. A $35.00 per hour fee will be accessed for all no-shows and late cancellations.

I have read and understand the statement on this page.

_____ _____
Patient's signature Date

_____ _____
Parent's signature (if minor patient) Date

LYNNWOODDENTAL

FINANCIAL STATEMENT

FINANCIAL STATEMENT

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. The following is a statement of our Financial Agreement, which we require you read prior to any treatment.

All patients must complete our Registration and Medical/Dental History form before seeing the providers.

* **FULL PAYMENT IS DUE AT THE TIME OF SERVICE.**
* **WE ACCEPT CASH, CHECKS, VISA/MASTERCARD, DISCOVER, AND AMEX.**

REGARDING INSURANCE
We will gladly estimate your deductible, your portion of treatment costs, and bill your insurance company for your treatment, all at no extra cost to you. We do require that you pay your portion of the treatment fee (Co-Pay and deductible) at the time of service. We will bill your insurance company if we are provided with your insurance information and a copy of your insurance card. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Please be sure to read and know your own insurance policy. We are more than happy to assist you in billing your primary dental benefits provider, however, **if your insurance company has not paid within 45 days, you will be responsible for the balance in full, and all insurance inquiries and follow-up become your responsibility.** ***The balance is your responsibility whether or not your insurance company deems your treatment to be a covered benefit.***

SECONDARY INSURANCE PLANS
We do not bill secondary insurance companies, but we will provide you with copies of the needed information so that you can forward that information to your secondary insurance company for reimbursement.

USUAL AND CUSTOMARY RATES
Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment of any insurance company's arbitrary determination of usual and customary rates.

PATIENTS WITHOUT INSURANCE
Patients without dental insurance are responsible for payment in full when treatment is received unless financial arrangements have been made prior to appointment.

FINANCIAL ARRANGEMENTS
In the event a short-term financial arrangement is necessary, payment options will be discussed on an individual basis.

NO-SHOW AND LATE CANCELLATIONS
To assure that each and every patient is seen in a timely manner, it is imperative that our office receive a 24 hour notice if you are unable to keep your appointment. A $35.00 per hour fee will be accessed for all no-shows and late cancellations.

INTEREST, LATE FEES and COLLECTION FEES
As stated on our Patient Registration form, we reserve the right to assess an annual 18% interest charge on all overdue accounts 60 days after original charge is made. Late fees will be assessed to payments received after the due date on statement. If payment is not made as agreed, patient shall be responsible for any reasonable attorney fees, costs of collection, and court costs incurred in efforts to enforce this agreement. The return of a check (electronic or paper) will result in a $35.00 returned check fee being placed on the account.

Thank you for understanding our Financial Agreement. Please let us know if you have any questions or concerns.

I hereby authorize and direct payment of dental insurance benefits to Lynnwood Dental, Sara B. Boren, DDS, PLLC.
I UNDERSTAND AND AGREE TO THIS FINANCIAL STATEMENT.

_____ _____

SIGNATURE DATE

LYNNWOODDENTAL

HIPAA

HIPAA Privacy Rule of Patient Authorization Agreement

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))

I,_____, (patient's name) understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment;
- a means of communication among the health professionals who may contribute to my healthcare;
- a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party payer can verify that services billed were actually provided;
- a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I have the right to read or be provided a copy of the ***Notice of Privacy Practices*** that provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this facility's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

Privacy Rule of Patient Consent Agreement

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.506(a))

I understand that:

- I have the right to review this facility's Notice of Information practices prior to signing this consent;
- This facility, reserves the right to change the notice and practices and that prior to implementation will mail a copy of any revised notice to the address I've provided if requested;
- I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that this facility is not required by law to agree to the restrictions requested.
- I may revoke this consent in writing at any time, except to the extent that this facility, has already taken action in reliance thereon.
- It is this facility's procedure to share Protected Health Information with labs, x-rays, consulting physicians, and hospitals. We will call the pharmacy of your choice regarding your prescriptions. We will only exchange minimum necessary Protected Health Information for each transaction.

Signature of Patient or Legal Representative Witness _____

Printed Name of Patient or Legal Representative Witness _____

Date:_____

LYNNWOODDENTAL

PHOTOGRAPH RELEASE

I _____, hereby authorize Dr. Sara Boren, "Lynnwood Dental" or any of their assignees to take photographs, slides, and / or videos of my face, jaws, and teeth.

I understand that the photographs, slides, and / or videos will be used as a record of my care, and may be used for educational purposes in lectures, demonstrations, advertising (including website publication, newspapers, magazines, phone books, television), and professional publications, (dental magazines and peer reviewed journals).

I further understand that if the photographs, slides, and / or videos are used in any publication or as part of a demonstration, my name or other identifying information could be used unless stated differently below. I do not expect compensation, financial or otherwise, for the use of these photographs.

Please initial:

_____ I do not mind if my name, and face are used in any of the above stated situations.

Exceptions:

_____ I do not wish to have my name shown, or released.

_____ I do not wish to have my face shown.

Signed _____

Date_____

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