TENNESSEE FAMILY DENTAL CARE

Patient Registration

Patient Information

Patient Name _____ Legal Name _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email Address _____ Patient DOB _____ Sex: ☐ M ☐ F

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Social Security # _____

☐ Full-time student If yes, where? _____ Responsible Party: ☐ Self ☐ Other _____

Patient's Employer _____ Driver License# _____

City _____ State _____ Zip _____

Spouse's Name _____ Spouse's Cell _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone _____ Work Phone _____

What brings you in today? _____

_____

How did you hear about our practice? _____

Dental Insurance

Primary Insurance Company _____ Subscriber Name _____

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

ID# _____ Group # _____ Subscriber's DOB _____

Subscriber's Employer _____

Secondary Insurance Company _____ Subscriber Name _____

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

ID# _____ Group # _____ Subscriber's DOB _____

Subscriber's Employer _____

Assignment and Release

I certify that I and/or my dependent(s) have insurance coverage with _____ *(Insurance Company)* and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance.
I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my healthcare information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____

Signature of Patient, Parent or Guardian **Date**

_____ _____

Please Print Name of Patient, Parent or Guardian **Relationship** to Patient

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Health History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ☐ Yes ☐ No If yes _____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes _____

Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes _____

Are you taking any medications, pills or drugs? ☐ Yes ☐ No If yes _____

Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No If yes _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ Yes ☐ No If yes _____

Are you on a special diet? ☐ Yes ☐ No If yes _____

Do you use tobacco? ☐ Yes ☐ No If yes _____

I am a woman who is... ☐ Pregnant/Trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives ☐ N/A

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Other _____

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics ☐ No Known Allergies

Do you use controlled substances? ☐ Yes ☐ No If yes _____

Do you have, or have you had any of the following?

☐ AIDS/HIV Positive
☐ Alzheimer's Disease
☐ Anaphylaxis
☐ Anemia
☐ Angina
☐ Arthritis/Gout
☐ Artificial Heart Valve
☐ Artificial Joint
☐ Asthma
☐ Blood Disease
☐ Blood Transfusion
☐ Breathing Problems
☐ Bruise Easily
☐ Cancer
☐ Chemotherapy
☐ Chest Pains
☐ Cold Sores/Fever Blisters
☐ Congenital Heart Disorder
☐ Convulsions
☐ Cortisone Medicine
☐ Diabetes
☐ Drug Addiction
☐ Easily Winded
☐ Emphysema
☐ Epilepsy or Seizures
☐ Excessive Bleeding
☐ Excessive Thirst
☐ Fainting Spells/Dizziness
☐ Frequent Cough
☐ Frequent Diarrhea
☐ Frequent Headaches
☐ Genital Herpes
☐ Glaucoma
☐ Hay Fever
☐ Heart Attack/Failure
☐ Heart Murmur
☐ Heart Pacemaker
☐ Heart Trouble/Disease
☐ Hemophilia
☐ Hepatitis A
☐ Hepatitis B or C
☐ Herpes
☐ High Blood Pressure
☐ High Cholesterol
☐ Hives or Rash
☐ Hypoglycemia
☐ Irregular Heartbeat
☐ Kidney Problems
☐ Leukemia
☐ Liver Disease
☐ Low Blood Pressure
☐ Lung Disease
☐ Mitral Valve Prolapse
☐ Osteoporosis
☐ Pain in Jaw Joints
☐ Parathyroid Disease
☐ Psychiatric Care
☐ Radiation Treatments
☐ Recent Weight Loss
☐ Renal Dialysis
☐ Rheumatic Fever
☐ Rheumatism
☐ Scarlet Fever
☐ Shingles
☐ Sickle Cell Disease
☐ Sinus Trouble
☐ Spina Bifida
☐ Stomach/Intestinal Disease
☐ Stroke
☐ Swelling of Limbs
☐ Thyroid Disease
☐ Tonsillitis
☐ Tuberculosis
☐ Tumors or Growths
☐ Ulcers
☐ Venereal Disease
☐ Yellow Jaundice

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes _____

Comments _____

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

Please Print Name of Patient, Parent or Guardian

_____ _____

Signature of Patient, Parent or Guardian **Date**