LENOIR CITY DENTAL
where smiles come alive

MEDICAL HISTORY

Date _____ Patient Name _____ Name you wish to be called _____
Physical Address _____ Home Phone _____
City _____ State _____ Zip Code _____ Work Phone _____
Mailing Address _____ Cell Phone _____
City _____ State _____ Zip Code _____
Best Time and Place to Reach You Live and In Person _____
Sex: ☐ M F ☐ Age _____ Birthdate _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
Patient SS # _____ Occupation _____ Employer _____
Employer Address _____ Employer Phone _____
Spouse Name _____ Birthdate _____ SS# _____
Occupation _____ Spouse's Employer _____

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IN CASE OF EMERGENCY PLEASE CONTACT (someone not living with you)
Name _____ Relationship to you _____
Address and Phone Number of Emergency Contact Person _____
Whom may we thank for referring you? _____
Who is responsible for this account? _____ Relationship to patient _____

****

Insurance Company _____ Group # _____
Is patient covered by additional insurance? ☐ yes ☐ no Subscriber's name _____
Subscriber's Birthdate _____ Subscriber's SS# _____ Relationship to Patient _____
Insurance company _____ Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to doctor otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____
Responsible Party Signature Relationship Date

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DENTAL HISTORY

Reason for today's visit _____
Former Dentist _____ City/State _____
Date of last dental visit _____ Date of last dental X-rays _____
Please check Yes or No to indicate if you have had any of the following:

Bad breath	No ☐ Yes ☐	Bleeding gums	No ☐ Yes ☐	Blisters on lips or mouth	No ☐ Yes ☐
Burning sensation on tongue	No ☐ Yes ☐	Chew on one side of mouth	No ☐ Yes ☐	Cigarette, pipe or cigar smoking	No ☐ Yes ☐
Clicking or popping Jaw	No ☐ Yes ☐	Dry mouth	No ☐ Yes ☐	Fingernail biting	No ☐ Yes ☐
Do you or have you ever experienced pain/discomfort in your jaw joint	No ☐ Yes ☐	Food collection between teeth		Chewing tobacco	No ☐ Yes ☐
Food collection tender	No ☐ Yes ☐	Foreign objects	No ☐ Yes ☐	Grinding teeth	No ☐ Yes ☐
Periodontal	No ☐ Yes ☐	Jaw pain or tiredness	No ☐ Yes ☐	Lip or cheek biting	No ☐ Yes ☐
Loose teeth or broken fillings	No ☐ Yes ☐	Mouth breathing	No ☐ Yes ☐	Orthodontic treatment	No ☐ Yes ☐
Pain around ear	No ☐ Yes ☐	Sensitivity to cold treatment	No ☐ Yes ☐	Gums swollen or	No ☐ Yes ☐
Sensitivity to heat	No ☐ Yes ☐	Sensitivity to sweets	No ☐ Yes ☐	Sensitivity when biting	No ☐ Yes ☐
Sores or growths in your mouth	No ☐ Yes ☐	How often do you floss _____		Do you like your smile	No ☐ Yes ☐
		How often do you brush? _____		Type of bristles	So☐ Medium☐ Hard☐
				Have you ever had a serious or difficult problem associated with previous dental work	No ☐ Yes ☐

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MEDICAL HISTORY

Physician's Name _____ Date of last visit _____

Please check yes or no to indicate if you have had any of the following:

AIDS	No ☐ Yes ☐	Epilepsy	No ☐ Yes ☐	Psychiatric Care	No ☐ Yes ☐
Anemia	No ☐ Yes ☐	Fainting or dizziness	No ☐ Yes ☐	Radiation Treatment	No ☐ Yes ☐
Arthritis, Rheumatism	No ☐ Yes ☐	Glaucoma	No ☐ Yes ☐	Respiratory Disease	No ☐ Yes ☐
		Headaches	No ☐ Yes ☐	Rheumatic Fever	No ☐ Yes ☐
Artificial heart valves	No ☐ Yes ☐	Heart Murmur	No ☐ Yes ☐	Scarlet Fever	No ☐ Yes ☐
		Heart Problems	No ☐ Yes ☐	Shortness of Breath	No ☐ Yes ☐
Artificial Joints	No ☐ Yes ☐	Hepatitis	No ☐ Yes ☐	Sinus Trouble	No ☐ Yes ☐
Asthma	No ☐ Yes ☐	Type _____		Skin Rash	No ☐ Yes ☐
Back Problems	No ☐ Yes ☐	Herpes	No ☐ Yes ☐	Special Diet	No ☐ Yes ☐
Bleeding abnormally (with extractions or surgery)	No ☐ Yes ☐	High Blood Pressure	No ☐ Yes ☐	Stroke	No ☐ Yes ☐
		Meds: _____		Swelling of Feet or ankles	No ☐ Yes ☐
	No ☐ Yes ☐	HIV Positive	No ☐ Yes ☐		
Blood Disease	No ☐ Yes ☐	Jaundice	No ☐ Yes ☐	Swollen Neck Glands	No ☐ Yes ☐
Cancer	No ☐ Yes ☐	Jaw Pain	No ☐ Yes ☐	Thyroid Problems	No ☐ Yes ☐
Chemical dependency	No ☐ Yes ☐	Joint replacement	No ☐ Yes ☐	Tonsillitis	No ☐ Yes ☐
Chemotherapy	No ☐ Yes ☐	Kidney Disease	No ☐ Yes ☐	Tuberculosis	No ☐ Yes ☐
Circulatory problems	No ☐ Yes ☐	Liver Disease	No ☐ Yes ☐	Tumor or growth on Head or Neck	☐Yes ☐ No
		Low Blood Pressure	No ☐ Yes ☐		
Congenital Heart Lesions	No ☐ Yes ☐	Mitral Valve Prolapse	No ☐ Yes ☐	Ulcer	No ☐ Yes ☐
		Nervous Problems	No ☐ Yes ☐	Venereal Disease	No ☐ Yes ☐
Cortisone treatments	No ☐ Yes ☐	Pacemaker	No ☐ Yes ☐	Weight Loss, unexplained	No ☐ Yes ☐
		Women:			
Cough, Persistent or bloody	No ☐ Yes ☐	Are you pregnant?	No ☐ Yes ☐	Any hospital stays	No ☐ Yes ☐
		Due date _____		Explain _____	
Diabetes	No ☐ Yes ☐	Are you nursing?	No ☐ Yes ☐	_____	
Do you wear Contact lenses	No ☐ Yes ☐	Are you taking birth control pills?	No ☐ Yes ☐	_____	
				_____	

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MEDICATIONS

Please list medications you are currently taking:

_____

_____

_____

_____

Pharmacy Name _____

Phone _____

ALLERGIES

Aspirin ☐
)Barbiturates (sleeping pills ☐
Codeine ☐
Iodine ☐
Latex ☐
Local Anesthetic ☐
Penicillin ☐
Sulfa ☐
_____ Other ☐
_____

I understand that I may be charged a 1.5% finance charge per month (18% annually) if my balance goes beyond 90 days. I also understand that I am responsible for all fees pertaining to my unpaid balance and/or missed appointments.

I give permission for my dentist and clinical team to take any necessary radiographs, study models, and photographs to make a complete diagnosis of my dental needs. I also give permission for my dentist and dental team to use my photographs for in-office patient education.

I consent to the use and disclosure of my protected health information to obtain payment information in connection with my dental claims.

_____ _____

Patient's Signature Date

_____ _____

Doctor's Signature Date

(I have read, agree to, and understand the statements listed above)

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Financial Policy

We are happy to have you as a patient and look forward to offering you and your family the finest dental care available. We know that providing comprehensive dental services include discussing all treatment and financial information. Before treatment is performed, we will discuss treatment and financial options. This will help you to fully understand your dental treatment, what to anticipate in fees and allow you time to make the necessary financial arrangements.

Payment is due at the time services are rendered. For your convenience we accept most major credit cards, debit cards, cash, and checks. We also offer care credit which you can apply for care credit (you can apply online or in office).

A returned check fee of $35.00 will be added to your account balance for any returned checks.

After 60 days, any unpaid balance will accrue a 3% interest fee on the balance of the account per month.

Initial: _____

Insurance

Dental Plan benefits are determined by your employer, not your dentist. Your dental plan policy is a contract between you and your plan company. Your plan and payment is your responsibility. A plan is not a guarantee of payment; it often does not cover all the costs involved in treatment. As a courtesy, we will be happy to file your claim for you if you present your dental plan wallet card and all required employer information.

You will be expected to pay for services rendered if this office is unable to verify your plan information before treatment.

Any deductible or estimated co-payment amount will be due at the time of treatment.

If payment for services already rendered has not been paid in full within 45 days, by your plan company, the remaining balance for your treatment is considered due and must be collected from you in full.

Initial: _____

Appointments

Appointments are reserved exclusively for you. As a benefit to you, our valued patient, we may offer to move your appointment to an earlier time if an opening should arise. We reserve the right to charge and collect $25.00 for any broken appointments. Broken appointments are considered those that are missed (no-show) or cancelled with less than 48 hours advanced notice.

Initial: _____

Separated or divorced parents of minors, who are responsible for one half of the cost of a child/childrens' dental care: The parent who brings the child in to the dental appointment is responsible for paying the co-payment or full fee. If it is necessary, we are happy to hold a credit/debit number from the non-custodial parent on file.

After hours Appointment

Emergencies: The office is closed on Weekends and Major Holidays. If you have an after-hours emergency simply call Dr. Christopher David Lee D.M.D. at 865-617-6001 and leave a message. After hours and dates the office is closed, there is a minimum emergency fee of $150.00 per hour on top of treatment rendered. The fee is subject to being pro-rated.

Initial: _____

Patient Consent & Authorization for Release of Protected Health Information

Please Print

Patient Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ ZIP Code: _____ Telephone Number: _____

E-mail Address: _____

Patient Authorization

I, _____, hereby authorize the release, use or disclosure of my health information as follows:

This authorization pertains to the following type of medical information about me:

_____

_____

I hereby authorize _____
Name of individual(s) and/or organization providing information

to release the above-described information to _____
Name of individual(s) and/or organization receiving this information

I understand that, per my request, this authorization will permit the above-named parties to use or disclose the identified health information for purposes beyond treatment, payment, or healthcare operations as provided by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I understand that I may revoke this authorization at any time by providing written notification to:

_____

The revocation will be effective on the date it has been received and processed by the above-named recipient. I understand that the revocation does not apply to actions taken in reliance upon this authorization prior to the effective date of revocation. I also understand that I do not have to sign this authorization in order to receive treatment, payment, or to enroll or be eligible for benefits.

Unless I request in writing otherwise, I understand that this authorization will expire on _____. If I do not specify an expiration date or event, this authorization will expire ninety (90) days from the date on which I signed this authorization.
Expiration date or event

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the named recipient, and may no longer be protected by HIPAA's privacy rules after the authorized disclosure.

Patient or Personal Representative

Signature: _____ Date: ___/___/___

Name: _____
Please Print

Relationship to Patient: _____

For Office Use Only

Received by: _____ Date: ___/___/___