TN DENTISTRY
HOSPITAL DENTISTRY AT ITS BEST

Patient Registration and Health History

Health History

*Required Fields

PLEASE CHECK YES OR NO DO NOT LEAVE BLANK

1. Has there been any changes in your general health within the past year?

- ○ Yes
- ○ No

2. Are you under the care of a physician for a current problem?

- ○ Yes
- ○ No

Nature of treatment:

Physician Name: _____

Phone: _____

3. Have you been hospitalized within the past 2 years?

- ○ Yes
- ○ No

Reason:

4. Are you taking any medications or drugs?

- ○ Yes
- ○ No

Medications

Medication Name: **Comments/Dosage:**

5. Have you received therapy for alcoholism or drug addiction during the past 2 years?

- ○ Yes
- ○ No

Please Specify

6. Have you ever had any ALLERGIC OR ADVERSE REACTIONS to anesthetics, antibiotics or other medications?

- ☐ Allergies
- ☐ Amoxicillin
- ☐ Aspirin
- ☐ AUGMENTIN
- ☐ Azethromycin
- ☐ BIAXIN
- ☐ CELEXA
- ☐ Cephalexin
- ☐ Cipro
- ☐ Codeine
- ☐ Dilantin
- ☐ DOXYCYCLINE
- ☐ Fentanyl
- ☐ Food allergies
- ☐ HADOL INJECTIONS
- ☐ IMIPRAMINE
- ☐ Insulin
- ☐ IVP DYE-IODINE
- ☐ Kempra
- ☐ Latex
- ☐ Novocain
- ☐ Nystatin
- ☐ Other
- ☐ Penicillin
- ☐ PERCOCET
- ☐ REGLAN
- ☐ Sulfa
- ☐ TEGOCOTOL
- ☐ Tramadol
- ☐ Triamcinolone

- [ ] COMPAZINE
- [ ] DEMEROL
- [ ] Depicot
- [ ] diazepam
- [ ] MADROBID
- [ ] metals
- [ ] MORPHINE
- [ ] NOVACAINE W/EPINEPHRINE
- [ ] Valium
- [ ] vicodin

7. Have you had abnormal bleeding with previous extractions, surgery, or trauma ?

- ○ Yes
- ○ No

If Yes Please Explain:

8. Have you ever had a blood transfusion?

- ○ Yes
- ○ No

Please Explain:

9. Have you ever had surgery and / or radiation for a tumor, growth or other condition?

- ○ Yes
- ○ No

Please Explain:

10. Have you ever been tested for HIV infection (AIDS)?

- ○ Yes
- ○ No

Result of test: Date:

_____

.

- ○ Negative
- ○ Positive

11. Date of last physical:

_____

Date of last dental exam:

_____

12. Do you have or have you had any of the following: (Please Check)

- ☐ ADHD/ADD
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Autism
- ☐ Cancer
- ☐ Cancer - Chemotherapy
- ☐ Colitis
- ☐ Congenital Heart Defect
- ☐ Diabetes
- ☐ Down Syndrome
- ☐ Epilepsy
- ☐ Fainting Spells
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mental disorders
- ☐ Mitral Valve
- ☐ Pacemaker
- ☐ Pre-Med needed
- ☐ Prosthetic Heart Valve
- ☐ Radiation Therapy
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ seasonal allergies
- ☐ Seizures
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Problems
- ☐ Stomach Ulcers
- ☐ Stroke
- ☐ temporalmandibular joint problems
- ☐ Thyroid Problems
- ☐ TMJ
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease

13. Do you have any disease, condition or problem not listed above?

- ○ Yes
- ○ No

Please Explain:

14. Are you required to Pre-Medicate with antibiotics prior to dental treatment?

- ○ Yes
- ○ No

If yes, did you PRE-MED for this visit? What medication was taken

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WOMEN:

15. Are you pregnant?

- Yes
- No

If yes what trimester?

_____

16. Are you nursing?

- Yes
- No

17. Do you take birth control pills? If yes, please be advised that if you take antibiotics, an alternate method of birth control must be used.

- Yes
- No

All of the above information is true to the best of my knowledge.

All fees are due on date of services rendered. Should this matter be turned over for collection, all costs, including reasonable collection fees and court costs incurred by TN Dentistry shall be done by the undersigned.

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- [ ] I hereby authorize treatment and the use of nitrous oxide, anesthesia, oral sedation and/ or other medication necessary for dental treatment.

Patient/ Guardian Signature: *

Sign

Reviewed by:

_____

Patient Information

*Required Fields

Patient First Name:*

Middle Name:

Patient Last Name:*

Sex:

- Male
- Female

Marital Status:

- Married
- Single
- Child
- Other

Other:

Social Security #:

Birth Date:*

E-mail:

Home Phone:

Work Phone:

Cell Phone:*

Address:*

City:*

State:*

Zip Code:*

If Full Time Student: Name of School:

If a new patient who may we thank for referring:

Responsible Party Information

Name:

Relationship to Patient:

Birth Date:

Address:

City:

Zip Code:

Phone (Home):

Cell:

Insurance Information

Name of Insured:

Last:

First:

MI:

is insured a patient?

- Yes
- No

Insurance Plan Name:

Ins Plan Phone #:

Subscriber's Birth Date: _____

SS #: _____

Group #: _____

Subscriber's Address: _____

Subscriber's Employer Name: _____

Occupation: _____

Patient's relationship to insured:

- ○ Self
- ○ Spouse
- ○ Child
- ○ Other

Other: _____

Secondary Insurance Information

Name of Insured:

Last: _____

First: _____

MI: _____

is insured a patient?

- ○ Yes
- ○ No

Insurance Plan Name: _____

Ins Plan Phone #: _____

Subscriber's Birth Date: _____

SS #: _____

Group #: _____

Subscriber's Address:

Subscriber's Employer Name:

Occupation:

Patient's relationship to insured:

- ○ Self
- ○ Spouse
- ○ Child
- ○ Other

Other:

Insurance card

Choose File No file chosen

Only .jpeg .jpg .png .pdf file allowed

ID

Choose File No file chosen

Only .jpeg .jpg .png .pdf file allowed

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination. In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof.

Financial Responsibility:

I further agree to pay all finance charges, collection cost, attorneys fees, and any other cost that may be incurred to enforce collection of any amount outstanding. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition. I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions of treatment and payment and agree to their content.

Signature of Patient, Parent or guardian/responsible party: *

Sign

Relationship to Patient: