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Knoxville, TN 37932

FAMILY DENTISTRY *Law*

Confidential New Patient Information

PERSONAL INFORMATION

Name:	Birth Date:	Date:

How would you like us to address you? *(nickname)* _____

Address: _____ City: _____ State: ___ Zip: _____

Daytime contact number(s): *Please check the preferred method of contact.*

☐Home _____ ☐Cell _____ ☐Work _____

☐Email _____

Marital Status: ☐Single ☐Married

Social Security Number: _____

Please provide us the name of a person you would like us to contact in the event of an emergency:

Name: _____ Phone: _____ Relationship: _____

Your occupation: _____

How did you hear about our office? Is there someone we can thank for referring you? _____

MEDICAL INFORMATION

Physician Name:	Physician's Phone:	Date of Last Exam:

PERSON RESPONSIBLE FOR ACCOUNT ☐ Same as above

Name:	Relationship to Patient:

Address: _____ City: _____ State: ___ Zip: _____

Daytime contact number(s): *Please check the preferred daytime contact number.*

☐Home _____ ☐Cell _____ ☐Work _____ ☐Email _____

Primary Insurance Information: *(please show dental card)*

Insured Name: _____

Social Security Number: _____

Insurance Company: _____

Employer: _____

Group Number: _____

Subscriber's Date of Birth: _____

Secondary Insurance Information: *(please show dental card)*

Insured Name: _____

Social Security Number: _____

Insurance Company: _____

Employer: _____

Group Number: _____

Subscriber's Date of Birth: _____

It is not always possible to predict which services are covered by insurance, or how much the plan will pay for a particular service. Patients with or without insurance are ultimately responsible for payment of their bills. I understand that payment is my obligation regardless of insurance or any other third party involvement.

Signature: _____ Date: _____

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I, _____, have recieved a copy of Law Family Dentistry's **Financial and Appointment Policy**. I have read and fully understand both.

Patient/Guardian Signature _____ Date _____

CONSENT FOR RELEASE OF PATIENT PERSONAL INFORMATION

I, _____, give my consent to the following: (check all that apply)

☐ Allow clinical information for the patient to be released to the individuals listed below.

☐ Allow account information for the patient to be released to the individuals listed below.

☐ Allow scheduling information for the patient to be released to the individuals listed below.

☐ Allow scheduling decisions to be made for the patient by the individuals listed below.

☐ Allow treatment decisions to be made for the patient by the individuals listed below.

Name _____ Relationship to Patient _____

Name _____ Relationship to Patient _____

We would like to thank you for helping us to protect your Personal Health Information. By signing below, you are stating that you are giving your conssent to have the selected above information released to the above individuals.

Patient's Name (print) Patient/Guardians Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES *You may refuse to sign this acknowledgement.

I have received a copy of this office's Notice of Privacy Practices.

Patient's Name (print) Patient/Guardians Signature Date

For Office Use Only We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices but acknowledgement could not be optained because:

☐ Communications barriers prohibited obtaining the acknowledgement ☐ Individual refused to sign

☐ An emergency situation prevented us from obtaining acknowledgement ☐ Other (specify) _____

DENTAL UPDATE

When was the last time you were seen by a dentist? _____ Were dental radiographs taken? ☐YES ☐NO

How many times a day do you brush? _____ How many times a day do you floss? _____

Please list any other hygiene products you use regularly (mouthrinse, tongue scraper, fluoride rinse): _____

Have you ever been told that you have a gum or periodontal problem? ☐YES ☐NO If yes, please describe: _____

Do you have any sores or growths in or around your mouth? ☐YES ☐NO If yes, please describe: _____

Do you clench your teeth? ☐YES ☐NO Do you grind your teeth? ☐YES ☐NO

Do you have pain in your jaw joints (TMJ)? ☐YES ☐NO Do you suffer from dry mouth? ☐YES ☐NO

Have you ever worn any type of appliance or nightguard? ☐YES ☐NO Do you experience excessive snoring or sleep apnea? ☐YES ☐NO

Describe any difficulties you may experience when chewing *(e.g. food caught between teeth)*: _____

Do you feel nervous about having dental treatment? ☐YES ☐NO

Have you ever bleached your teeth? ☐YES ☐NO Are you interested in doing so? ☐YES ☐NO

Are you happy with your smile? ☐YES ☐NO If no, please describe why: _____

CONSENT TO TREATMENT

I authorize treatment of the person named above by Law Family Dentistry, PLLC. I am responsible for informing the doctors about any changes in the health history provided prior to treatment. I understand that this medical history information will be used as necessary for diagnosis and treatment by Law Family Dentistry, PLLC.

Signature _____ Date _____