Dentistry of Chattanooga

Thank you for choosing our office to assist you with your dental needs.
Please fill out the information below and don't forget to provide your signature at the end.

Patient's name_____Date of Birth _____

Sex:_____ Marital Status: Single ☐ Married ☐ Other ☐ Your SS#_____

If minor, name of legal guardian_____

Home phone_____Mobile phone_____Work phone_____

Email address_____

Mailing address_____City_____State_____Zip_____

Employer_____

Emergency Contact (name/telephone number)_____

INSURANCE INFORMATION: ❑ Not covered by dental insurance
Member ID#_____Dental Insurance Co_____

Group number_____Claims Address_____

Covered by spouse's insurance? ❑ yes ❑ no Spouse's Name _____

Spouse's dental insurance company_____Group number _____

Spouse's birthday_____SS# or Member ID# _____

MEDICAL HEALTH HISTORY

Do you have, or have you had any of the following? (Please check any that apply)

- ❑ **Are you required to Pre-medicate before any dental treatment?**
- ❑ Glaucoma
- ❑ Blood Problems (Anemia)
- ❑ Blood transfusion
- ❑ Heart problems:_____
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Pacemaker
- ❑ Stroke
- ❑ Nervous Disorders
- ❑ Artificial Bones, Joints, or Valves
- ❑ High or low blood pressure (circle one)
- ❑ Tuberculosis or other lung problems
- ❑ Kidney disease
- ❑ Hepatitis, jaundice or other liver disease
- ❑ Diabetes TYPE 1 or TYPE 2
- ❑ Epilepsy or Neurological disorders
- ❑ Thyroid problems
- ❑ Arthritis
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Cancer/ Tumor
- ❑ Radiation or Chemotherapy
- ❑ Abnormal bleeding after any surgery
- ❑ Headaches or Migraines
- ❑ Sinus/ Allergies
- ❑ Asthma
- ❑ Smoke, tobacco use or vape
- ❑ **Other**:_____
  _____

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Latex
- ❑ Penicillin
- ❑ Local anesthetics
- ❑ Codeine
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ **Other**:_____

Are you taking any of the following?

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners e.g. Coumadin)
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Insulin other diabetes drugs
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medicine
- ❑ Natural supplements
- ❑ other:_____

Please List Medications or provide list:

_____
_____
_____

Name of your physician and phone number:

_____

Women:

- ❑ Are your pregnant or plan to become pregnant
- ❑ Taking hormones or contraceptives

Signature of patient (or parent)_____**Date**_____

Dentistry of Chattanooga

DENTAL OFFICE FINANCIAL AGREEMENT

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require that you read and sign prior to any treatment.

General:
Understand that regardless of any insurance status, you are responsible for the balance due on your account. You are responsible for any and all professional services rendered.

INSURANCE:
Please remember your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy to you, our office provides certain services to assist you. It is physically impossible for us to have knowledge and keep track of every aspect of your insurance. **It is up to you to contact your insurance company and inquire as to what benefits your employer has purchased for you.** If you have any questions concerning estimates and/or fees for service, it is your responsibility to have these answered prior to treatment to minimize any confusion on your behalf.

Please be aware some or perhaps all of the services provided may or may not be covered by your insurance policy. Any balance is your responsibility whether or not your insurance company pays any portion.

Understand that you are responsible for all cost not paid by your insurance company within 60 days of the insurance claims submittals.

PAYMENT:
FULL PAYMENT is due at the time of service when insurance is not involved.
If insurance benefits apply, **ESTIMATED PAYEMENTS** are due at the time of service, unless other arrangements are made.

We accept payment as indicated below:

Cash or check
Visa, MasterCard, Discover, American Express
Care Credit
Health Savings Accounts

I have read, understand and agree to the terms and conditions of this Financial Agreement.
I acknowledge by my signature below that I understand the charge incurred for any services rendered in this office is my sole responsibility, and I agree by this signature that should I default in payment of my obligation and this note is placed in the hands of an attorney for collection that all collection fees, cost and all other expenses will be paid by the undersigned. All parties here on whether maker or endorser, each for himself, waives notice of dishonor, demand, and protest, and consents to any extension of time the holder may grant. All exemptions are waived.

Signature:_____ **Date:**_____

Dentistry of Chattanooga

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement*

I, (print name)_____have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

The following person(s) have my permission to pick up any records, or receive any information about my dental health:

_____

_____

_____

Below for office use only:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign

Communications barriers prohibited obtaining the acknowledgement An emergency situation prevented us from obtaining acknowledgement

Other (Please Specify)