Patient Registration

Patient First Name: _____ Last Name: _____

Preferred Name: _____ DOB: _____ SS#: _____

Address: _____ Apt #_____

City, State, Zip: _____

Cell Phone: _____ Work Phone: _____ Home Phone:_____

Email Address: _____ May we email you? _____

How did you hear about our office? _____

Marital Status (Circle): Married Single Widowed Divorced

Work Status (Circle): Full Time Part Time Student Retired Unemployed

Emergency Contact: _____ Phone:_____

Relationship:_____

Responsible Party (if someone other than patient)

Full Name: _____ Relation to Patient: _____

DOB: _____ SS#: _____

Address: _____ Apt #_____

City, State, Zip: _____

Cell Phone: _____ Work Phone: _____ Home Phone:_____

Dental Insurance

Policy Holder Information

Policy Holder Name: _____ DOB: _____

SS#: _____ Relation to Patient: _____

Insurance Company:_____ Employer:_____

Subscriber/Policy ID (may be SS#):_____ Group #: _____

Please let our front desk team know if you have secondary insurance.

Medical History Form/Consent Form

Disclaimer: 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.

Have you been seen by a primary care physician in the last 2 years?	YES	NO
Are you taking any medications?	YES	NO
Do you have diabetes? If yes, what was your last HgbA1C_____	YES	NO
Do you have or are being treated for high blood pressure?	YES	NO
Are you pregnant or trying to get pregnant?	YES	NO

Are you allergic to any of the following? Please circle any that apply.

Aspirin	Penicillin	Codeine	Metal/Titanium
Latex	Sulfa Drugs	Local Anesthetics	Other?_____

Please circle any of the following conditions that apply to your Past Medical History.

Infectious Endocarditis	Cardiac Transplant	Congenital Heart Disease Repair
Artificial Heart Valves	Joint Replacement	If Yes to any, What year?_____

Do you have any autoimmune disorders? Please circle any that apply.

Sjogren Syndrome	Systemic Lupus	Scleroderma	Rheumatoid Arthritis

Have you ever taken any of the following medications?

Fosamax	Actonel	Boniva	Reclast	Zometa

Do you take an anticoagulant? Please circle any that apply.

Warfarin(Coumadin)	Aspirin	Plavix	Pradaxa
Xarelto	Eliquis	Other_____	

Have you ever been treated with any of the following?

Glucocorticoids	Cyclosporin	Tamoxifen	Aromatase Inhibitors

Please Circle any that apply to your Health History.

Hospitalized in past 5 years	Chest pain/Angina	Heart Attack	Stroke
Congestive Heart Failure	Thyroid Disease	Hyperparathyroid	Dry Mouth
COPD	Asthma	IBD	Stomach Ulcers
Liver Problems	Osteoporosis	Osteomyelitis	Fibrous Dysplasia
Paget Disease	Tobacco Use	Alcohol Use	Radiation Therapy
Psychological Problems	Bruxism		

Please Circle any that apply to your Health History.

AIDS/HIV Positive	Alzheimer's	Drug Addiction	Hepatitis A,B, or C
Epilepsy or Seizure	High Cholesterol	Shingles	Hypoglycemia
Kidney Problems	Frequent Headaches	Low Blood Pressure	Glaucoma
Chemotherapy	Cold Sores/Fever	Tumor or Growths	Heart Pacemaker

Have you had any other serious illness or condition that your dentist may need to know about?_____

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. I certify that I have read and understand the above information to the best of my knowledge. The questions have been accurately answered. I release any information, including diagnosis and records of any treatment or examination to the third party payers and/or health practitioners involved in my care.

Signature of Patient, Parent or Guardian: Date:

X_____ _____

Preference Form

Name _____

How did you hear about us? (Please circle the best answer)

Insurance | Online/Website | Mailer | Sign | Specialist

Friend/Colleague/Family Member Name: _____

On a scale of 1-10 where would you place yourself: (1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10)

1 → "I'll wait until it breaks or hurts, then try and fix it"

10 → "I'm proactive, my teeth are a high priority to me, I would be very upset to lose any!"

On a scale of 1-10 where would you place yourself: (1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10)

1 → "Just give me the bottom line, what do I need and how much does it cost"

10 → "I appreciate lots of information and education regarding my options"

Dental History (Check any conditions that apply to you)

Grinding/Clenching of teeth	Periodontal/Gum Disease
Bleeding Gums	Sores/Swelling/lumps in mouth
Pain when biting	History of Trauma to face and/or mouth
Pain drinking hot or cold liquids	Bad Breath
Clicking or Popping of Jaw	Cigarette, Pipe, Cigar Smoking
Loose teeth	Smokeless tobacco
Food getting stuck between teeth	Bad Dental Experiences

I am interested in….

- ❑ Dental Implants
- ❑ Teeth Whitening
- ❑ Crowns or Veneers
- ❑ Bridges
- ❑ Dentures
- ❑ Orthodontic treatment
- ❑ Smile Consult

CRA (Caries Risk Assessment) RISK FACTORS → Answered by Patient:

1. Do you notice plaque buildup on your teeth between brushings? Yes / No
2. Do you feel you have a dry mouth at any time during the day or at night? Yes / No
3. Do you drink liquids other than water more than 2 times daily between meals? Yes / No
4. Do you snack daily between meals? Yes / No
5. Do you have oral appliances present? Yes / No
6. Do any of these other health concerns apply to you? (circle all that apply)
    a. Frequent Tobacco Use Yes / No
    b. Acid Reflux Yes / No
    c. Diabetes Yes / No
    d. Head/Neck Radiation Therapy Yes / No
    e. Other Drug Use Yes / No
    f. Bulimia Yes / No
    g. Sjogren's Syndrome Yes / No

----------DISEASE INDICATORS → **Answered by Doctor**----------

New/Progressing Visible Cavitations Yes / No

New/Progressing Approximal Radiographic Radiolucencies Yes / No

New/Active White Spot Lesions Yes / No

Decay history is a concern: Yes / No

Caries Risk: Low — Med — High — Extreme

Doctor's Recommendations:

Fl Varnish 2x/year | MI Paste 2-3x/week | Custom Trays for MI Paste | Chlorhexidine Rinse

DAVIS FAMILY DENTAL CARE
7003 Shallowford Road, Suite 101
Chattanooga, TN 37421

OFFICE POLICY

Davis Family Dental Care's goal is to help you achieve optimal dental health, comfort, function and esthetics. We believe that a cooperative effort between you and our office will result in a dental service that we are proud to render and you are pleased to receive. We want to be able to meet your needs in a way that adds significant value to your life.

Payment is due at the time treatment is rendered. We offer the following payment options:

1. Cash or check.
2. We accept VISA, MasterCard, Discover & American Express.
3. Other financing options may be available upon credit approval. If you have questions regarding this form of payment please let us know.

Our office is happy to cooperate with patients who are covered by dental insurance by completing all forms pertaining to your claims, at no charge to you, and assisting you in receiving the maximum benefit to which you are entitled. Your policy is a contract between you and your insurance company, which dictates your coverage. We are not a party to that contract. We work for you, not your insurance company. Dental insurance benefits are an aid provided by your employer, not meant to cover 100% of all treatment required. Treatment that we recommend for you is not dictated by your insurance coverage.

For patients with insurance, we make every effort to inform you of your portion of the copayment at the time treatment is rendered. For all diagnostic testing and services rendered, we will attempt to bill your insurance, but you may be responsible for any unpaid amount or denial by your insurance company. The amount we ask to you pay at the time of service is based on an estimate of what the insurance coverage will be. Please keep in mind that this is only an estimate. You will receive an Explanation of Benefit from your insurance company when we receive payment or nonpayment for services rendered. At that point if payment has not been received in full you can expect to receive a statement from Davis Family Dental Care. If two statements are sent without payment received, the account may be sent to a Collection Agency. The patient is responsible for the balance and the collection costs.

Appointment Cancellations: Patients are asked to notify the office 48-hours in advance if they are unable to attend their scheduled appointment. A $75 cancellation or no show fee will be applied per hour for any failed appointments or cancellations less than 24 hours in advance. This fee is not billable to insurance and is required to be paid prior to future appointments being scheduled.

I have read and understand Davis Family Dental Care's office policies.

_____ _____

Patient Name Date

_____ _____

Patient Signature Relationship to Patient

General Consent for Care and Treatment
& Photography Release

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended treatment or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended.

This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s). This consent provides us with your permission to perform reasonable and necessary dental examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your dentist about the purpose, potential risks and benefits of any diagnostic service provided to you. If you have any concerns regarding any test or treatment recommended by your healthcare provider, we encourage you to ask questions.

I voluntarily request that Dr. Davis and any hygienist providing services for him perform reasonable and necessary dental examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I understand that the photographs, slides, and/or videos will be used as a record of my care, and may be used for educational purposes in study club meetings, lectures, seminars, demonstrations, professional publications (journals, magazines, website) or as marketing materials.

I, hereby authorize Dr. Joel A. Davis or his assistants to take photographs, slides, and/or videos of my face, jaws, mouth, and teeth. I further understand that if the photographs, slides, and/or videos are used in any publication or as a part of a demonstration, my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents. If I prefer for my images only to be used in office and for the continuation of my care, I will indicate it by initialing accordingly below.

Patient Name: _____Date:_____

Patient Signature:_____Please initial below accordingly.

_____ I consent to my images being used for purpose mentioned above at the discretion of Davis Family Dental Care.

_____I DO NOT consent to my images being used for purposes other than my treatment and diagnosis.

Davis Family Dental Care

Privacy Is Important to Us

Acknowledgement of Receipt of Notice of Privacy Policies

I received a copy/a copy of the Notice of Privacy Practices for Davis Family Dental Care has been made available to me. I hereby authorize, as indicated by my signature below, Davis Family Dental Care, to use and to disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent form.

_____ _____

Print Name Address

_____ _____

Signature Date

Please check your preferred means of communication:

□ You may contact me at my home telephone number: _____
□ You may contact me on my mobile telephone number: _____
□ You may contact me on my work telephone number: _____
□ You may send me an email at: _____
□ Other: _____

Please list authorized persons with whom we may discuss your Protected Health Information (PHI). Please notify us if you desire to remove a name from this list in the future.

1. _____ Relationship: _____ Date ___/___/____ added/removed

2. _____ Relationship: _____ Date ___/___/____ added/removed

3. _____ Relationship: _____ Date ___/___/____ added/removed

****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
□ Communication barriers prohibited obtaining the acknowledgement
□ An emergency situation prevented us from obtaining the acknowledgement
□ Other (Please Specify): _____
Staff Person Initials: _____