Patient Registration

First name:_____ Middle initial:_____ Last name:_____

Preferred name:_____ Date of Birth:_____ Soc Sec# :_____

Circle One: Male or Female Circle One: Married Single Divorced Widowed Minor

Address:_____

City: _____ State:_____ Zip:_____

Name of Current Employer: _____

Driver License # and State: _____

Home #:_____ Work #:_____ Ext:_____ Cell #:_____

By checking one of these boxes below, you are giving our dental office permission to send appointment reminders, information about treatment, payment information, insurance information, account information and other communications. Please tell us how you would like us to communicate with you.

check all that apply: ☐ Call me

☐ Text me

☐ Call me and Text me

☐ Contact me by US Mail at the address listed above

☐ Contact me by email at the following email address

E-Mail Address:_____

☐ I wish not be contacted for any of the above

Signature:_____ Date:_____

Responsible Party Information: * *To be completed only if Patient is a minor******

Full Name: _____ Date of Birth:_____

Address: _____ City: _____ St:_____ Zip:_____

Dental Insurance Information

Name of Insured:_____ Relationship to Patient:_____

Insured Soc Sec #:_____ Insured Date of Birth:_____

Employer:_____ Ins. Company:_____

Subscriber ID #:_____ Group #:_____

MEDICAL HISTORY

PATIENT NAME_____ **BIRTH DATE**_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems or medication could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? □ Yes If yes, please explain:_____
Have you ever been hospitalized or had a major operation? □ Yes If yes, please explain:_____
Have you ever had a serious head or neck injury? □ Yes If yes, please explain:_____
Are you taking any medication, pills, or drugs? □ Yes If yes, Please List: _____

Do you take, or have you taken, Phen-Fen or Redux? □ Yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? □ Yes
Are you on a special diet? □ Yes
Do you use tobacco? □ Yes
Do you use controlled substances? □ Yes

Women Only: are you

Pregnant & how many weeks? Yes _____ Nursing? Yes Trying to get Pregnant? Yes Taking oral contraceptives? Yes

Are you Allergic to any of the following?

□ Aspirin □ Penicillin □ Codeine □ Local Anesthetics □ Acrylic □ Metal □ Latex □Sulfa Drugs
□ Other if yes, please explain:_____

Do you have, or have you had, any of the following?

AIDS/HIV positive	□ YES	Cortisone Medicine	□ YES	Hemophilia	□ YES	Radiation	□ YES
Alzheimer's Disease	□ YES	Diabetes	□ YES	Hepatitis A	□ YES	Weight Loss	□ YES
Anaphylaxis	□ YES	Drug Addiction	□ YES	Hepatitis B or C	□ YES	Renal Dialysis	□ YES
Anemia	□ YES	Easily Winded	□ YES	Herpes	□ YES	Rheumatic fever	□ YES
Angina	□ YES	Emphysema	□ YES	High blood pressure	□ YES	Rheumatism	□ YES
Arthritis/Gout	□ YES	Epilepsy/Seizures	□ YES	High Cholesterol	□ YES	Scarlet Fever	□ YES
Artificial Heart Valve	□ YES	Excessive Bleeding	□ YES	Hives or Rash	□ YES	Shingles	□ YES
Artificial Joint	□ YES	Excessive Thirst	□ YES	Hypoglycemia	□ YES	Sickle cell disease	□ YES
Asthma	□ YES	Fainting/Dizziness	□ YES	Irregular Heartbeat	□ YES	Sinus Trouble	□ YES
Blood Disease	□ YES	Frequent Cough	□ YES	Kidney Problems	□ YES	Spina Bifida	□ YES
Blood Transfusion	□ YES	Frequent Diarrhea	□ YES	Leukemia	□ YES	Stomach disease	□ YES
Breathing Problem	□ YES	Frequent Headaches	□ YES	Liver Disease	□ YES	Stroke	□ YES
Bruise Easily	□ YES	Genital Herpes	□ YES	Low blood pressure	□ YES	Swelling of limbs	□ YES
Cancer	□ YES	Glaucoma	□ YES	Lung Disease	□ YES	Thyroid disease	□ YES
Chemotherapy	□ YES	Hay Fever	□ YES	Mitral valve prolapse	□ YES	Tonsillitis	□ YES
Chest Pains	□ YES	Heart Attack/Failure	□ YES	Osteoporosis	□ YES	Tuberculosis	□ YES
Cold Sores/fever blister	□ YES	Heart Murmur	□ YES	Pain in jaw joints	□ YES	Tumors or Growths	□ YES
Congenital heart disorder	□ YES	Heart Pacemaker	□ YES	Parathyroid disease	□ YES	Ulcers	□ YES
Convulsions	□ YES	Heart Disease	□ YES	Psychiatric Care	□ YES	Venereal disease	□ YES

Have you ever had any serious illness not listed above?_____

Comments?_____

To the best of my knowledge, the questions on this form have been accurately answered. 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 my medical status.

Signature of patient, parent or guardian:_____ **Date:**_____

Tedford Family Dentistry

S. Keith Tedford, DMD
9380 Bradmore Lane, Suite 108
Ooltewah, TN 37363

Name:

_____ Date: _____

Whom may we thank for referring you? _____

Past Dental History

	Yes	No	Please Explain
Do you have any known problems at this time?	O	O	
Are any of your teeth sensitive to hot, cold, biting pressure, or sweets?	O	O	
Do your gums bleed when you floss?	O	O	
Have you ever been told you have periodontal disease?	O	O	
Are there any areas in your mouth you avoid chewing on?	O	O	
Do your joints (TMJ) click, pop, or cause pain?	O	O	
Are you aware of any night time grinding or clenching?	O	O	
Do your teeth show any signs of chipping or wear?	O	O	
Have you had any routine x-rays in the past year?	O	O	
Have you had your wisdom teeth removed?	O	O	
Are you missing any other teeth?	O	O	
Do you have a replacement for any missing teeth?	O	O	
Have you ever had braces?	O	O	

How often do you brush your teeth? _____

What type of toothpaste and/or mouthwash do you use? _____

Tedford Family Dentistry
9380 Bradmore Lane, Suite 108
Ooltewah, TN 37363
Financial Policy, Informed Consent, Receipt of HIPPA

1) Payment is due at the time services are provided. Our office accepts cash, checks, MasterCard, Visa, and upon approval, Care Credit. Future appointments will not be scheduled until your account is current.

2) As a courtesy, we will file your primary insurance claims. We do not file secondary insurance.

3) All incurred charges are ultimately your responsibility, regardless of insurance coverage. We must emphasize that as a dental care provider, our relationship is with you, our patient, and not with your insurance company. Please also be advised your insurance will only pay what they consider reasonable charges, meaning our fees may be higher than what your insurance will pay. You will be responsible for the difference in our fees and what insurance pays.

4) I authorize Dr. Tedford to perform any necessary dental services (i.e. x-rays, study models, photographs, or other diagnostic aids) deemed appropriate by him to make a thorough diagnosis. I also authorize the doctor to perform any and all forms of treatment, medication, and therapy in connection with my diagnosis and treatment.

5) There is a $35 returned check fee.

6) A $50 fee will be added to your account if the account is sent to a collections agency.

7) If the patient is a minor, payment is due from the person bringing the child at the time services are rendered.

Receipt of the Notice of Privacy Practices

I, the undersigned, have read the above policies and understand they apply to every patient at Tedford Family Dentistry. I also acknowledge that I read and/or received a copy of the Notice of Privacy Practices.

Signature_____ Date_____

Print Name_____