First Name:_____ MI:_____ 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:_____

Home# _____ Cell #_____ Work # _____

Name of Current Employer : _____

Driver License # and State: _____

By Checking that boxes the apply, you are giving Tedford Family Dentistry 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 ◯ Text Best number to call: ◯ Cell ◯ Home ◯ Work

◯ I wish not to be contacted for any of the above.

We cannot discuss your health information with anyone other than yourself unless you authorize us to do so. Please list below names of the individuals you authorize our office to discuss care with.

Name _____ Relationship _____ Phone_____

Name _____ Relationship _____ Phone_____

Signature: _____ Date: _____

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

Full Name:_____ Date of Birth:_____

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

Phone number:_____

Dental Insurance Information:

Name of Insured:_____ Relationship to patient:_____

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

Employer:_____

Insurance Company:_____

Subscriber/Member ID/Policy #:_____ _____ Group#:_____

Name: _____ Date: _____

*Whom may we thank for referring you?*_____

Please explain all that apply

Approximate date of your last dental visit? _____

Have you had any routine dental x-rays in the past year? **Yes / No** _____

Do you have any know dental problems at this time? **Yes / No** _____

Are any of your teeth sensitive to hot, cold, biting pressure or sweets? **Yes / No** _____

Do your gums bleed when you floss? **Yes / No** _____

Have you ever been told you have periodontal disease? **Yes / No** _____

Are there any areas in your mouth you avoid chewing on? **Yes / No** _____

Do your joints (TMJ) click, pop or cause pain? **Yes / No** _____

Are you aware of any night time grinding or clenching? **Yes / No** _____

Do your teeth show any signs of chipping or wear? **Yes / No** _____

Have you had your wisdom teeth removed? **Yes / No** _____

Are you missing any other teeth? **Yes / No** _____

Do you have a replacement for any missing teeth? **Yes / No** _____

Have you ever had braces? When & Where? **Yes / No** _____

How often do you brush your teeth? _____

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

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.

Are you under a physician's care now? Just routine or □ No □ Yes – Please explain: _____

Have you ever been hospitalized or had a major operation? □ No □ Yes - Please explain:_____

Are you taking any medications, pills or drugs? □ No □ Yes - Please explain: _____

Have you ever had a serious head or neck injury? □ No □ Yes - Please explain: _____

Do you or have you ever taken Fosamax, Boniva, Actonel or other medications containing bisphosphonates? □ No □ Yes

Are you on a special diet? □ No □ Yes – please explain: _____

Do you use tobacco? □ No □ Yes – please explain:_____

Do you use controlled substances? □ No □ Yes – please explain:_____

Women Only : are you

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

Acid Reflux	□ Yes	Convulsions	□ Yes	Hemophilia	□ Yes	Radiation	□ Yes
AIDS/HIV positive	□ Yes	Cortisone medication	□ Yes	Hepatitis A	□ Yes	Weight loss	□ Yes
Alzheimer's	□ Yes	Diabetes	□ Yes	Hepatitis B or C	□ Yes	Renal dialysis	□ Yes
Anaphylaxis	□ Yes	Drug Addiction	□ Yes	Herpes	□ Yes	Rheumatic fever	□ Yes
Anemia	□ Yes	Easily Winded	□ Yes	High blood pressure	□ Yes	Rheumatism	□ Yes
Angina	□ Yes	Emphysema	□ Yes	High cholesterol	□ Yes	Scarlet fever	□ Yes
Arthritis/Gout	□ Yes	Epilepsy/Seizures	□ Yes	Hives or Rash	□ Yes	Shingles	□ Yes
Artificial Heart Valve	□ Yes	Excessive bleeding	□ Yes	Hypoglycemia	□ Yes	Sickle cell disease	□ Yes
Artificial Joint	□ Yes	Excessive thirst	□ Yes	Irregular heartbeat	□ Yes	Sinus trouble	□ Yes
Asthma	□ Yes	Fainting/Dizziness	□ Yes	Kidney problems	□ Yes	Spina Bifida	□ Yes
Blood disease	□ Yes	Frequent cough	□ Yes	Leukemia	□ Yes	Stomach disease	□ Yes
Blood transfusion	□ Yes	Frequent diarrhea	□ Yes	Liver disease	□ Yes	Stroke	□ Yes
Breathing problems	□ Yes	Frequent headaches	□ Yes	Low blood pressure	□ Yes	Swelling of limbs	□ Yes
Bruise easily	□ Yes	Genital herpes	□ Yes	Lung disease	□ Yes	Thyroid problems	□ Yes
Cancer	□ Yes	Hay fever	□ Yes	Mitral valve prolapse	□ Yes	Tonsillitis	□ Yes
Chemotherapy	□ Yes	Heart attack/failure	□ Yes	Osteoporosis	□ Yes	Tuberculosis	□ Yes
Chest pains	□ Yes	Heart murmur	□ Yes	Pain in jaw joints	□ Yes	Tumors or growths	□ Yes
Cold sores/fever blister	□ Yes	Heart pacemaker	□ Yes	Parathyroid disease	□ Yes	Ulcers	□ Yes
Congenital heart disorder	□ Yes	Heart disease	□ Yes	Psychiatric care	□ Yes	Venereal disease	□ Yes

Have you ever had any serious illness not listed above or 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:**_____

(PLEASE CONTINUE ON BACK)

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 insurance claims.

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 fee may be higher than what your insurance will pay. You will be responsible for the difference in our fees and what your 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 that 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 is sent to a collections agency.

7) If the patients is a minor, payments 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: _____