Welcome

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Patient # ______
SS#/SIN ______
Date ______

Patient Information (CONFIDENTIAL)

Name ______ Birthdate ______ Home Phone ______
Address ______ City ______ State/Prov. ______ Zip/P.C. ______
Email ______ Cell Phone ______
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
If Student, Name of School/College ______ City ______ State/Prov. ______ ☐ Full Time ☐ Part Time
Patient or Parent/Guardian's Employer ______ Work Phone ______
Business Address ______ City ______ State/Prov. ______ Zip/P.C. ______
Spouse or Parent/Guardian's Name ______ Employer ______ Work Phone ______
Whom may we thank for referring you? ______
Person to contact in case of emergency ______ Phone ______

Responsible Party

Name of Person Responsible for this Account ______ Relationship to Patient ______
Address ______ Home Phone ______
Email ______ Cell Phone ______
Driver's License# ______ Birthdate ______ Financial Institution ______
Employer ______ Work Phone ______ SS#/SIN ______
Is this person currently a patient in our office? ☐ Yes ☐ No
For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.
☐ Cash ☐ Personal Check Credit Card ☐ VISA ☐ MasterCard ☐ I wish to discuss the office's payment policy.

Insurance Information

Name of Insured ______ Relationship to Patient ______
Birthdate ______ SS#/SIN ______ Date Employed ______
Name of Employer ______ Union or Local# ______ Work Phone ______
Address of Employer ______ City ______ State/Prov. ______ Zip/P.C. ______
Insurance Company ______ Group# ______ Policy/ID# ______
Ins. Co. Address ______ City ______ State/Prov. ______ Zip/P.C. ______
How much is your deductible? ______ How much have you used? ______ Max. annual benefit ______

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING:

Name of Insured ______ Relationship to Patient ______
Birthdate ______ SS#/SIN ______ Date Employed ______
Name of Employer ______ Union or Local# ______ Work Phone ______
Address of Employer ______ City ______ State/Prov. ______ Zip/P.C. ______
Insurance Company ______ Group# ______ Policy/ID# ______
Ins. Co. Address ______ City ______ State/Prov. ______ Zip/P.C. ______
How much is your deductible? ______ How much have you used? ______ Max. annual benefit ______

Over Please

Patient Medical History

Physician ______________________ Office Phone ______________________ Date of Last Exam ______________

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	☐	☐
If yes, please explain ______________________		
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐
If yes, what medication(s) are you taking? ______________________		
4. Have you ever taken Fen-Phen/Redux?	☐	☐
5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?	☐	☐
6. Have you taken Viagra, Revati, Cialis or Levitra in the last 24 hours?	☐	☐
7. Do you use tobacco?	☐	☐
8. Do you use controlled substances?	☐	☐
10. Are you wearing contact lenses?	☐	☐
11. Are you allergic to or have you had any reactions to the following?		
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other (please list) ______________________		
12. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	☐	☐
13. Women Only:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

9. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever / Allergies	☐	☐
Fainting / Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy / Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble	☐	☐
Kidney Diseases	☐	☐	Hepatitis / Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Mitral Valve Prolapse	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles / Ulcers	☐	☐	Other ______	☐	☐

Patient Dental History

Name of Previous Dentist and Location ______________________ Date of Last Exam ______________

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials?	☐	☐
If yes, date of placement ______________		
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16. Do you like your smile?	☐	☐

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

X ____

Signature of patient (or parent/guardian if minor) Date

Doctor's Comments ____

____

Signature ______________________ Date ______________

ROAN MOUNTAIN DENTAL CENTER
7996 HWY 19E SUITE 6
P.O. BOX 410
ROAN MOUNTAIN, TN 37687

We are committed to providing you with the best possible care. If you have dental insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

Payment for services is due at the times services are rendered. We accept cash, checks and most major credit cards (Master Card, Visa and Discover). We will be happy to help you process your insurance for reimbursement. A copy of your insurance card must accompany any such request at the first visit.

Returned checks and balances older than 30 days may be subject to additional collection fees and interest charges of 1.5% per month. **A $20.00 CHARGE WILL BE ASSESSED FOR BROKEN APPOINTMENTS AND APPOINTMENTS CANCELLED WITHOUT A 24 HOUR ADVANCE NOTICE.**

We will gladly discuss your proposed treatment and answer any questions relating to your insurance:

You must realize however, that

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier.
3. Not all services are a covered benefit in all contracts. Some insurance arbitrarily select certain services they will not cover.

We must emphasize that as dental care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility for the date the services are rendered. **IF YOUR BILL IS NOT PAID WITHIN 90 DAYS OF SERVICE, WE WILL HAVE NO CHOICE BUT TO TURN YOUR ACCOUNT OVER TO A COLLECTION AGENCY. AN ADDITIONAL 50% WILL BE ADDED TO YOUR BILL FOR FINANCE CHARGES AND TO COVER THE COST OF THE AGENCY.** We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

I WILL PAY TODAY BY CASH___CHECK__CREDIT OR DEBIT CARD ___

I understand and agree that, (regardless of my insurance status); I am ultimately responsible to the balance on my account for any professional services rendered. I have read all of the information above and understand it fully.

____ Date____________________
SIGNATURE

____ Date____________________
PARENT (If Minor)

ROAN MOUNTAIN DENTAL CENTER

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I ______________________________ am aware of this
Patient Name
office's Notice of Privacy Practices.

____

Please Print Name

____

Signature

____

Date