Sequatchie Valley Dental Associates, PC - FAMILY DENTISTRY

Chart # _____
FOR OFFICE USE ONLY

PATIENT INFORMATION

Patient Name: _____ Date: _____
LAST FIRST MI

☐ Male ☐ Female ☐ Married Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext. _____ Best time to call: _____

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Anytime ☐ M ☐ T ☐ W ☐ Tr ☐ F ☐ S

Address: _____
STREET APARTMENT #

_____
CITY STATE ZIP CODE

HEALTH INFORMATION

Date of last dental visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

- ☐ **AIDS**
- ☐ **Allergies** _____ _____
- ☐ **Anemia**
- ☐ **Arthritis**
- ☐ **Artificial Joints**
- ☐ **Asthma**
- ☐ **Blood Disease**
- ☐ **Cancer**
- ☐ **Diabetes**
- ☐ **Dizziness**
- ☐ **Epilepsy**
- ☐ **Excessive Bleeding**
- ☐ **Fainting**
- ☐ **Glaucoma**
- ☐ **Growths**
- ☐ **Hay Fever**
- ☐ **Head Injuries**
- ☐ **Heart Disease**
- ☐ **Heart Murmur**
- ☐ **Hepatitis**
- ☐ **High Blood Pressure**
- ☐ **Jaundice**
- ☐ **Kidney Disease**
- ☐ **Liver Disease**
- ☐ **Mental Disorders**
- ☐ **Nervous Disorders**
- ☐ **Pacemaker**
- ☐ **Pregnancy**
  Due Date: _____
- ☐ **Radiation Treatment**
- ☐ **Respiratory Problems**
- ☐ **Rheumatic Fever**
- ☐ **Rheumatism**
- ☐ **Sinus Problems**
- ☐ **Stomach Problems**
- ☐ **Stroke**
- ☐ **Tuberculosis**
- ☐ **Tumors**
- ☐ **Ulcers**
- ☐ **Venereal Disease**
- ☐ **Codeine Allergy**
- ☐ **Penicillin Allergy**
- ☐ **OTHER:**

Medications allergic to:

_____
_____
_____
_____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you presently under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
  Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

Emergency Contact: Name _____ **Phone #** _____

List any medication(s) you are currently taking: _____

_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
SIGNATURE OF PATIENT, PARENT OR GUARDIAN

Sequatchie Valley Dental Associates, PC - FAMILY DENTISTRY

SPOUSE OR RESPONSIBLE PARTY INFORMATION

The following is for: ☐ the patient's spouse ☐ the person responsible for my payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
STREET APARTMENT #

_____
CITY STATE ZIP CODE

EMPLOYMENT INFORMATION

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
STREET CITY STATE ZIP CODE

INSURANCE INFORMATION

Primary

Name of Insured: _____ is an insured patient? ☐ Yes ☐ No
LAST FIRST MI

Insured's Birth Date: _____ ID#: _____ Group #: _____

Insured's Address: _____
STREET CITY STATE ZIP CODE

Insured's Employer Name: _____

Address: _____
STREET CITY STATE ZIP CODE

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Secondary Insurance: _____ Insured's Name: _____

SS#: _____ Place of employment: _____

CONSENT FOR SERVICES

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A Service charge of 1 ½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay in the event of default, all cost of collection, including court costs, and reasonable attorney's fees incurred in the collection of this account.

I grant my permission to you or your assignee to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to patient: _____
SIGNATURE OF PATIENT, PARENT OR GUARDIAN

Sequatchie Valley Dental Associates, PC
PERSONAL DENTAL PROFILE

What dental problems have you had in the past?

_____

_____

What has been your experience with dentistry in the past?

_____

_____

Why did you change from your last dental office?

_____

_____

Do your gums bleed? ☐ Yes ☐ No

Do you feel you have bad breath? ☐ Yes ☐ No

Do you wish your teeth were whiter? ☐ Yes ☐ No

Do you like the way your teeth are shaped? ☐ Yes ☐ No

Are you pleased with the appearance of your smile? ☐ Yes ☐ No

On a scale from 1-10, how would you rate your apprehension with dental visits?
(10 being very nervous) _____

On a scale from 1-10, how important is it for you to keep your teeth for a lifetime?
(10 being very important) _____

What expectations do you have for your oral health in the future and how will you achieve these objectives?

_____

_____

_____

_____