JOHNSON CITY SMILES
MARK DAMRON DMD

Date _____

Whom may we thank for referring you? _____

PATIENT INFORMATION

Patient Name _____ Preferred Name _____
Address _____ City/State _____ Zip Code _____
Home Phone _____ Work Phone _____ Cell Phone _____
Email Address _____ Best time of day and which phone # to reach you _____
Important Note: **(We use the cell phone number and email address to remind patients of future appointments)**
Sex Female/Male Age _____ Birthdate _____ Marital Status _____ SSN _____
Employer _____ Occupation _____
Employer Address _____ Employer Phone _____
Spouse Name _____ Birthdate _____ SSN _____

GUARDIAN INFORMATION (if applicable)

Name _____
Address _____ City/State _____ Zip Code _____
Home Phone _____ Work Phone _____ Cell Phone _____
Email Address _____ Best time of day and which phone # to reach you _____
Birthdate _____ SSN _____
Employer _____ Occupation _____
Employer Address _____ Employer Phone _____

Who is responsible for this account? _____

INSURANCE INFORMATION

Primary Insurance Information

Insurance Company _____
Name of Primary Policy Holder _____ Birthdate _____
Policy Holder address _____
SSN _____ Relationship to the patient _____
Policy # _____ Group # _____
Anniversary Date of Policy _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to doctor otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____
Responsible Party Signature Relationship Date

EMERGENCY INFORMATION

Who may we contact in case of an emergency? _____ Relationship _____

Phone # _____ Cell # _____ Pharmacy phone # _____

2800 Peoples Street, Suite 90, Johnson City, TN 37604
Tel: (423) 928-0345, Fax: (423) 926-4358

JOHNSON CITY SMILES
MARK DAMRON DMD

Patient Name _____

Birthdate _____

DENTAL HISTORY

Reason for today's visit _____

Former Dentist _____ Phone # _____ City/State _____

Date of Last Dental Visit _____ Date of last dental X-Rays _____

Date of Last Dental Cleaning _____

How often do you brush your teeth? _____ How oftern do you floss? _____

What other dental aids do you use? Manual Toothbrush _____ Soft _____ Medium _____ Hard

Toothpick Fluoride Rinse _____ Electric Toothbrush Other _____

Have you received any formal oral hygiene instruction? Y / N How long ago? _____

Do you like your smile? Y / N

How do you feel about the appearence of your teeth? _____

What do you wish could be changed? _____

Are you interested in straightening your teeth (Orthodontic treatment)? Y / N Have you had braces before? Y / N

Please circle YES or NO to indicate if you have had or currently have any of the following:

Cold Sores or growths in mouth	Y N	Sensitivity when biting	Y N	Pain around ear	Y N
Sore or Bleeding gums	Y N	Sensitivity with sweets	Y N	Change/Shift in your bite	Y N
Blisters on lips or mouth	Y N	Sensitivity to cold	Y N	Experience pain in jaw joint	Y N
Burning sensation on tongue	Y N	Sensitivity to heat	Y N	Grinding teeth	Y N
Swollen Gums	Y N	Hold foreign objects with your teeth	Y N	Clenching teeth	Y N
Dry Mouth	Y N	Chew on one side of mouth	Y N	Chewing tobacco	Y N
Bad Breath	Y N	Fingernail biting	Y N	Smoke (circle) Cigarette, pipe, cigar	Y N
Mouth breathing	Y N	Lip or cheek biting	Y N	Difficulty with any dental work	Y N
Loose teeth	Y N	Clicking or Popping of the jaw	Y N	Problems getting numb	Y N
Broken fillings	Y N	Difficult in opening or closing mouth	Y N	Wear a bite plate or mouthguard	Y N
Frequent headaches	Y N	Tired jaws, especially in the morning	Y N	Excessive stress or pressure	Y N

A serious injury to the mouth or head Y N Please describe including the cause _____

Food collection between teeth Y N Please indicate location _____

Oral Surgery (Extractions) Y N

Endodontic Treatment (Root Canals) Y N

Periodontal Treatment (Gums- Deep Cleaning) Y N If yes: please indicate"

- Osseous Surgery Date _____
- Tissue Gingival Grafts Date _____
- Tissue Management (Scaling, Curetage) Date _____

Do you feel nervous about having dental treatment? Y N

Have you ever had an upsetting dental experience? Y N

Is there anything else about having dental treatment that you would like us to know? Y N

If yes to any of the above, please describe _____

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Patient Name _____

Birthdate _____

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

Address _____ City _____ State _____ Zip Code _____

Have you been under the care of a medical doctor during the past two years ? _____ Y N

If yes, for what? _____

Please check yes or no to indicate if you have had any of the following:

AIDS/ HIV positive	Y N	Emphysema	Y N	Pacemaker	Y N
Alcoholism/Drug Abuse	Y N	Epilepsy or Seizures	Y N	Psychological Problems	Y N
Anemia	Y N	Fainting or Dizzy Spells	Y N	Psychiatric Care	Y N
Arthritis, Rheumatism	Y N	Glaucoma	Y N	Radiation Treatment	Y N
Artificial Heart Valves	Y N	Hay Fever	Y N	Respiratory Disease	Y N
Asthma	Y N	Headaches	Y N	Rheumatic Fever	Y N
Back Problems	Y N	Heart Murmur	Y N	Scarlet Fever	Y N
Bleeding Abnormally	Y N	Heart Problems	Y N	Shortness of Breath	Y N
Blood Disease	Y N	Hemophilia	Y N	Sickle Cell Disease	Y N
Blood Transfusion	Y N	Hepatitis Type _____	Y N	Sinus Trouble	Y N
Cancer	Y N	Herpes	Y N	Skin Rash	Y N
Chemical Dependency	Y N	High Blood Pressure	Y N	Stomach Disorder (Ulcers)	Y N
Chemotherapy	Y N	High Cholesterol	Y N	Stroke	Y N
Circulatory Problems	Y N	Jaundice	Y N	Swelling of Feet or Ankles	Y N
Congenital Heart	Y N	Jaw Pain	Y N	Swollen Neck Glands	Y N
Contact Lenses	Y N	Joint Replacement When / Type _____	Y N	Thyroid Problems	Y N
Cortisone Treatments	Y N	Kidney Disease	Y N	Tonsillitis	Y N
Cough, Persistent/Bloody	Y N	Liver Disease	Y N	Tuberculosis	Y N
Cysts/Tumors Where _____	Y N	Low Blood Pressure	Y N	Tumor or Growth on Head or Neck	Y N
Diabetes	Y N	Mitral Valve Prolapse	Y N	Ulcer	Y N
Diet (Restricted / Special)	Y N	Neurological Disorders	Y N	Venereal Disease	Y N
Eating Disorders	Y N	Nervous or Anxiety Problems	Y N	Weight Loss or Gain, Unexplained	Y N

Allergies [ ] NONE [ ] Amoxicillin [ ] Aspirin [ ] Barbiturates [ ] Codeine [ ] Epinephrine [ ] Erythromycin [ ] Keflex
[ ] Iodine [ ] Latex [ ] Lortab [ ] Morphine [ ] Penicillin [ ] Sulfa [ ] Tetracycline [ ] Other _____

List medications currently taking (name and dosage) _____

_____

Do you have or have you had any disease, condition or problem not listed above? Y N

If yes, please explain: _____

Do you need to take any antibiotics (pre-medicate) before any dental appointment? Y N

Have you been in the hospital or had a serious illness within the past five years? Y N

If yes, Please explain: _____

Women: Are you pregnant? Y N Due date _____ Are you nursing? Y N Do you take Birth Control Pills? Y N

I understand the above information is necessary to provide me with the dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient / Parent / Guardian Signature X _____ Date _____

Doctor Signature _____ Date _____

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Patient Name _____ DOB _____

Broken or cancelled appointments

Your appointment time is valuable and has been reserved specifically for you. If you need to cancel an appointment, please notify us **at least 48 hours in advance** for Tuesday through Friday appointments and no later than 2 pm Thursday for Monday appointments. **We charge up to $100 for each canceled or broken appointment if you do not give us the required advance notice.** Please notify us if an emergency makes it impossible for you to give 48 hours notice so we can discuss with you.

If you arrive 15 minutes late or more to your appointment you will likely be rescheduled unless our schedule can still accommodate you.

Signature of patient or responsible party I acknowledge and understand the cancellation policy **X_____**

Insurance and Financial Agreement

Our practice is in-network for many insurance carriers but not all. Please provide your insurance card on your first visit and let us know of any changes in coverage or carriers on subsequent visits. As a courtesy, we file all necessary paperwork with your insurance company, and we are happy to help you maximize your benefits. Many dental insurance companies have exclusions and limitations that can affect your out-of-pocket cost.

At the time of service, you will need to pay us the estimated insurance deductible and any estimated amount that we expect insurance will not cover. Remember that many procedures are not fully covered, and, in those instances, you are responsible for the remaining amount. Please remember that your dental insurance is a contract between you, your employer, and the insurance company. **Please keep in mind that you are responsible for the total amount should your insurance benefits result in less coverage than anticipated.**

We will provide a written estimate of fees. However we cannot be sure what the insurance company will pay, if anything, until the claim is submitted. It is not unusual for insurance companies to give us erroneous information about coverage and benefits. **This is important because you are responsible for all the treatment charged whether your insurance company provides any benefits. Also, after 90 days from the date of service if your insurance has not paid the claim it becomes your responsibility.**

We want you to feel comfortable and confident in all aspects of our practice. We DO NOT treat according to your insurance – we treat you as an individual and care about your dental health and are dedicated to providing the best treatment available.

Balances over 60 days past due are subject to a 5% billing charge and balances over 90 days past due will be turned over to a collection's agency with a 33.33% collections fee being added to the balance. At that time, you will be dismissed from our practice.

I have read, understand, and agree to the above financial agreement. Any questions or concerns were answered to my full satisfaction. I understand that I am responsible for all fees and/or balances due and agree to pay them in a timely manner to avoid any additional charges. I agree to the above policies and charges.

X_____ Date_____

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Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

Patient name _____ Birthdate_____

I have received either a paper or an electronic copy of the HIPAA Notice of Privacy Practices for Johnson City Smiles. I understand I am entitled to receive a paper copy of the Notice if I ask for it, even if I have already agreed to receive only an electronic copy.

X_____ Date Signed _____

Signature of patient, guardian or personal representative

If applicable:

Patient's guardian or representative's name _____ Phone _____

Representative's relationship to patient _____

Representative's address _____

Permission to Discuss Treatment or Billing Information

I give my permission to discuss my treatment and billing information with:

_____ Relationship to patient _____

_____ Relationship to patient _____

Appointment Reminders

We will remind you of upcoming appointments by using text and e-mail messages. Please make sure that we have your current cell phone numbers or email address for your reminders.

Cell Phone Number _____

Email Address _____

For office use only:

We made a good faith effort to obtain a written Acknowledgement of Receipt of Notice of Privacy Practices, but an acknowledgement could not be obtained because"

___ The patient or the patient's personal representative refused to sign

___ A communication barrier prevented us from obtaining an acknowledgement

___ An emergency situation prevented us from obtaining an acknowledgement

___ Other (please explain)_____

Completed by _____ Position _____

Date completed_____