Middlecoff Dental Group, PLLC
17965 Highway 64 E.
Somerville, TN 38068
(901)465-0501

Patient Information

Please take a moment to enter or update your information to help us insure the quality of your care is excellent.

Patient Name ______________________________ ____________
Last First MI Preferred Name

Gender: Male __ Female ___ Family Status: Married ___ Single ___ Child ___ Other ___

Birth Date: ____________ Email Address ________________ Social Security # ____________

Phone ____________ ____________ ____________
Home Work Mobile

Address ______________________________
City, State, Zip

Responsible Party Information

______________________________ ____________
Last First MI Relationship to Patient

Gender: Male ___ Female ___ Family Status: Married ___ Single ___ Child ___ Other ___

Birth Date: ________________ Email Address ________________

Phone ____________ ____________ ____________
Home Work Mobile

Address ______________________________
City, State, Zip

Employment Information

Employer Name ________________________ Phone ____________

Address ______________________________
City, State, Zip

Primary Dental Insurance

Name of Insured ______________________________
Last First MI

Insured's Birth Date ____________ ID# ____________ Group # ____________

Insured's Address ______________________________
City, State, Zip

Insured's Employer Name ________________________ Phone ____________

Employer Address ______________________________
City, State, Zip

Patient's Relationship to insured: Self ___ Spouse ___ Child ___ Other ___

Insurance Carrier ____________________

Insurance Address ____________________

City, State, Zip

Secondary Dental Insurance

Do you have Secondary Dental Insurance? Yes ____ No ____ (Bring information to appointment)

Consent for Services

The practice depends upon reimbursement from patients for the costs incurred in their care. Fanancial responsibility on the part of each patient must be determined before treatment

All emergency dental services must be paid for in cash at the time services are performed.

Patients with dental insurance understand that all dental services 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 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.

I understand that any fee estimate 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 by this practice, I agree to pay the charges in full or my estimated portion after insurance for the services at the time of treatment.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

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

____
Date

Dental History

Patient Name ____________________

Last First MI

Do you have a specific dental problem? If yes, describe.

____

____

Do you have dental examinations on a routine basis? Yes ____ No ____

Do you brush and floss on a routine basis? Yes ____ No ____

Date of last dental visit. Date of last full mouth or panoramic x-ray.

____

Do your gums ever bleed? Discuss

____

____

Do you use tobacco? If yes, describe.

____

____

Medical History

Are you under a physician's care now? If yes, describe reason.

____

____

Name of physician and phone number.

____

____

Have you ever been hospitalized or had a major operation? Discuss

____

____

Have you ever had a serious injury to your head or neck? Discuss

____

____

List any prescribed or over the counter drugs you are presently taking.

____

____

Are you allergic to: Aspirin ___ Penicillin ___ Codeine ___ Acrylic ___

Metal ___ Latex Rubber ___ Milk ___ Sulfa ___

Other allergies: List

____

____

Women (check) Pregnant/trying to get pregnant ___ Nursing ___ Taking oral contraceptives ___

Do you now have or have you ever had any of the following or take any of these medicines? Please check appropriate boxes. *If yes to any of the starred conditions, please call prior to your appointment..PREMEDICATION or changes in medication may be required.

___ Heart Disease/Surgery* ___ Heart Murmur or Defect* ___ Irregular Heart Beat

___ Angina/Chest Pain ___ Heart Attack/Failure ___ Congenital Heart Disorder*

___ Mitral Valve Prolapse* ___ Scarlet Fever ___ Rheumatic Fever*

___ Artificial heart Valve* ___ Heart Pace Maker* ___ Pulmonary Shunt*

___ High Blood Pressure ___ Low Blood Pressure ___ Bacterial Endocarditis

___ Unexplained Fever ___ Bruise Easily/Blood Disease ___ Anemia

___ Coronary Stent* ___ Excessive Bleeding ___ Sickle Cell Disease

___ Hemophilia(Bleeding Problem) ___ Leukemia ___ Recent Blood Transfusion

___ Swelling of Limbs ___ Lung Disease ___ Breathing Problem

___ Shortness of Breath ___ Frequent Cough ___ Hay Fever

___ Sinus Trouble ___ Asthma ___ Bloody Sputum

___ Emphysema ___ Tuberculosis ___ Cancer

___ ___

___ Radiation Treatments ___ Chemotherapy ___ Osteoporosis

___ Bisphosphonates ___ Osteonecrosis of Jaw ___ Aredia I.V.

___ Zometa I.V. ___ Fosamax, Actonel, Boniva ___ Stomach/Intestinal Disease

___ Ulcers ___ Recent Weight Loss ___ Frequent Diarrhea

___ Diabetes ___ Excessive Thirst ___ Hypoglycemia

___ Liver Disease ___ Hepatitis A, B, or C ___ Protease Inhibitor

___ Night Sweats ___ Yellow Jaundice ___ Kidney Problems

___ Renal Dialysis ___ Thyroid Disease ___ Parathyroid Disease

___ Arthritis/Gout ___ Rheumatism ___ Cortisone Medicine

___ Artificial Joint* ___ Venereal Disease ___ Aids

___ HIV Positive ___ Drug Addiction/Alcoholism ___ Tattoos/Body piercing

___ Fever Blisters ___ Herpes ___ Stroke

___ Convulsions ___ Epilepsy or Seizures ___ Fainting or Dizziness

___ Glaucoma ___ Tumors or Growths ___ Nervousness

___ Psychiatric Care ___ Alzheimer's Disease ___ Fen-Phen

___ Cochlear Implants

Have you ever had any other serious illness not checked above? Discuss

____

____

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at he next appointment without fail.

___ I agree with the information listed above. ________________

Date