

**Middlecoff Dental Group, PLLC**  
**17965 Highway 64 E.**  
**Somerville, TN 38068**  
**phone-(901)466-0501 fax-(901)466-1130**

**Patient Information**

How did you hear about our office? \_\_\_\_\_

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

**If Patient is a Minor, Person Financially Responsible (Responsible Party Must Sign)**

\_\_\_\_\_

Last                                      First                                      MI                                      Relationship to Patient

Birth Date: \_\_\_\_\_      Email Address \_\_\_\_\_

Phone \_\_\_\_\_

Home                                      Work                                      Mobile

Address \_\_\_\_\_

City, State, Zip                                      Social Security Number

**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)

## Insurance Filing & Acknowledgement of Financial Responsibility

Middlecoff Dental Group participates in many dental insurance plans. I understand that if my insurance plan is one the practice does not participate in, my benefits may be *reduced* or *not cover* the services.

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

I understand that the dental office will be happy to file my insurance for dental treatment with an assignment of benefits. Payment for services rendered, however are ultimately the responsibility of the patient and are not contingent upon the insurance settlement. I will be asked to pay *deductibles* and *ESTIMATED co-insurance*

I authorize the release of any information necessary to process my claims.

The information I have given is accurate and true to the best of my knowledge. I understand that I am responsible to pay for services rendered, including reasonable attorney's fees and costs of collection up to 40% of charges in the event of default.

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.

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

If I am a minor or filing for benefits through my parent's/guardian's insurance, I authorize you to release information concerning my dental care to my parent(s) or legal guardian. (Patient and responsible party must also sign below.)

Signed (patient) \_\_\_\_\_ Signed (responsible party) \_\_\_\_\_

\_\_\_\_\_  
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, had a major operation or head injury? Discuss

\_\_\_\_\_  
List any prescribed or over the counter drugs you are presently taking. Please Mark if no medications \_\_\_\_\_

Are you allergic to: Aspirin \_\_\_ Penicillin \_\_\_ Codeine \_\_\_ Acrylic \_\_\_  
 Metal \_\_\_ Latex Rubber \_\_\_ Milk \_\_\_ Sulfa \_\_\_

Other allergies: List \_\_\_\_\_ **Please Mark if no Allergies** None \_\_\_\_\_

**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.

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Aids                        | <input type="checkbox"/> Fen-Phen                     | <input type="checkbox"/> Osteoporosis               |
| <input type="checkbox"/> Alzheimer's Disease         | <input type="checkbox"/> Fever Blisters               | <input type="checkbox"/> Parathyroid Disease        |
| <input type="checkbox"/> Anemia                      | <input type="checkbox"/> Fosamax, Actonel, Boniva     | <input type="checkbox"/> Protease Inhibitor         |
| <input type="checkbox"/> Angina/Chest Pain           | <input type="checkbox"/> Frequent Cough               | <input type="checkbox"/> Psychiatric Care           |
| <input type="checkbox"/> Aredia I.V.                 | <input type="checkbox"/> Frequent Diarrhea            | <input type="checkbox"/> Pulmonary Shunt*           |
| <input type="checkbox"/> Arthritis/Gout              | <input type="checkbox"/> Glaucoma                     | <input type="checkbox"/> Radiation Treatments       |
| <input type="checkbox"/> Artificial heart Valve*     | <input type="checkbox"/> Hay Fever                    | <input type="checkbox"/> Recent Blood Transfusion   |
| <input type="checkbox"/> Artificial Joint*           | <input type="checkbox"/> Heart Attack/Failure         | <input type="checkbox"/> Recent Weight Loss         |
| <input type="checkbox"/> Asthma                      | <input type="checkbox"/> Heart Disease/Surgery*       | <input type="checkbox"/> Renal Dialysis             |
| <input type="checkbox"/> Bacterial Endocarditis      | <input type="checkbox"/> Heart Murmur or Defect*      | <input type="checkbox"/> Rheumatic Fever*           |
| <input type="checkbox"/> Bisphosphonates             | <input type="checkbox"/> Heart Pace Maker*            | <input type="checkbox"/> Rheumatism                 |
| <input type="checkbox"/> Bloody Sputum               | <input type="checkbox"/> Hemophilia(Bleeding Problem) | <input type="checkbox"/> Scarlet Fever              |
| <input type="checkbox"/> Breathing Problem           | <input type="checkbox"/> Hepatitis A, B, or C         | <input type="checkbox"/> Shortness of Breath        |
| <input type="checkbox"/> Bruise Easily/Blood Disease | <input type="checkbox"/> Herpes                       | <input type="checkbox"/> Sickle Cell Disease        |
| <input type="checkbox"/> Cancer                      | <input type="checkbox"/> High Blood Pressure          | <input type="checkbox"/> Sinus Trouble              |
| <input type="checkbox"/> Chemotherapy                | <input type="checkbox"/> HIV Positive                 | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Cochlear Implants           | <input type="checkbox"/> Hypoglycemia                 | <input type="checkbox"/> Stroke                     |
| <input type="checkbox"/> Congenital Heart Disorder*  | <input type="checkbox"/> Irregular Heart Beat         | <input type="checkbox"/> Swelling of Limbs          |
| <input type="checkbox"/> Convulsions                 | <input type="checkbox"/> Kidney Problems              | <input type="checkbox"/> Tattoos/Body piercing      |
| <input type="checkbox"/> Coronary Stent*             | <input type="checkbox"/> Leukemia                     | <input type="checkbox"/> Thyroid Disease            |
| <input type="checkbox"/> Cortisone Medicine          | <input type="checkbox"/> Liver Disease                | <input type="checkbox"/> Tuberculosis               |
| <input type="checkbox"/> Diabetes                    | <input type="checkbox"/> Low Blood Pressure           | <input type="checkbox"/> Tumors or Growths          |
| <input type="checkbox"/> Drug Addiction/Alcoholism   | <input type="checkbox"/> Lung Disease                 | <input type="checkbox"/> Ulcers                     |
| <input type="checkbox"/> Emphysema                   | <input type="checkbox"/> Mitral Valve Prolapse*       | <input type="checkbox"/> Unexplained Fever          |
| <input type="checkbox"/> Epilepsy or Seizures        | <input type="checkbox"/> Nervousness                  | <input type="checkbox"/> Venereal Disease           |
| <input type="checkbox"/> Excessive Bleeding          | <input type="checkbox"/> Night Sweats                 | <input type="checkbox"/> Yellow Jaundice            |
| <input type="checkbox"/> Excessive Thirst            | <input type="checkbox"/> Osteonecrosis of Jaw         | <input type="checkbox"/> Zometa I.V.                |
| <input type="checkbox"/> Fainting or Dizziness       |   |   |

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.

3/11/2011

\_\_\_\_\_ Date

\_\_\_\_\_ Signature