

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

**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

**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 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.

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