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 # _____

_____ _____ _____ Would you like text message reminders?
Home Number Work Number Mobile Number Yes _____ No _____

_____
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 _____

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 _____

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)

Do you like your smile? ___

Do you want whiter teeth? ___

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 ____

_____

_____

Do you take any blood thinners ? Yes ___ No ___

Do you take medication of osteoporosis? Yes ___ No ___

Do you have any artificial joints ? Yes ___ No ___

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

Metal ___ Latex Rubber ___ Milk ___ Sulfa ___

Please Mark if no Allergies **None** ____

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.

___ Aids
___ Alzheimer's Disease
___ Anemia
___ Angina/Chest Pain
___ Arthritis/Gout
___ Artificial heart Valve*
___ Artificial Joint*
___ Asthma
___ Bacterial Endocarditis
___ Bloody Sputum
___ Bruise Easily/Blood Disease
___ Cancer
___ Chemotherapy
___ Cochlear Implants
___ Congenital Heart Disorder*
___ Coronary Stent*
___ Diabetes
___ Drug Addiction/Alcoholism
___ Emphysema
___ Epilepsy or Seizures
___ Excessive Bleeding
___ Fainting or Dizziness
___ Glaucoma
___ Hay Fever
___ Heart Attack/Failure
___ Heart Disease/Surgery*
___ Heart Murmur or Defect*
___ Heart Pace Maker*
___ Hepatitis A, B, or C
___ Herpes
___ High Blood Pressure
___ HIV Positive
___ Hypoglycemia
___ Irregular Heart Beat
___ Kidney Problems
___ Leukemia
___ Liver Disease
___ Low Blood Pressure
___ Lung Disease
___ Mitral Valve Prolapse*
___ Osteonecrosis of Jaw
___ Osteoporosis
___ Psychiatric Care
___ Pulmonary Shunt*
___ Radiation Treatments
___ Recent Blood Transfusion
___ Renal Dialysis
___ Rheumatic Fever*
___ Scarlet Fever
___ Shortness of Breath
___ Sickle Cell Disease
___ Stomach/Intestinal Disease
___ Stroke
___ Tattoos/Body piercing
___ Thyroid Disease
___ Tuberculosis
___ Ulcers

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.

6/24/2014

_____ Date

_____ Signature

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Dear Patient:

In an effort to provide you with flexible payment arrangements, we have expanded our payment policy.

PAYMENT ARRANGEMENTS ARE REQUESTED AT THE TIME OF YOUR VISIT
We now offer the following payment options:

___ Payment by cash

___ Payment by check

___ Payment by credit card

___ Automatic monthly billing to your Visa or Master Card

___ Guarantee any amount not covered by insurance with Visa or MasterCard

Please make your choice, sign below and return to Office Manager before treatment.

Our office is a fully approved and accredited user of the *Visa and MasterCard Health Care Program* which will enable you to use your Visa and MasterCard to automatically cover amounts not paid by your insurance. You may also choose a comfortable amount to be automatically billed to your Visa or MasterCard on a monthly basis.

If none of the above apply, please see the office manager. Thank you.

_____
Print your name here and sign below
*x*_____

*Date:*_____

Cancellation and Missed Appointment Policy

We always provide courtesy reminder calls or e-mails to remind you of your reserved appointment time. We ask that you confirm your appointment either by a return phone call or e-mail. If we do not get a confirmation from you regarding your appointment we reserve the right to remove your appointment from our schedule if that time is needed for another patient.

If you must reschedule or cancel your appointment we require 24 hours notice to avoid a broken appointment fee. The fee for a 1st broken appointment is $25.00. The 2nd and 3rd broken appointment fee is $50. After 3 broken appointments we will only be able to see you on a walk in basis if our schedule allows.

The best way to contact me or other family members _____

May we contact you at work? _____ Work #_____ Cell #_____

_____ _____

Patient or Responsible Party Date

Insurance Filing and Financial Responsibility

As a service to our patients with insurance, Middlecoff Dental Group agrees to accept an **estimated** co-payment at the time service is rendered and bill insurance for the balance.

Even with our best efforts, we can only **estimate** what insurance will pay. We are never given a **guarantee** of coverage or benefits from your insurance carrier and situations may arise when insurance will deny a claim or a portion of a claim when we submit it for payment.

We will always restore teeth with tooth colored composite fillings since we feel that this type of restoration is far superior to silver amalgam fillings. Many insurance companies allow an alternate treatment of, or ***downgrade*** to silver amalgam fillings on back teeth, molars and sometimes premolars (even insurance companies recognize that this is not the best restoration). If your insurance company downgrades the difference between the cost of a composite restoration and amalgam restoration would not be paid by insurance. If you are scheduled for fillings, please let us know before hand if you prefer to have silver amalgam fillings rather than tooth colored composite fillings.

Insurance is a contract between **you** and **your carrier** and if you have concerns we strongly suggest that you contact your carrier prior to your visit.

In the event that insurance pays less than estimated or not at all, I agree to pay any amount not paid by my insurance to Middlecoff Dental Group.

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.

_____ _____

Patient or Responsible Party Date

I have been provided with a copy of Middlecoff Dental Group's Privacy Policy.

_____ _____

Patient or Responsible Party Date

3/11/11