Cosmetic Dentistry of Murfreesboro

PATIENT INFORMATION

Mr/Mrs/Ms/Miss/Dr_____
First Middle Last Suffix
Birth date_____**Social Security #** _____ **Sex: M F**

Address_____

Phone Numbers
Home_____**Work**_____**Cell**_____ **Email**_____

What do you prefer to be called?_____

GUARDIAN INFORMATION (For Minor Patients)

Mr/Mrs/Ms/Miss/Dr_____
First Middle Last Suffix
Address_____

Phone Numbers
Home_____**Work**_____**Cell**_____**Email**_____

INSURANCE INFORMATION

Primary Insurance_____**Group#**_____
Address_____**Phone#**_____
Employer_____**Employee's name**_____
Employee's SS #_____**Birth Date**_____

Secondary Insurance_____**Group#**_____
Address_____**Phone#**_____
Employer_____**Employee's name**_____
Employee's SS#_____**Birth Date**_____

OTHER INFORMATION

Whom may we thank for referring you to our office?_____

In case of emergency, whom may we contact?_____
Address_____**Phone#**_____

I understand that, where appropriate, credit bureau reports may be obtained.

Signature (Guardian's signature if minor)_____**Date**_____

DENTAL HISTORY

Reason for today's visit?_____

Are you currently having dental pain? YES / NO If "yes", where?_____

Last cleaning date?_____**Dentist/Address?**_____

Are you interested in hearing about Cosmetic Improvements for your smile? YES / NO

MEDICAL HISTORY

Primary Physician's name:_____

Are you allergic to any medications? YES / NO

Aspirin Cephalosporin Codeine Demerol Erythromycin
Penicillin Amoxicillin Sulfa Drugs Anesthetic (Novacaine/Lidocaine)
Other Drugs_____

Please circle any of the following conditions that you currently have or had in past.

Rheumatic fever	**Heart Attack**	**Emphysema**
Heart Murmur	**Hepatitis A, B, C, D**	**Epilepsy/Seizures**
Mitral Valve Prolapse	**Thyroid Disease**	**Stroke**
Artificial Heart Valve	**Angina Pectoris**	**Sickle Cell Disease**
Artificial Joints(Hip,Knee,etc)	**Heart Pacemaker**	**Glaucoma**
Bacterial Endocarditis (SBE)	**AIDS or HIV**	**High Blood Pressure**
Pulmonary-Systemic shunt	**Liver Disease**	**Diabetes**
Congenital Heart Disease	**Kidney Disease**	**Tuberculosis**

Please write any other medical conditions that you may have that are not listed above

_____

What medications are you currently taking? _____

_____

For Women Only:

Are you currently pregnant? YES / NO What trimester? 1st 2nd 3rd
Are you nursing? YES / NO Taking Birth Control Pills? YES / NO

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, my signature below serves as an authorization for other health care providers to release necessary information. I agree to notify the doctor of any change in my health or medications

Patient/Guardian Signature_____ **Date** _____

Cosmetic Dentistry of Murfreesboro

1819 Lascassas Pike,
Murfreesboro, TN 37130
(615)893-5500
fax (615)893-5506

You have the right to refuse to sign this document

By signing below, I acknowledge that I have been offered a copy of Cosmetic Dentistry of Murfreesboro's Notice of Privacy Practices as required under the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

_____ _____ _____

Please print Patient's Name **Date of Birth** **Soc. Sec. #**

_____ _____ _____

Signature of Patient or Guardian **Today's Date** **Print Guardian Name**

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Cosmetic Dentistry of Murfreesboro has my permission to contact me to provide appointment reminders or information about treatment alternatives or other health-related benefits or services. Messages can be left for me with an individual answering or on an answering machine or service or postcard reminders may be sent. **( )Yes ( )No**

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Cosmetic Dentistry of Murfreesboro has my permission to discuss my appointment matters or health status with the following individuals (please provide us with the names of specific family members or friends, not insurance companies, other doctors, employers, etc.), or send postcard reminders:

1._____

2._____

3._____

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Cosmetic Dentistry of Murfreesboro has my permission to discuss my billing matters with the following individuals (please provide us with the names of specific family members or friends, not insurance companies, other doctors, employers, etc.):

1._____

2._____

3._____

Cosmetic Dentistry of Murfreesboro, 1819 Lascassas Pike, Murfreesboro TN 37130

Written Financial Policy

Thank you for choosing Cosmetic Dentistry of Murfreesboro. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

<u>Payment Options:</u>

You can choose from:

Cash, Check, Visa, Mastercard, Discover Card, American Express

NO INTEREST* Payment Plans from CareCredit**

- **Allows you to pay over time with NO INTEREST***
- **Convenient, low monthly payment plans ** also available**
- **No annual fees or pre-payment penalties**

Please note:

Cosmetic Dentistry of Murfreesboro requires payment prior to the beginning of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

For larger, more comprehensive treatment plans of $250 or more, a 10% deposit is required to secure your initial treatment appointment.

For patients with dental insurance, we are happy to work with your carrier to maximize your benefit and bill them for your covered treatment on your behalf .

A fee of $50 will be charged for patients who miss an appointment, without giving 24 hours notice.

Cosmetic Dentistry of Murfreesboro charges $25 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

*** If paid within the promotional period. Otherwise, interest assessed from purchase date. Minimum monthly payment required.**
**** Subject to credit approval**