Welcome To Dental Care of Franklin
Jason R. White, DDS
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Franklin, TN 37067
(615)778-1442

ABOUT YOU

Today's Date:_ ____ / ____ /_____
Patient Name:_____
Last First MI
What You Prefer To Be Called: _____ □ Male □ Female
Birthday: _____ Age: _____ SS#: _____
Mailing Address: _____
City _____ State _____ Zip _____
Home Phone # _____ Work Phone # _____
Cell Phone # _____ E-mail Address: _____
Referred By: _____
Employer: _____
Employer's Address: _____
Street City State Zip
Occupation: _____
Status: □ Single □ Married □ Youth Other _____
Spouse's Name: _____
Do you have children? □ Yes □ No How many? _____
Are you aware that we also see children? _____

ACCOUNT INFORMATION

Person ultimately responsible for account.

Name: _____
Relation: _____
Address: _____
_____
City State Zip
SS #: _____
Drivers License #: _____
Work Phone #: _____

IN THE EVENT OF EMERGENCY

Who should be contacted? _____
Home Phone #: _____
Work Phone #: _____
Cell Phone #: _____
Who is your medical doctor? _____
Doctor's Phone #: _____

DENTAL INFORMATION

Reason for today's visit: □ Exam □ Emergency □ Consultation

Are you in pain? □ No □ Yes How long? _____

Please check if you have had any of the following problems:

- □ Discomfort, clicking or popping jaw
- □ Red, swollen, or bleeding gums
- □ Sensitive tooth, teeth, or gums
- □ Food getting caught between teeth
- □ Locking jaw
- □ Soreness when biting
- □ Lost or broken filling(s)
- □ Teeth grinding or clenching
- □ Stained teeth
- □ Broken or chipped tooth
- □ Bad breath
- □ Other: _____

Do you require pre-medication? □ Yes □ No □ Unsure

Last Dental Cleaning and exam? _____ Last x-rays _____

How would you rate your smile? (worst) 1 2 3 4 5 6 7 8 9 10 (best)

MEDICAL HISTORY

Please list any medications your are taking: _____

Do you have or have you had any of the following diseases, medical conditions, or procedures?

Y N Heart Attack/Stroke
Y N Congenital Heart Defect
Y N Heart Surgery/Pacemaker
Y N Chest Pains
Y N Heart Murmur
Y N Scarlet Fever
Y N Rheumatic Fever
Y N Mitral Valve Prolapse
Y N Artificial Valves
Y N Heart Disease
Y N High / Low Blood Pressure
Y N Nervousness
Y N Psychiatric Problems
Y N Fainting/Seizures/Epilepsy
Y N Cancer/Tumors
Y N Radiation Treatment
Y N Chemotherapy
Y N Respiratory Problems
Y N Sinus Problems
Y N Tuberculosis
Y N Emphysema
Y N Asthma
Y N Difficulty Breathing
Y N Leukemia
Y N Anemia
Y N Bleeding Problems
Y N Kidney Problems
Y N Thyroid Problems
Y N Liver Problems
Y N Hepatitis
Y N Shingles
Y N Stomach Problems/Ulcers
Y N HIV+/AIDS/ARC
Y N Venereal Disease
Y N Alcohol/Drug Abuse
Y N Cosmetic Surgery
Y N Diabetes/Hypoglycemia
Y N Glaucoma
Y N Arthritis/Rheumatism
Y N Artificial Bones/Joints
Y N Jaw Problems TMJ/TMD
Y N Severe/Frequent Headaches
Y N Frequent neck pain
Y N Back problems

Please list any other medical condition(s) you have or ever had: _____

_____

Please check if you are allergic to any of the following?

□ Latex □ Penicillin/Amoxicillin □ Tetracycline □ Aspirin □ Dental Anesthetics

Other: _____

Do you use tobacco? □ No □ Yes How used? _____ How much? _____ How long? ____

Do you wear contact lenses? □ Yes □ No

For Women: Are you taking birth control pills? □ Yes □ No

Are you pregnant? □ No □ Yes / How far along?_____ Are you nursing? □ Yes □ No

We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

I understand the above information and to the best of my knowledge all information filled out is correct. It is my responsibility to inform this office on any changes that may occur.

I hereby authorize assignment of insurance rights and benefits directly to the provider for services rendered. I fully understand that I am solely responsible for any balance not paid by my insurance company.

_____ signature

_____ date

DENTAL INSURANCE

We are happy to file the forms necessary to see that you receive the full benefits of your insurance coverage; however, we cannot guarantee any estimated coverage. **Because the insurance policy is an agreement between you and the insurance company, we consider all patients directly responsible for all charges.** We are pleased to assist you in understanding your responsibilities concerning your insurance, but your insurance coverage is your responsibility. If for some reason your insurance company has not paid their portion within 60 days from the start of treatment, you are responsible for payment at that time. **Interest is charged on all accounts with balances over 60 days. All balances over 90 days will be sent to collections. Any collection costs and/or attorney fees will be added to the account balance.**

PAYMENT OPTIONS

CASH OR CHECK: We offer a 5% pre-payment courtesy if full payment is made at the start of any treatment plan of $2000 or more. Any insurance payments that may come to us later for that treatment will be promptly reimbursed to you.

CREDIT CARDS: For your convenience, we have made arrangements to accept payment by Debit cards, Visa, MasterCard, Discover, and American Express.

PAYMENT PLAN: For patients who desire a monthly payment plan, we have made arrangements with a finance company. There are no application fees or down payment, and we will pay the interest for up to one year. Applications are available from our front desk coordinator, and approval is provided quickly.

MISSED/ CANCELLED APPOINTMENT POLICIES

We know your time is valuable and we want to serve you on schedule and in an efficient manner. For this reason, we enlist your help in arriving on time for appointments, if not a little early. Also we require 24 hours notice for cancellations in order to allow another patient who may need an appointment to utilize that time. We do reserve the right to charge $30.00 per hour for missed or cancelled appointments with less than 24 hours notice.

_____ _____

Signature of patient Date

Acknowledgement of Receipt of Notice of Privacy Practices

* You May Refuse to Sign This Acknowledgment*

I, _____, have received a copy of this office's Notice of Privacy Practices.

Print Name_____

Signature_____

Date_____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

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