TENNESSEE CENTERS FOR LASER DENTISTRY

PATIENT REGISTRATION

ID ____________

Chart ID ____________

First Name ____________ Last Name ____________ Middle Initial ____________

Patient is ☐ Policy Holder ☐ Responsible Party Preferred Name ____________

Responsible Party (if someone other than the patient)

First Name ____________ Last Name ____________ Middle Initial ____________

Address ____________ Address 2 ____________

City ____________ State ____________ Zip ____________ Pager ____________

Home Phone ____________ Mobile Phone ____________ Work Phone ____________ Ext ____________

Birth Date ____________ Soc. Sec. ____________ Driver License ____________

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address ____________ Address 2 ____________

City ____________ State ____________ Zip ____________ Pager # ____________

Home Phone ____________ Mobile Phone ____________ Work Phone ____________ Ext ____________

Sex ☐ Male ☐ Female Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date ____________ Soc. Sec. ____________ Driver License ____________

E-mail ____________ ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status ☐ Full Time ☐ Part Time ☐ Retired Student Status ☐ Full Time ☐ Part Time

Medicaid ID ____________ Employer ID ____________ Carrier ID ____________

Pref. Dentist ____________ Pref. Pharmacy ____________ Pref. Hyg. ____________

Section 3

Occupation ____________ Employer ____________ Who referred you? ____________

Primary Insurance Information

Name of Insured ____________ Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec. ____________ Insured Birth Date ____________

Employer ____________

Address ____________

Address 2 ____________

City, State, Zip ____________

Rem. Benefits ____________

Insurance Company ____________

Address ____________

Address 2 ____________

City, State, Zip ____________

Rem. Deduct: ____________

Secondary Insurance Information

Name of Insured ____________ Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec. ____________ Insured Birth Date ____________

Employer ____________

Address ____________

Address 2 ____________

City, State, Zip ____________

Rem. Benefits ____________

Insurance Company ____________

Address ____________

Address 2 ____________

City, State, Zip ____________

Rem. Deduct: ____________

TENNESSEE CENTERS FOR LASER DENTISTRY

HEALTH HISTORY

Patient Name ______________________

Birthdate ______________________

Date Created ______________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Question			
Are you under a physician's care now?	☐ Yes	☐ No	If yes ______
Have you ever been hospitalized or had a major operation?	☐ Yes	☐ No	If yes ______
Have you ever had a serious head or neck injury?	☐ Yes	☐ No	If yes ______
Are you taking any medications, pills or drugs?	☐ Yes	☐ No	If yes ______
Do you use tobacco?	☐ Yes	☐ No	If yes ______
Do you take, or have you taken, Phen-Fen or Redux?	☐ Yes	☐ No	If yes ______
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	☐ Yes	☐ No	If yes ______
Are you on a special diet?	☐ Yes	☐ No	
Do you take any form of blood thinner?	☐ Yes	☐ No	If yes ______

Women, are you... ☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Other?	☐ Yes	☐ No	If yes ______
Do you use any controlled substances?	☐ Yes	☐ No	If yes ______

Do you have, or have you had any of the following?

☐ AIDS/HIV	☐ Cortisone Medicine	☐ Hemophilia	☐ Recent Weight Loss
☐ Alzheimer's Disease	☐ Diabetes	☐ Hepatitis A	☐ Renal Dialysis
☐ Anaphylaxis	☐ Drug Addiction	☐ Hepatitis B or C	☐ Rheumatic Fever
☐ Anemia	☐ Easily Winded	☐ Herpes	☐ Rheumatism
☐ Angina	☐ Emphysema	☐ High Blood Pressure	☐ Scarlet Fever
☐ Arthritis/Gout	☐ Epilepsy or Seizures	☐ High Cholesterol	☐ Shingles
☐ Artificial Heart Valve	☐ Excessive Bleeding	☐ Hives or Rash	☐ Sickle Cell Disease
☐ Artificial Joint	☐ Excessive Thirst	☐ Hypoglycemia	☐ Sinus Trouble
☐ Asthma	☐ Fainting Spells/Dizziness	☐ Irregular Heartbeat	☐ Spina Bifida
☐ Blood Disease	☐ Frequent Cough	☐ Kidney Problems	☐ Stomach/Intestinal Disease
☐ Blood Transfusion	☐ Frequent Diarrhea	☐ Leukemia	☐ Stroke
☐ Breathing Problems	☐ Frequent Headaches	☐ Liver Disease	☐ Swelling of Limbs
☐ Bruise Easily	☐ Genital Herpes	☐ Low Blood Pressure	☐ Thyroid Disease
☐ Cancer	☐ Glaucoma	☐ Lung Disease	☐ Tonsillitis
☐ Chemotherapy	☐ Hay Fever	☐ Mitral Valve Prolapse	☐ Tuberculosis
☐ Chest Pains	☐ Heart Attack/Failure	☐ Osteoporosis	☐ Tumors or Growths
☐ Cold Sores/Fever Blisters	☐ Heart Murmur	☐ Pain in Jaw Joints	☐ Ulcers
☐ Congenital Heart Disorder	☐ Heart Pacemaker	☐ Parathyroid Disease	☐ Venereal Disease
☐ Convulsions	☐ Heart Trouble/Disease	☐ Psychiatric Care	☐ Other: ______
☐ Yellow Jaundice	☐ Eating Disorder	☐ Radiation Treatments	

Comments ______________________

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian ______________________ Date ______________

TENNESSEE CENTERS FOR LASER DENTISTRY

CONSENT / AUTHORIZATION / ACKNOWLEDGEMENT

1. **I authorize Dr. Chad O. Edwards & Dr. Ryan Torti and Tennessee Centers for Laser Dentistry, hereafter referred to as "practice," to take necessary radiographs, study models, photos and other diagnostic aids as needed to make a thorough diagnosis.**

2. **I authorize this practice to perform all recommended treatment and agreed upon treatment. I also authorize the use of anesthetics, sedatives and other medication (as needed) and am fully aware that using anesthetic agents involves certain risks.**

HIPAA: Consent for Use and Disclosure of Health Information:

(Notice of privacy practices: You have the right to read this practice's Notice of Privacy Practices before you decide to sign this Consent. Our Notice of Privacy Practices provides a description of our treatment payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. Please read this Notice prior to signing this Consent. This practice reserves the right to change the privacy practices as described in our Notice of Privacy Practices. If changes are made, a revised Notices of Privacy Practices containing the modifications will be issued. These changes may apply to any of your protected health information that we maintain on file. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice at any time by contacting us at 615-595-8070, 3046 Columbia Ave., Ste 201, Franklin, TN 37064.

You have the right to revoke this Consent for use and Disclosure of Health Information at any time by giving us written notice of your revocation submitted to the Contact Person listed above. This revoke will not affect previous consent. We reserve the right to provide further treatment on your behalf or that of your dependents if this Consent is revoked.

10. **I have had the opportunity to review and obtain a copy of this practice's Notice of Privacy Practices. I hereby authorize, as indicated by my signature below, to use and disclose my protected health information to carry out treatment, payment activities and health care operations.**

Signatures below indicate that I have read this entire document and fully understand the contents of this Consent/Authorization/Acknowledgment. I have been provided with the opportunity to ask questions and obtain further clarification.

______________________________________ ____________________

Signature of Patient, Parent or Guardian   Date of Birth

Circle One: Adult Patient / Guardian / Personal Representative

If signature provided represents the patient's guardian or "personal representative" please complete the following:

____

Patient Name   Date of Birth

TENNESSEE CENTERS FOR
LASER DENTISTRY

FINANCIAL POLICY

Thank you for choosing our office as your dental health care provider. We are committed to providing you with the highest quality lifetime dental care, so that you may fully attain optimum oral health. Please understand that payment of your bill is considered part of your treatment.

Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, and Discover. Outside financing is available upon request and approval.

- **Please check if you would like more information about financing options.** ☐
- **Does your insurance have any waiting periods?** ☐ **Yes** ☐ **No** ☐ **I don't know**

Please note: Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance, you will be responsible for any collection and or legal charges incurred. A $30 charge will be billed to the patient for any no show or broken appointments with less than 24 hours notice for an office visit.

Do you have insurance?

- As a courtesy to you, we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you. However, it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible.
- All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer and your insurance company. Our office is not a party to that contract.
- Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payments regardless of any insurance company's arbitrary determination of usual and customary rates.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.
- We ask that you pay the deductible and co-payment, which is the estimated amount not covered by your insurance company, by cash, by check, MasterCard, Visa or Discover at the time we provide the service to you.
- Insurance payments are ordinarily received within 30–60 days from the time of filing. If your insurance company has not made payment within 60 days, we ask that you contact your insurance company to be sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into dispute with your insurance company over any claim.

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our financial policy.

I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office.

Signature of Patient, Parent or Guardian ____________________

Date of Birth ____________________

TENNESSEE CENTERS FOR LASER DENTISTRY

DENTAL HISTORY

Please check any of the following problems that apply to you.

- ☐ Sensitivity (hot, cold, sweet)
  Where? ☐ UR ☐ UL ☐ LR ☐ LL
- ☐ Headaches, earaches, neck pain
- ☐ Jaw joint pain
- ☐ Teeth or fillings breaking
- ☐ Grinding or clenching teeth
- ☐ Bleeding, swollen or irritated gums
- ☐ Loose, chipped or shifting teeth
- ☐ Bad breath or bad taste in your mouth

Do you have or have you had any of the following?

- ☐ Dentures
- ☐ Partial Dentures
- ☐ Braces
- ☐ Periodontal (gum) treatments

Please share the following dates:

Your last cleaning ____/____

Your last oral cancer screening ____/____

Your last complete X-Rays ____/____

Name of Previous Dentist

____

City ______________________________

State ______________________________

Phone Number ______________________________

What is the most important thing to you about your future smile and dental health?

____

If you could whiten your teeth for a cost anyone could afford, would you do it?

☐ Yes ☐ No

Do you smoke or use chewing tobacco? How much? For how long?

____

If you could change your smile, you would:

- ☐ Make my teeth brighter
- ☐ Make my teeth straighter
- ☐ Close spaces
- ☐ Replace black metal fillings with natural, tooth-colored fillings
- ☐ Repair chipped teeth
- ☐ Replace missing teeth
- ☐ Replace old crowns that don't match
- ☐ Have a smile makeover

On a scale of 1–10, with 10 being the highest rating:

How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

Where do you want your dental health to be?

1 2 3 4 5 6 7 8 9 10

Why did you leave your previous dentist?

____

____

What is the most important thing to you about your dental visit today?

____

____

______________________________ Signature of Patient, Parent or Guardian

______________________________ Date of Birth