PATIENT INFORMATION

Date_____

Title_____Patient Name _____
Last First Middle

Preferred Name_____ ☐ Male ☐ Female

Home Address_____ _____ _____ _____
Street, Box or Rural Route City State Zip

Home Phone (_____) _____ Cell Phone (_____) _____

Work Phone (_____) _____ E- Mail Address _____

Date of Birth _____ Social Security # _____

Employer Name and Address_____

(If Student) Grade Level _____School_____

Marital Status: Single____ Married____ Divorced ____ Widowed ____

If Married, Name of Spouse _____ Employer _____Work # (____)_____

Responsible Party (if other than self) _____
Last First Middle

Relation _____ Address_____ _____ _____ _____
(if different) Street City State Zip

Who should we contact in case of emergency?_____

Who may we thank for your referral? _____

What are your favorite hobbies and interests?_____

DENTAL INSURANCE INFORMATION

Do you have dental insurance (Y/N)? _____

Employee/Subscriber Name: _____
Last First Middle

Relationship to Subscriber _____ Group/Employer Name _____

Subscriber SSN: _____ Subscriber DOB: _____

Group # _____ Subscriber ID#: _____

Insurance Company _____ Telephone Number _____

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? ☐Excellent ☐Good ☐Fair ☐Poor

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1. hospitalization for illness or injury _____	☐	☐
2. an allergic or bad reaction to any of the following:	☐	☐
☐ aspirin, ibuprofen, acetaminophen, codeine		
☐ penicillin		
☐ erythromycin		
☐ tetracycline		
☐ sulfa		
☐ local anesthetic		
☐ fluoride		
☐ chlorhexidine (CHX)		
☐ metals (nickel, gold, silver, _____)		
☐ latex		
☐ nuts _____		
☐ fruit _____		
☐ other _____		
3. heart problems, or cardiac stent within the last six months ___	☐	☐
4. history of infective endocarditis _____	☐	☐
5. artificial heart valve, repaired heart defect (PFO) _____	☐	☐
6. pacemaker or implantable defibrillator _____	☐	☐
7. orthopedic implant (joint replacement) _____	☐	☐
8. rheumatic or scarlet fever _____	☐	☐
9. high or low blood pressure _____	☐	☐
10. a stroke (taking blood thinners) _____	☐	☐
11. anemia or other blood disorder _____	☐	☐
12. prolonged bleeding due to a slight cut (INR > 3.5) _____	☐	☐
13. pneumonia, emphysema, shortness of breath, sarcoidosis ___	☐	☐
14. chronic ear infections, tuberculosis, measles, chicken pox ___	☐	☐
15. asthma _____	☐	☐
16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus)	☐	☐
17. kidney disease _____	☐	☐
18. liver disease _____	☐	☐
19. jaundice _____	☐	☐
20. thyroid, parathyroid disease, or calcium deficiency _____	☐	☐
21. hormone deficiency _____	☐	☐
22. high cholesterol or taking statin drugs _____	☐	☐
23. diabetes (HbA1c = _____) _____	☐	☐
24. stomach or duodenal ulcer _____	☐	☐
25. digestive or eating disorders (e.g., celiac disease, gastric reflux, bulimia, anorexia) _____	☐	☐

	YES	NO
26. osteoporosis/osteopenia (i.e. taking bisphosphonates) ___	☐	☐
27. arthritis _____	☐	☐
28. autoimmune disease _____ (i.e. rheumatoid arthritis, lupus, scleroderma)	☐	☐
29. glaucoma _____	☐	☐
30. contact lenses _____	☐	☐
31. head or neck injuries _____	☐	☐
32. epilepsy, convulsions (seizures) _____	☐	☐
33. neurologic disorders (ADD/ADHD, prion disease) _____	☐	☐
34. viral infections and cold sores _____	☐	☐
35. any lumps or swelling in the mouth _____	☐	☐
36. hives, skin rash, hay fever _____	☐	☐
37. STI/STD/HPV _____	☐	☐
38. hepatitis (type ___) _____	☐	☐
39. HIV/AIDS _____	☐	☐
40. tumor, abnormal growth _____	☐	☐
41. radiation therapy _____	☐	☐
42. chemotherapy, immunosuppressive medication _____	☐	☐
43. emotional difficulties _____	☐	☐
44. psychiatric treatment _____	☐	☐
45. antidepressant medication _____	☐	☐
46. alcohol/recreational drug use _____	☐	☐
ARE YOU:		
47. presently being treated for any other illness _____	☐	☐
48. aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea) _____	☐	☐
49. taking medication for weight management _____	☐	☐
50. taking dietary supplements _____	☐	☐
51. often exhausted or fatigued _____	☐	☐
52. experiencing frequent headaches _____	☐	☐
53. a smoker, smoked previously or use smokeless tobacco ___	☐	☐
54. considered a touchy/sensitive person _____	☐	☐
55. often unhappy or depressed _____	☐	☐
56. taking birth control pills _____	☐	☐
57. currently pregnant _____	☐	☐
58. diagnosed with a prostate disorder _____	☐	☐

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)

_____

List all medications, supplements, and or vitamins taken within the last two years.

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

ASA _____ (1-6)

DENTAL HISTORY

Name_____ Nickname_____ Age_____

Referred by_____How would you rate the condition of your mouth? ☐Excellent ☐Good ☐Fair ☐Poor

Previous Dentist _____How long have you been a patient?_____Months/Years

Date of most recent dental exam _____/_____/_____ Date of most recent x-rays _____/_____/_____

Date of most recent treatment (other than a cleaning) _____/_____/_____

I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

	YES	NO
PERSONAL HISTORY		
1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [___]_____	☐	☐
2. Have you had an unfavorable dental experience?_____	☐	☐
3. Have you ever had complications from past dental treatment?_____	☐	☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic?_____	☐	☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age?_____	☐	☐
6. Have you had any teeth removed or missing teeth that never developed or lost teeth due to injury or facial trauma?_____	☐	☐
GUM AND BONE		
7. Do your gums bleed or are they painful when brushing or flossing? _____	☐	☐
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____	☐	☐
9. Have you ever noticed an unpleasant taste or odor in your mouth? _____	☐	☐
10. Is there anyone with a history of periodontal disease in your family? _____	☐	☐
11. Have you ever experienced gum recession? _____	☐	☐
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?_____	☐	☐
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth? _____	☐	☐
TOOTH STRUCTURE		
14. Have you had any cavities within the past 3 years?_____	☐	☐
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____	☐	☐
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____	☐	☐
17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?_____	☐	☐
18. Do you have grooves or notches on your teeth near the gum line? _____	☐	☐
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?_____	☐	☐
20. Do you frequently get food caught between any teeth?_____	☐	☐
BITE AND JAW JOINT		
21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____	☐	☐
22. Do you feel like your lower jaw is being pushed back when you bite your back teeth together?_____	☐	☐
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? _____	☐	☐
24. In the past 5 years, have your teeth changed (become shorter, thinner or worn) or has your bite changed?_____	☐	☐
25. Are your teeth becoming more crooked, crowded, or overlapped? _____	☐	☐
26. Are your teeth developing spaces or becoming more loose? _____	☐	☐
27. Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together?__	☐	☐
28. Do you place your tongue between your teeth or close your teeth against your tongue?_____	☐	☐
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____	☐	☐
30. Do you clench or grind your teeth together in the daytime or make them sore?_____	☐	☐
31. Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth?___	☐	☐
32. Do you wear or have you ever worn a bite appliance? _____	☐	☐
SMILE CHARACTERISTICS		
33. Is there anything about the appearance of your teeth that you would like to change (shape, color, size)?_____	☐	☐
34. Have you ever whitened (bleached) your teeth? _____	☐	☐
35. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____	☐	☐
36. Have you been disappointed with the appearance of previous dental work? _____	☐	☐

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Rippy Family Dentistry
661 Nashville Pike Gallatin, TN 37066
615-451-9300
www.gallatinfamilydentist.com

Office Authorization/Acknowledgement

Clinical

I authorize *Rippy Family Dentistry* referred to as "practice" hereafter, to take necessary radiographs, study models, photos and other diagnostic aids as needed to make a thorough diagnosis. I authorize photos and radiographs to be sent to referring providers and insurance companies.

I authorize this practice to perform all recommended 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.

_____
Initial

HIPPA: Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have read and understand the Notice of Privacy Practices provided to me by the practice. I understand that this notice will be in effect until further notice from the practice.

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.

_____
Initial

Authorization to Obtain Outside Medical Records

Rippy Family Dentistry has my authorization to request my Protected Health Information from another physician, hospital, dentist, or other personnel involved with my care in order to facilitate my treatment.

_____
Initial

Authorization to Reveal Medical and Billing Information

I authorize the practice and staff to reveal to the following individuals, as needed, information regarding my protected health information and billing information. I understand that once this information is disclosed to these individuals, the practice will not have responsibility over to whom these individuals reveal this information. I may revoke this authorization by giving written notice to the practice.

Name: _____ Relationship:_____

Name: _____ Relationship:_____

_____ _____
Print Name **Relationship**

_____ _____
Signature **Date**

Office Financial and Insurance Policy

Financial

We are committed to providing you with the highest quality of care. Our fees are a reflection of the quality of care we provide. We continue our commitment by offering a variety of financial options to enable you to receive the dental care you need. We accept cash, check, Visa and MasterCard debit cards, and Visa, MaterCard and Discover credit cards. We have also partnered with CareCredit* to provide outside financing options with up to 18 month payment plans with no annual fees or pre-payment penalties. Please be advised that while we gladly accept personal checks if your check is returned for any reason, we will charge your account a $25 processing fee.

Payment is expected at the time of service. A delinquent account impedes our ability to provide you with the quality dental care that you deserve. It is our policy that the parent or guardian who accompanies a child to our office for treatment is responsible for payment of all services rendered. In a continued effort to maintain completive prices a 1.5% MRP or 18% APR is automatically tabulated into an account with a balance over 60 days. It is unfortunate that failure to make payment when due is a basis for legal action. If an account is placed for collection the patient or responsible party will be held accountable for any and all cost for collections, including agency fees, attorney's fees and court costs.

We are committed to respecting your time and ask that you make every effort to keep the appointment time reserved exclusively for you. We understand there may be times when you are unable to keep your scheduled appointment, however any appointment missed may be subject to a missed appointment fee of $30. Should you find it necessary to reschedule an appointment, please provide us with a notice of 24 hours to avoid being charged a missed appointment fee.

I acknowledge that I am responsible for payment for all services rendered on my behalf and on behalf of my dependents. I have been informed of this offices financial policies described above.

_____
Initial

Insurance

Dental insurance is a contract between the patient and the insurance company. It is a benefit to assist you with the cost of dental care. We are happy to help submit your claims to receive the benefits of your coverage. However, we can make no guarantee of payment. If we do not receive payment from your insurance carrier within 90 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

Your estimated portion of the fee will be due at the time of service. If the insurance pays more than expected, a refund check will be sent to the responsible party on the account within 15 days of our office receiving the insurance payment. Please be aware that some of the services provided may not be covered, or will be considered above the usual and customary fees. At no time should insurance benefits compromise your doctor's diagnosis or affect your choice of treatment.

It is your responsibility to present accurate, current insurance coverage information at the time of check in. By signing below you are authorizing this practice to submit claims for payment for services rendered or pre-authorizations necessary to our insurance company, on your behalf and in your name listed as "signature on file" and assign to this practice the insurance benefits providing assignment is accepted. Furthermore you are authorizing the practice to release to staff, hospitals, health care service plans, insurance companies, self-insurers or their representatives, any and all information, records and radiographs about my medical history, services rendered and treatment necessary.

By signing below I acknowledge that I am responsible for payment of my account including but not limited to; deductibles, co-payments and any excess over the annual maximum regardless of any insurance company's arbitrary determination of fees.

_____ _____

Print Name **Relationship**

_____ _____

Signature **Date**