

# VONORE

D E N T A L  
P R A C T I C E , P . C .

Name: \_\_\_\_\_  
Last First MI Title

Preferred Name: \_\_\_\_\_ Male Female

Address: \_\_\_\_\_

SSN: \_\_\_\_\_ DOB: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Marital Status: Single Married Divorced Widowed Separated Domestic Partner

How did you hear about our office? \_\_\_\_\_

Do you prefer to be contacted for appointment confirmation via e-mail or phone? (Please circle preference)

### ■ Insurance – Primary ■

Subscriber Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Subscriber SSN/ID: \_\_\_\_\_ Subscriber DOB: \_\_\_\_\_

Subscriber Employer: \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

Insurance Company Phone: \_\_\_\_\_ Group Number: \_\_\_\_\_

### ■ Insurance – Secondary ■

Subscriber Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Subscriber SSN/ID: \_\_\_\_\_ Subscriber DOB: \_\_\_\_\_

Subscriber Employer: \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

Insurance Company Phone: \_\_\_\_\_ Group Number: \_\_\_\_\_

### ■ Assignment and Release ■

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Vonore Dental all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Date: \_\_\_\_\_



Please print name here:

\_\_\_\_\_  
 Last First MI

**Medical History**

Do you have a personal physician? Yes No

Physician's Name: \_\_\_\_\_ Physician's Phone: \_\_\_\_\_

Date of last visit: \_\_\_\_\_

Your current physical health is: Good Fair Poor

Are you currently under the care of a physician? Yes No

Please explain: \_\_\_\_\_

Do you use tobacco in any form? Yes No

Have you had any metal rods, pins or implants placed? Yes No

Are you taking any medications? Yes No

Please list each one: \_\_\_\_\_

Have you ever had any surgical procedures? Yes No

Please list each one: \_\_\_\_\_

Are you aware of heart Murmurs Yes No

Have you ever taken Fosamax, Zometa, Aredia or any other oral or intravenous treatment (bisphosphonates) for bone tumors, excessive calcium in your blood or osteoporosis? **(please circle prescription drugs taken)**

Have you taken any prescription drugs fenfluramine, fenfluramine combined with phentermine (fen-phen), dexfenfluramine (redux), or other weight loss products? **(please circle prescription drugs taken)**

Circle any Conditions that apply to you, the patient:

Yes	No	Yes	No	Yes	No
					Sickle Cell Disease
	Abnormal Bleeding		Glaucoma		Sinus Problems
	Alcohol Abuse		HIV+ AIDS		Stroke
	Allergies		Heart Attack		Thyroid Problems
	Anemia		Heart Surgery		Tuberculosis
	Angina		Pectoris Hemophilia		Ulcers
	Arthritis		Hepatitis A		
	Artificial Heart Valve		Hepatitis B		
	Asthma		Hepatitis C		
	Blood Transfusion		High Blood Pressure		
	Cancer		Joint Replacement		
	Chemotherapy		Kidney Problems		
	Colitis		Liver Disease		
	Congenital		Heart Defect		
	Diabetes		Low Blood Pressure		
	Difficulty Breathing		Mitral Valve Prolapse		
	Drug Abuse		Pace Maker		
	Emphysema		Psychiatric Problems		
	Epilepsy		Radiation Therapy		
	Facial Surgery		Rheumatic Fever		
	Fainting Spells		Seizures		
	Fever Blisters		Sexually Transmitted Disease		
	Frequent Headaches		Shingles		

Yes	No	Allergies
		Aspirin
		Codeine
		Dental Anesthetics
		Erythromycin
		Jewelry
		Latex
		Metals
		Penicillin
		Tetracycline

Yes	No	If Female, Please Answer
		Are you taking Birth Control Pills?
		Are you pregnant?
		If so, # of Weeks _____
		Are you nursing?

## Dental History

Name: \_\_\_\_\_  
Last First MI Title

Preferred Name: \_\_\_\_\_ Male Female

How may we help you today? \_\_\_\_\_

Your current dental health is:  Good  Fair  Poor

Do you require antibiotics before dental treatment?  Yes  No

Are you currently in pain?  Yes  No

Have you ever had gum treatment?  Yes  No

Do you now or have you had any pain/discomfort in your jaw joint? (TMJ)  Yes  No

Are you under stress? (new job,moving,relationships)  Yes  No

Do you like your smile?  Yes  No

Is there anything you would like to change about your smile?  Yes  No

Are you happy with the color of your teeth?  Yes  No

How many times a do you: floss/week? \_\_\_\_\_ brush/day? \_\_\_\_\_

Are your teeth sensitive to head, cold or anything else?  Yes  No

Have you lost any teeth?  Yes  No

Have you ever had a serious/difficult problem with any previous dental work?  Yes  No

Have you ever had any unfavorable dental experiences?  Yes  No

When was your last dental cleaning? \_\_\_\_\_

When was your last dental visit? \_\_\_\_\_

Why did you leave your previous dentist? \_\_\_\_\_

How can we accommodate you better during your dental visit? \_\_\_\_\_

Here at Vonore Dental we offer a wide variety of services to enhance and keep your smile beautiful. Please circle any services below you would like our friendly staff to discuss with you during your visit.

Tooth Whitening

Veneers

Invisalign

Smile Makeover

Bonding

Sealants

Crown and Bridge

Implant Crowns

Partials/Dentures

Night/Sport Guards

**Vonore Dental, P.C.**  
*Your Privacy Is Important to Us*

**Acknowledgement of Receipt of Notice of Privacy Policies  
(Adult)**

I have received a copy of the Notice of Privacy Practices of Vonore Dental, P.C. I hereby authorize, as indicated by my signature below, to use and to disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent form.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Please check all means of communication that apply / Include phone numbers:**

- You may contact me at my home telephone number \_\_\_\_\_
- You may contact me on my mobile telephone number \_\_\_\_\_
- You may contact me on my work telephone number \_\_\_\_\_
- You may send me an email at: \_\_\_\_\_
- You may also text my mobile telephone for appointment reminders.  
(Text and email reminders are a free of charge service offered to you for future appointments.)

Please list authorized persons with whom we may discuss your Protected Health Information (PHI) in addition to custodial parents and legal guardians:

1. \_\_\_\_\_ Phone# \_\_\_\_\_ Date Added / Removed: \_\_\_\_\_
2. \_\_\_\_\_ Phone# \_\_\_\_\_ Date Added / Removed: \_\_\_\_\_
3. \_\_\_\_\_ Phone# \_\_\_\_\_ Date Added / Removed: \_\_\_\_\_
4. \_\_\_\_\_ Phone# \_\_\_\_\_ Date Added / Removed: \_\_\_\_\_
5. \_\_\_\_\_ Phone# \_\_\_\_\_ Date Added / Removed: \_\_\_\_\_

\* \* \*

**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
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining the acknowledgement
- Other (Please Specify) \_\_\_\_\_

Staff Person Initials \_\_\_\_\_

## PATIENT CONSENT

### Clinical

1. I authorize Vonore Dental, P.C. to perform all recommended treatment.
2. I authorize the Practice to take radiographs, study models, photos, and other diagnostic aids or materials (collectively, "Diagnostic Material") as needed to make a thorough diagnosis. I authorize that such Diagnostic Material may be released to third-party payors and/or other health professionals.
3. I authorize the use of anesthetics, sedatives, and other medication, as needed, and am fully aware that using anesthetic agents involves certain risks, including but not limited to redness and swelling of tissues, pain, itching, vomiting, dizziness, miscarriage, cardiac arrest, drowsiness, and/or lack of coordination.

### Financial

4. I am responsible for payment for all services rendered on my behalf. **I understand that full payment is due when services are rendered.** I am aware that a 1.5% MPR or 18% APR automatically tabulated into my account if my balance is 30 days old or older. Should my account become delinquent, I will be responsible for all additional collection costs, including reasonable attorney fees.

### Missed Appointments

5. I am aware Vonore Dental requires a 24 hours notice of cancellation prior to my appointment. **Vonore Dental reserves the right to refuse to schedule appointments if a pattern of missed appointments without proper notice develops. I am aware after three missed appts without proper notice may result in dismissal from Vonore Dental.**

### Insurance

6. I authorize the Practice to release to staff, hospitals, health care service plans, insurance companies, self-insurers or their representatives, any and all information, records, and other Diagnostic Material about my medical history, services rendered, or recommended treatment.
7. I authorize the Practice to submit claims for payment for services rendered or pre-authorizations necessary to my insurance company, on my behalf and in my name listed as "signature on file" and assign to the Practice the insurance benefits providing assignment is accepted. I am responsible for payment regardless of coverage provided.
8. I understand that Vonore Dental participates in the following insurance plans: Blue Cross Blue Shield of Tennessee Preferred, and Delta Dental Premier. Most plans cover only a part of the dental fee, which means you are responsible for what your plan does not cover and any deductible. Many plans have exclusions and limitations, which will affect your out-of-pocket expense. **Please note that while we bill your insurance as a courtesy, it is ultimately your responsibility to understand the provisions and limitations of your policy.**

**I have read this Patient Consent and agree to all terms and conditions herein.**

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Patient's Address: \_\_\_\_\_