VONORE
D E N T A L
PRACTICE, 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**	
		Abnormal Bleeding			Glaucoma			Sickle Cell Disease
		Alcohol Abuse			HIV+ AIDS			Sinus Problems
		Allergies			Heart Attack			Stroke
		Anemia			Heart Surgery			Thyroid Problems
		Angina			Pectoris Hemophilia			Tuberculosis
		Arthritis			Hepatitis A			Ulcers
		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?

VONORE
DENTAL
PRACTICE, P.C.

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
(Minor)

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, Vonore Dental, P.C. 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 (MINOR)

Clinical

1. As the parent/legal guardian of ______________________ ("Patient"), I authorize **Vonore Dental, P.C.** to perform all recommended treatment on the Patient.

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 behalf of the Patient**.** **<u>I understand that full payment is due when services are rendered.</u>** I am aware that a 1.5% MPR or 18% APR is 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. **<u>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 appointments without proper notice may result in dismissal from Vonore Dental.</u>**

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 radiographs about the Patient's 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 or on Patient's 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 the 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. **<u>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.</u>**

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

Patient's Name: ____ DOB: ___________________________

Signature of Parent/Guardian: ______________________________________ Date: ____________________________

Relationship to Patient: ___________________________________ Address: _________________________________