FORD DENTAL
1740 Big Springs Road, Maryville TN, 37801

Personal Information

Patient Name_____

Preferred Name_____ Male_____ Female_____

Brithdate:_____/_____/_____ Age:_____ Social Security Number:_____

Mailing Address:_____City:_____

State:_____ Zip:_____ Home Phone: (_____)_____Work Phone:(_____)_____

Cell Phone: (_____)_____ Carrier:_____

E-mail Address:_____ Referred by:_____

Employer:_____ Occupation:_____

Employer Address:_____

Driver's License #:_____Status:__Minor__Single__Married__Divorced__Separated__Widowed

Spouse's Name:_____ Do you have children? __Yes __No

Dental Insurance Information

Company Name:_____

Address:_____

Phone: (_____)_____ ID#:_____ Group #:_____

Relation:_____

Emergency Contact Information

Whom should we contact?_____ Relation:_____

Home Phone:(_____)_____ Work Phone:(_____)_____Cell Phone:(_____)_____

Who is your Medical Doctor?_____Medical Doctor's Phone:(_____)_____

_____ Date:_____

Signature of Patient/Responsible Party of Minor

Adult and Family Dentistry
Health History

WOMEN ONLY:

Yes No Are you or could you be pregnant or nursing? Yes No Birth control?

I. EVERYONE: CIRCLE APPROPRIATE ANSWER (leave blank if you do not understand the question):

1. Yes No Is your general health good?
2. Yes No Are you in pain now?
3. Yes No Has there been a change in your health within the last year?
4. Yes No Have you been hospitalized or had a serious illness in the last three years?
   If YES, why? _____
5. Yes No Are you being treated by a physician now? For what? _____ Date? _____
6. Yes No Have you had problems with prior dental treatments? If so, what? _____

II. HAVE YOU EVER EXPERIENCED:

7. Yes No Chest pains (angina)?
8. Yes No Swollen ankles?
9. Yes No Shortness of breath?
10. Yes No Recent weight loss, fever, night sweats?
11. Yes No Persistent cough, coughing up blood?
12. Yes No Bleeding problems, bruising easily?
13. Yes No Sinus problems?
14. Yes No Difficulty swallowing?
15. Yes No Diarrhea, constipation, blood in stools?
16. Yes No Frequent vomiting, nausea?
17. Yes No Difficulty urinating or blood in urine?
18. Yes No Dizziness?
19. Yes No Ringing in ears?
20. Yes No Headaches?
21. Yes No Fainting spells?
22. Yes No Blurred vision?
23. Yes No Seizures?
24. Yes No Excessive thirst?
25. Yes No Frequent urination?
26. Yes No Dry mouth?
27. Yes No Jaundice?
28. Yes No Joint pain, stiffness?

III. DO YOU HAVE OR HAVE YOU HAD:

29. Yes No Heart disease?
30. Yes No Heart attack, heart defects?
31. Yes No Heart murmurs?
32. Yes No Arthritis, rheumatism?
33. Yes No Stroke, hardening of arteries?
34. Yes No High blood pressure?
35. Yes No Asthma, TB, emphysema, other lung diseases?
36. Yes No VD (syphilis or gonorrhea)?
37. Yes No Family history of diabetes, heart problems, tumors
38. Yes No HPV, other liver disease?
39. Yes No Allergies to drugs, food, medications, latex?*
40. Yes No AIDS/HIV+?
41. Yes No Tumors, cancer?
42. Yes No Rheumatic fever?
43. Yes No Eye disease?
44. Yes No Skin diseases?
45. Yes No Anemia?
46. Yes No Herpes? Hepatitis?
47. Yes No Stomach problems/ulcers?
48. Yes No Kidney/bladder disease?
49. Yes No Thyroid disease?
50. Yes No Diabetes??

PLEASE list all allergies: _____

IV. DO YOU HAVE OR HAVE YOU HAD:

51. Yes No Psychiatric care?
52. Yes No Radiation treatments? Chemotherapy?
53. Yes No High Cholesterol?
54. Yes No Prosthetic heart valve?
55. Yes No Artificial joint?
56. Yes No Hospitalization?
57. Yes No Blood transfusions?
58. Yes No Surgeries?
59. Yes No Pacemaker?
60. Yes No Contact lenses?

PLEASE list any disease or medical problem(s) NOT on this form: _____

_____

V. ARE YOU TAKING:

61. Yes No Recreational drugs?
62. Yes No Drugs/medications/over-the-counter medicines (including Aspirin)? Natural remedies?
63. Yes No Tobacco in any form?
64. Yes No Alcohol?

PLEASE list all meds you are currently taking _____

_____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any changes in my health and/or medication.

Patient's/Guardian's Signature _____ ***Date:*** _____

ADULT AND FAMILY DENTISTRY

RANDALL L. FORD, DDS
1740 BIG SPRINGS RD
MARYVILLE, TN 37801
(865) 681-7645

Notice of Privacy Practices

I understand that my healthcare information concerning my diagnosis, treatment, payment and insurance will be disclosed when necessary for filing my insurance, and in communicating with other health professionals in the course of my treatment of their offices. Limited information will also be disclosed to businesses supporting the operations of this office such as dental or medical labs, hospitals, accountant, computer support, billing personnel, answering services, and consultants. These businesses are restricted in the use and disclosure of your information by contract. Disclosure may also occur for any necessary legal purpose or appropriate governmental authorities. If a family member or person is paying for your healthcare with your knowledge, we may disclose information to that member or person.

I understand that my files are stored on shelves in the business office. Only staff and janitorial personnel may have access to this office during non-business hours. I understand that this office will make every effort to keep my information secure and correct any violation of my privacy if this should occur.

I understand that I have the right to access, copy or inspect and correct my healthcare information, the right to restrict disclosures and obtain an accounting of disclosures. I have the right to voice my concerns about privacy to the practice and/or the Secretary of Health and Human Services within 180 days of my discovery of a disclosure violation without fear of retaliatory acts by this office. I may correct my records in the form of a letter signed by me. I also have the right to revoke my authorization for disclosure. (A minimal fee or 20 cents per page will be charged to me for copies of records that I request)

I understand that I will receive communication in the form of phone calls and/or postcards to remind me of an existing appointment, or that it is time to schedule an appointment. I may receive mail containing financial information, such as ledgers or bills. Communication may also be sent to me in the forms of fax or e-mail or other electronic means. I understand that if a message is left for me to return a call, the message will contain the doctor's name and phone number. Complete messages concerning my health information may be left on my personal home or work voice mail.

I have read and understand this office policy. I understand that by signing this agreement, I give my permission for the use and disclosure of my personal and health information in order to carry out treatment, payment activities, insurance claims, and healthcare operations. This office retains the right to revise the privacy policy.

_____ **Date:__/__/____**

Signature of Patient or Responsible Party if Minor

I have read this form and do not wish to sign._____(Please Initial)

ADULT AND FAMILY DENTISTRY

RANDALL L. FORD, DDS
1740 BIG SPRINGS RD
MARYVILLE, TN 37801
(865) 681-7645

Patient Privacy Questionnaire

Patient's Name:_____ Date of Birth:__/__/____

1. May we leave medical information concerning you or your child with anyone answering the telephone at your home? YES_____ NO_____

2. May we leave information regarding appointments, return calls for test results, etc. regarding your or your child on your home answering machine or voice mail?

YES_____ NO_____

3. May we leave information with anyone answering the telephone regarding you or your child's appointments, lab results, or other healthcare information at numbers other than your home number?

YES_____ NO_____

If yes, please list number(s): (___) ___-_____; (___) ___-_____

4. If we are unable to reach you by any of the above options, may we leave confidential messages with health info about you or your child at your place of employment?

If we are unable to reach you by any other means, we will send information through the U.S. Postal Service to your home address that appears in your file.

_____ **Date:__/__/____**

Signature of Patient or Responsible Party if Minor

I have received a copy of Adult and Family Dentistry's Notice of Information Practices. I understand that this notice describes how my or my child's health information may be used or disclosed by the dentist and other providers practicing at Adult and Family Dentistry and I should read it carefully. I am aware that the notice many be changed at anytime. I may obtain a revised copy of the notice by requesting one at Adult and Family Dentistry office.

_____ **Date:__/__/____**

Signature of Patient or Responsible Party if Minor

ADULT AND FAMILY DENTISTRY

RANDALL L. FORD, DDS
1740 BIG SPRINGS RD
MARYVILLE, TN 37801
(865) 681-7645

THANK YOU FOR CHOOSING US AS YOUR DENTAL CARE PROVIDER. WE ARE COMMITTED TO YOUR TREATMENT BEING SUCCESSFUL. PLEASE UNDERSTAND THAT PAYMENT OF YOUR BILL IS CONSIDERED A PART OF YOUR TREATMENT. THE FOLLOWING IS A STATEMENT OF OUR FINANCIAL POLICY WHICH WE REQUIRE YOU READ AND SIGN PRIOR TO ANY TREATMENT.

***ALL PATIENTS MUST COMPLETE OUR INFORMATION AND INSURANCE FORMS BEFORE SEEING THE DOCTOR**
**WE ACCEPT CASH, CHECKS, CASH, CREDIT CARDS, CASH, MONEY ORDERS, CASH, CARE CREDIT, AND CASH.
*THERE IS A DOWNPAYMENT OF 50% FOR TREATMENT COSTING $200 OR MORE.

REGARDING INSURANCE
We bill your insurance as a courtesy to you. We cannot bill your insurance unless you bring in all insurance information and an original insurance claim (if your insurance requires one). Your insurance policy is a contract between you and your insurance company. We are not a party of that contract. If your insurance company has not paid your account in full within 45 days, that balance will be automatically transferred to you. Please be aware some and perhaps all of the services provided may be non-covered services and not considered reasonable and necessary under the dental program and/or other insurance. The balance is your responsibility whether your insurance company pays or not.

USUAL AND CUSTOMARY RATES
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 payment regardless of any insurance company's arbitrary determination of usual and customary rates. Note: In the case where we are forced to forward delinquent accounts to collection, all fees for this action will be added to your total amount due.

MISSED APPOINTMENTS
Unless canceled at least 24 hours in advance, our policy is to charge you for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments.

RETURNED CHECKS
If for any reason your check is returned for insufficient funds, a $30.00 service charge will be added to your account.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I have read the financial policy and I understand and agree to the financial policy. I authorize Randall L. Ford, DDS to give me reasonable and proper dental care by today's standards.

I MUST PROVIDE A COPY OF MY INSURANCE CARD OR CARDS. IF I FAIL TO DO SO I UNDERSTAND I WILL BE LIABLE FOR THE FULL BALANCE.

_____ **Date:__/__/____**
Signature of Patient or Responsible Party if Minor

_____ **Date:__/__/____**
Witness