





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 Are you aware of heart Murmurs? 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

Explain: \_\_\_\_\_

Have you ever had any surgical procedures? Yes No

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

Are you taking any medications? Yes No Please list each one: \_\_\_\_\_

Cont. \_\_\_\_\_

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)**

Do you snore? Yes No Do you get sleepy during the day? Yes No Sleepiness while driving? Yes No

Do you suffer from difficult to control hypertension? Yes No Has anyone seen you stop breathing while sleeping? Yes No

Have you ever taken a sleep study test or been advised to do a sleep study? Yes No If yes, when? \_\_\_\_\_

**Circle any Conditions that apply to you, the patient:**

- |                     |                      |                     |                       |                  |
|---------------------|----------------------|---------------------|-----------------------|------------------|
| Abnormal Bleeding   | Difficulty Breathing | HIV + AIDS          | Low Blood Pressure    | Sinus Problems   |
| Alcohol Abuse       | Drug Abuse           | Heart Attack        | Mitral Valve Prolapse | Stomach Problems |
| Anemia              | Emphysema            | Heart Disease       | Pace Maker            | Stroke           |
| Arthritis           | Epilepsy             | Heart Surgery       | Pneumocystis          | Thyroid Problems |
| Asthma              | Facial Surgery       | Hemophilia          | Radiation Therapy     | Tuberculosis     |
| Blood Transfusions  | Fainting Spells      | Hepatitis A,B or C  | Rheumatic Fever       | Ulcers           |
| Cancer Chemotherapy | Fever Blisters       | High Blood Pressure | Seizures              | Venereal Disease |
| Congenital Heart    | Frequent Headaches   | Kidney Problems     | Shingles              | Yellow Jaundice  |
| Diabetes            | Glaucoma             | Liver Disease       | Sickle Cell Disease   | Sleep Apnea      |

Organ/Valve/Joint/Replacement: Y N Type: \_\_\_\_\_ Date: \_\_\_\_\_

**Allergies (Please circle):** Aspirin \* Codeine \* Dental Anesthetics \* Erythromycin \* Jewelry \* Latex \* Metals \* Novocain

Penicillin \* Sulfur \* Tetracycline \* Other: \_\_\_\_\_

**If Female:** Are you pregnant? Yes No If so, # of weeks: \_\_\_\_\_ Are you nursing? Yes No Are you taking birth control? Yes No



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\_\_\_\_\_

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### Dental History

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 do you: Floss/week? \_\_\_\_\_ Brush/day? \_\_\_\_\_

Are your teeth sensitive to heat, 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

Sealants

Smile Makeover

Bonding

Custom Partial/Dentures

Night/Sport Guards

Surgical Implants & Implant Crowns

Crown and Bridge

**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	City	State	Zip
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.

### After Hours Emergency

5. In the event of an emergency after regular business hours a \$50.00 emergency fee will be charged for established patients in addition to the necessary treatment fees. Patients who are not established in the practice will be charged \$100.00 for an after hour emergency.

### Missed Appointments

6. 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 appointments without proper notice may result in dismissal from Vonore Dental.**

### Insurance

7. 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.
8. 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.
9. I understand that Vonore Dental participates in several insurance plans including but not limited to: Blue Cross Blue Shield of Tennessee Preferred, Delta Dental Premier/PPO, Cigna, Metlife and United Healthcare. 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: \_\_\_\_\_